Bundle Public Board Meeting 28 May 2021

	Agenda
	Final Public Board agenda 28 May 2021.docx
1	09:00 - Welcome, introductions and apologies
2	Declarations of interest (Brodie Clark)
3	Questions from members of the public (Brodie Clark)
	****Minutes adoption for approval****
4	Minutes of previous meeting and matters arising (Brodie Clark)
4.a	Minutes of the meetings held on 26 March 2021
	Item 4a Draft Public Board minutes 26 March 2021 V4 BC.docx
4.b	Actions' log: (Brodie Clark)
	Item 4b Public Board 28 May 2021 action log.doc
5	09:15 - Patient's story - CAMHS (Steph Lawrence)
6	09:35 - Chief Executive's report: including Covid-19 update (Thea Stein)
	Item 6 CEO Report May 2021.docx
7	09:45 - Committee Chairs' Assurance Reports:
7.a	Audit Committee: 16 April 2021 (Khalil Rehman)
	Item 7a Audit Committee assur report April 2021.docx
7.b	Quality Committee: 26 April 2021 and 24 May 2021 - verbal report (Helen Thomson)
	Item 7b QC Chairs assurance report April 2021.docx
7.c	Business Committee: 28 April 2021 and 26 May 2021 (verbal report) (Richard Gladman)
	Item 7c Business Committee Chairs assurance report April 2021.docx
8	10:00 - Performance brief and domain reports: April 2021 (Bryan Machin)
	Item 8 Performance Brief Cover Paper (Board) bm.DOCX
	Item 8i Performance Brief (Apr 2021) Board bm edit.DOCX
9	10:15 - Significant Risks and Board Assurance Framework (BAF) Summary Report (Thea Stein)
	Item 9 Significant risks and risk assurance report May 2021.docx
10	10:25 - Mortality reports (Ruth Burnett)
10.a	Quarterly report Q4 2020-21
	Item 10ai Mortality report Q4 20.21.docx
	Item 10ai(1) Appendix (1) ABU Mortality report Q4 Jan to March 21.pdf
	Item 10ai(2) Appendix (2) Childrens Mortality Group Q4 2020 21 Flash Report QAIG.pdf
10.b	Annual report 2020-21
	Item 10b Mortality annual report 20.21 final.docx
11	10:35 - Ageing well update (Sam Prince)
	Item 11 Ageing Well - May 2021.docx
12	10:45 - Health equity strategy update (Ruth Burnett)
	Item 12 Health Equity strategy cover paper Public Board Meeting.docx
	Item 12i Our health equity strategy v3.docx
	Item 12ii Health equity strategy implementation v4.docx
	Item 12iiiHealth equity strategy and implementation appendices.pdf
13	10:55 - Third sector strategy update (Sam Prince)
	Item 13 Third Sector Strategy Update - May 2021.docx
14	11:05 - Corporate governance report (Thea Stein)
	Item 14 Corporate Governance Report May 2021.doc
14.a	Board and committee effectiveness review
14.b	Audit Committee annual report 2020-21

14.c	Committees' terms of reference review
14.d	Register of sealings
15	11:20 - Chair's actions (Brodie Clark) Item 15 Chief Executive Chair's actions.docx
15.a	Telephony contract
15.b	Extra annual leave
16	11:25 - Leeds Primary Healthcare Collaborative -Disbanding the joint Committees in Common between the GP Confederation and Leeds Community Healthcare NHS Trust and creating a strategic forum (Thea Stein) Item 16 Disbanding the joint CIC between GP Confederation and LCH and creating a strategic forum.docx
17	11:35 - Compliance with NHS Provider Licence (self-certification) Item 17 Compliance with NHS provider licence 2020-21.docx
18	11:45 - Approved minutes and briefing notes for noting (Brodie Clark)
18.a	Audit Committee: 12 March 2021 Item 18a Audit Committee minutes 12 March 2021.docx
18.b	Quality Committee: 22 March 2021 and 26 April 2021 Item 18b QC minutes 22 March 2021.docx
18.c	Business Committee: 24 March 2021 and 28 April 2021 Item 18c BC Minutes 24 March 2021.docx
18.d	West Yorkshire Mental Health Services Collaborative Committees in Common – 22 April 2021 Item 18d PUBLIC_WYMHSC Committees In Common Meeting Notes 22.04.2021 FINAL.pdf
18.e	West Yorkshire and Harrogate Integrated Care System Mental Health, Learning Disability and Autism Committee In Common – 22 April 2021 Item 18e WYMHSC Committees in Common_AAA Report_22.04.2021 FINAL.pdf
19	11:50 - Board workplan (Thea Stein) Item 19 Public Board workplan 2021-22 v1 27 04 2021.pdf
20	11:55 - Any other business
21	12:00 - Close of the Board meeting held in public (Brodie Clark)

Agenda Board Meeting held in public
Virtual meeting and live streamed

Date	28 May 2021
Time	9:00 - 12:00
Location	Microsoft Teams

AGENDA

1	**Welcome, introductions and apologies**
(9.00)	*(Brodie Clark)*
2	**Declarations of interest**
	(Brodie Clark)
3	**Questions from members of the public**
	(Brodie Clark)
4	**Minutes of previous meeting, action log and matters arising**
	(Brodie Clark)
4.a	Minutes of the meetings held on 26 March 2021
4.b	Actions' log
5	**Patient's story: CAMHS**
(9.15)	*(Steph Lawrence)*

QUALITY AND DELIVERY

6	**Chief Executive's report: including Covid-19 update**
(9.35)	*(Thea Stein)*
7	**Committee Chairs' Assurance Reports**
(9.45)	
7.a	Audit Committee: 16 April 2021
	(Khalil Rehman)
7.b	Quality Committee: 26 April 2021 and 24 May 2021 (verbal report)
	(Helen Thomson)
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	(Richard Gladman)
8	**Performance brief and domain reports: April 2021**
(10.00)	*(Bryan Machin)*
9	**Significant Risks and Board Assurance Framework (BAF) Summary Report**
(10.15)	*(Thea Stein)*
10	**Mortality reports**
(10.25)	*(Ruth Burnett)*
10.a	Quarterly report Q4 2020-21
10.b	Annual report 2020-21
11	**Ageing well update**
(10.35)	*(Sam Prince)*

NHS
Leeds Community Healthcare
NHS Trust

STRATEGY

12 **Health equity strategy (for approval)**
(10.45) *(Ruth Burnett)*

13 **Third sector strategy update**
(10.55) *(Sam Prince)*

SIGN OFF /APPROVAL

14 **Corporate governance report**
(11.05) *(Thea Stein)*
14.a Board and committee effectiveness review
14.b Audit Committee annual report 2020-21
14.c Committees' terms of reference review
14.d Register of sealings

15 **Chair's actions**
(11.20) (Brodie Clark)
15.a Telephony contract
15.b Extra annual leave

16 **Leeds Primary Healthcare Collaborative -** Disbanding the joint Committees in Common between the GP Confederation and Leeds Community Healthcare NHS Trust and creating a strategic forum
(11.25) *(Thea Stein)*

17 **Compliance with NHS Provider Licence (self-certification)**
(11.35) *(Thea Stein)*

FOR NOTING

18 **Approved minutes and briefing notes for noting**
(11.45) *(Brodie Clark)*
18.a Audit Committee: 12 March 2021
18.b Quality Committee: 22 March 2021
18.c Business Committee: 24 March 2021
18.d West Yorkshire Mental Health Services Collaborative Committees in Common – 22 April 2021
18.e West Yorkshire and Harrogate Integrated Care System Mental Health, Learning Disability and Autism Committee In Common – 22 April 2021

19 **Board workplan**
(Thea Stein)

20 **Any other business**
(11.55) *(Brodie Clark)*

21 **Close of the board meeting held in public**
(12.00) *(Brodie Clark)*

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (4a)

Title: Draft Trust Board meeting minutes 26 March 2021

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
	Professor Ian Lewis	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 Stuart Murdoch	Deputy Executive Medical Director (deputising for Dr Ruth Burnett)
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Khalil Rehman	Associate Non-Executive Director
	Rachel Booth	Associate Non-Executive Director
	Diane Allison	Company Secretary
	Amanda Jackson	0-19 Clinical Team Manager Outer East Team (for Item 132)
	Dr Nagashree Nallapeta	Guardian for Safe Working Hours (for Item 137)
Minutes:	Liz Thornton	Board Administrator
Observers:	Em Campbell	Health Equity Lead, Leeds Community Healthcare NHS Trust
	Stuart Morrison	Healthwatch Leeds
Members of the public:	None present	

2020-21 (128)

Discussion points

Welcome introduction, apologies and preliminary business

The Chair of Leeds Community Healthcare opened the public Trust Board meeting and reminded members and attendees that the meeting was live streamed and could be accessed via a link on the Trust's website.

He welcomed Em Campbell, Health Equity Lead, Leeds Community Healthcare NHS Trust and Stuart Morrison, Healthwatch Leeds who were both attending as observers, Amanda Jackson, 0-19 Clinical Team Manager Outer East Team who was attending to support the patient story item and a parent who had agreed to give a personal perspective on the Trust's 0-19 service.

Apologies

Apologies were received and accepted from Dr Ruth Burnett, Executive Medical Director and Jenny Allen, 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 said that pressure on the Trust services continued but it was also a time of high commitment; great adaptation and important opportunity. He placed on record his thanks to members of the Board and all staff throughout the Trust who had done so much to sustain the quality, the relevance and the consistency of the Trust's services.

He particularly recognised two recent events. Firstly, John Walsh and Kulvant Sandhu who richly deserved their winner's award at the recent Health Service Journal Event - for their contribution within the Trust and further afield, in the Freedom to Speak up category and equally as important to acknowledge that it reflected on the focus that the Trust placed on 'speaking up' and 'calling out' across an organisation which strived to ensure that everyone had a voice and was listened to. Secondly, appreciation to the team, led by Heather Thrippleton for being a runner up in the system led support for carers category.

The time and context was also marked by the impending transfer of the Little Woodhouse Hall CAMHS inpatient services to Leeds and York Partnership NHS Foundation Trust (LYPFT). An important occasion and one that the Trust believed to be in the best interests of this increasingly complex and very challenging group of patients. He expressed thanks to all those staff who had given so much to that unit and contributed to handing over a positive 'going concern' to LYPFT.

The pace of work continued and against a backcloth of a quite outstanding vaccination program and a Trust, undergoing a significant transformation alongside the development of the Integrated Care System and the Integrated Care Partnership and the Trust would play an important role in defining and the shaping of the arrangements for both of these governance domains.

Item 2020-21 (129)

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.

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2020-21 (131)

Discussion points:

a) Minutes of the previous meeting held on 5 February 2021

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

b) Items from the actions' log

Item 2020-21 (116): *Health and Safety Executive's inspection report* - the report had been shared with newly appointed non-executive directors. **Action closed.**

Item 2020-21 (117): *the new performance management dashboard to be shared with Non-Executive (JM)*- completed. **Action closed**

Item 2020-21 (115): *increasing the level of assurance to the Board about safe staffing levels* - the Executive Director of Nursing and Allied Health Professionals advised that a more robust method of reporting safe staffing levels would be developed over the next 12 months with the aim of providing more assurance to the Board.

The Chair asked for an update on progress to be made to the Board as part of the next safe staffing report in August 2021.

Item 2020-21 (132)

Discussion points:

Patient's story

The Executive Director of Nursing and Allied Health Professionals introduced the patient's story item and welcomed a parent who had agreed to talk about his perspective of the Trust's 0-19 Public Health Integrated Nursing Service (PHINS, Health Visiting Service). Amanda Jackson, Clinical Team Manager from the service was also welcomed to the meeting.

He began his story by proving some background to his family life and career. He said that before becoming a parent his expectation was that he would be treated as if he had equal responsibility for his child alongside his partner and he had taken an equal role in all aspects of parenting his daughter since her birth in 2015.

He said that he had many positive things to say about the 0-19 service:

- appointments for routine checks were well organised and were arranged as close to home as possible
- staff were knowledgeable and had an excellent rapport with children and parents
- the mix of staff was ethnically diverse
- responses to questions were well thought through and advice was clear, well researched and appropriate to family circumstances.

From his personal perspective the primary focus was on the female parent and an assumption made from the start that she undertook most of the responsibility for parenting. He said that he had felt excluded from conversations and if he did contribute his answers were double checked with his partner.

He particularly wanted to make the Board aware of his concerns in relation to the offer of a safeguarding check. He said that this was offered to his partner but not to him and he questioned why this was when men could equally be victims of domestic violence. He felt that this was a missed opportunity but acknowledged that this was reflected across all services both nationally and locally.

The Trust Chair thanked the parent for attending the Board meeting and sharing his personal story and perspectives and invited Amanda Jackson to tell the Board what changes had been implemented as a result of this feedback.

Amanda said that the service acknowledged a number of the issues which had been raised and changes had already been made:

- a parent carer group had been established to discuss how changes could be made with membership to include both parents
- a parental (rather than maternal) mental health pathway had been established where both parents were supported independently
- correspondence about children was addressed to both parents
- practitioners were trained about the importance of both parents
- the service was working with external organisations to ensure that it met the needs and expectations of families including both parents.

The Executive Director of Nursing and Allied Health Professionals observed that the story provided learning for services across the whole organisation in recognising gender equality in terms of parental responsibility. Work would begin across the Trust to address these issues including the importance of offering safeguarding checks to both parents and steps were being taken to develop a policy on this.

Non-Executive Director (AL) said that it was important to embrace the idea that men could also be victims of domestic violence and abuse. She said that there were also many areas where men would benefit from support including for example after their partner had suffered a miscarriage.

Non-Executive Director (IL) said that health professionals often failed to recognise individuals within families during consultations and needed to think more carefully about their approach.

The Director of Workforce, Organisational Development and System Development (LS) said that the Trust was in the process of developing a domestic violence and abuse policy for staff and a working group had been set up specifically for male members of staff as a safe space for them to discuss issues which were of concern to them.

The Trust Chair thanked the parent for attending the Board meeting and for providing his feedback on the service and he welcomed the proactive response which had already resulted from his constructive feedback.

Item 2020-21 (133)

Discussion points:

Chief Executive's report –including Covid-19

The Chief Executive presented her report particularly highlighting:

- Covid response
- HSJ Award: Speaking Up Organisation of the Year
- Post pandemic ways of working
- Leeds integrated staff training offer
- Leeds integrated research governance, management and delivery service

The Chief Executive provided a verbal update on the vaccination programme.
in Leeds. The key vaccination figures were:

- Infection rates in Leeds were now below 100 per 100k
- Over 300k vaccinated – 44% of the registered population
- Outreach work across the city has been nationally recognised as excellent and was gaining more momentum every day:
    - Re-furbished library buses had been particularly successful in reaching individuals who were harder to reach including those not registered with a general practice.
    - Dispelling vaccination myths by working and encouraging take–up in communities by engaging with leaders to spread the message.

- The Care Home Silver Group continued to meet and there was a protocol in place to ensure that visiting professionals have been tested before visiting. Three care homes in the city

currently had active Covid-19 outbreaks.

- On 17 March 2021 the Freedom to Speak Up Team, led by John Walsh and Kulvant Sandhu, won the prestigious Health Service Journal (HSJ) Award for Speaking up Organisation of the Year; recognised for their work to build an effective and caring speaking up culture in the Trust and across the wider system.

Non-Executive Director (IL) said that it was pleasing to read about the focus on developing the research capability in primary care including consideration of some judicial investment in this area but he questioned where research leaders would be drawn from.

The Deputy Executive Medical Director said that a number of initiatives were being considered and he suggested that a discussion outside the meeting might be helpful to explain the plans to develop a research leadership group in more detail.

Associate Non-Executive Director (RB) was pleased to see that the work of the Freedom to Speak Up Team had received national recognition and asked what more could be done to reinforce the open culture messages across the Trust.

The Chief Executive said that promoting and fostering a caring speaking up culture within a listening and hearing organisation was fundamental to the Trust and was an integral part of the induction programme for all staff.

Outcome: the Board

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

Helen Thomson joined the meeting

Item 2020-21 (134)

Discussion points:

Assurance reports from sub-committees

a) – Audit Committee 12 March 2021

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

- **Internal Audit**: the committee received an update on the current status of the remaining audits, which were being completed and noted that sufficient progress had been made against the 2020/21 internal audit programme for the internal auditor to provide an interim opinion that the overall audit opinion for the Trust would be 'reasonable'.

  The Committee also approved the 2021/22 internal audit plan which had been developed in consultation with the Senior Management Team, and reviewed by the Business and Quality Committees.
- **External audit update**: the Committee had received the external auditor's strategy for the year ending 31 March 2021 which summarised Mazars audit scope, approach and timeline.
- **Annual report and accounts 2020/21:** the Committee received an update on progress with the Trust's annual report, accounts and associated activities. All were proceeding to schedule.

b) – Quality Committee – 22 February 2021 (written report) and 22 March 2021 (verbal report)

The reports were presented by the Deputy Chair of the Committee and Non-Executive Director (HT). A verbal report was provided from the meeting on 22 March 2021 and the key issues discussed were highlighted, namely:

- **Clinical Governance:** a further deep dive was taking place in relation to the increase in Serious Incidents across Podiatry. At its next meeting the Committee will receive a paper in relating to the increase in deaths in Leeds Mental Wellbeing Service and how this is being

managed.

- **Quality Improvement Plan (CQC):** the majority of 'must do' actions had been completed with the remaining scheduled for completion by May 2021.

c) – Business Committee – 24 February 2021 and 24 March 2021 (verbal report)
The reports were presented by the Chair of the Committee (RG). A verbal report was provided from the meeting on 24 March 2021and the key issues discussed were highlighted, namely:

- **Reset and recovery:** the Committee received a high level view of the cross-cutting workstreams within the Reset and Recovery Programme. These included: virtual consultations, backlogs and waiting lists, self-management, internal integration, reset of admin review, adapting call centres and offices, and safe working environments and staff wellbeing.
- **Leeds Sexual Health system replacement:** the Committee received an options appraisal for a new electronic patient record system to replace the existing one which was considered no longer fit for purpose. The Committee approved the recommended option: to implement SystmOne as the new electronic patient record system within that service.
- **Backlog maintenance:** the Committee reviewed a report on the current position with backlog maintenance of the estate and was advised of the risk-based approach that had led to a significant reduction in the overall backlog.

d) – Charitable Funds Committee 26 February 2021
The report was presented by the Trust Chair and Chair of the Committee (BC) who highlighted the key issues discussed namely:

- **Charitable development updates:** the new organisational structure arrangements were in place and the Charitable Funds Operational Group meets every month and includes representation from the Trust' Youth Board.
- **Finance report:** the Committee received a finance report which showed that the current value of Charitable Funds was over £200,000. Some of this was already committed but £150,000 was still available.
- **Bid for funds:** the Committee reviewed a bid for funds for staff lunches to support health and wellbeing. As the value exceeded £25,000 the bid required Board approval and would be considered as part of the agenda for this meeting.

e) – Nomination and Remuneration Committee 26 February 2021
The report was presented by the Trust Chair and Chair of the Committee (BC) who highlighted the key issues discussed namely:

- **Very Senior Managers (VSM) Pay Award:** the Committee approved the nationally negotiated VSM salary increase for the 20/21 financial year of 1.03% - backdated to 1 April 2020.
- **Clinical Excellence Awards:** the Committee noted that there would be no scheme running in 2020/21 and there was an ongoing consultation in the future of the scheme.

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

Item 2020-21 (135)

Discussion points:
Performance Brief and Domains Report: February 2021
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.

The report was structured in line with the Care Quality Commission (CQC) domains with the addition of finance.

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 February 2021.

The Board reviewed the February 2021 performance data which had also been reviewed in depth by the Quality and Business committees on 22 and 24 March 2021 respectively.

The Trust Chair invited questions on the performance pack.

Safe
No questions raised.
Caring
No questions raised.
Effective
No questions raised.
Responsive
Associate Non-Executive Director (KR) asked for more background on the 159 children waiting for Paediatric Audiology.

The Executive Director of Operations explained that this was a service that was paused by national direction in wave one. This decision affected two areas of performance, firstly the 6-week diagnostic target and if patients have not been referred on the agreed pathway by this time the 18-week waiting time target. The Audiology service was now operational and able to provide a similar number of appointments as prior to the pandemic. The service is fully staffed but there is insufficient capacity to address the backlog. A business case is being discussed with commissioners in relation to recruiting more staff.

Well-Led
No questions raised.

Finance
Non-Executive Director (HT) asked if the 2020/21 national agreement linked to overtime pay entitlements in respect of holiday pay under the NHS terms and conditions of service would have a significant impact on the Trust's finances.

The Executive Director of Finance and Resources said that provision for this had been included in the forecast outturn position and would not impact on the Trust achieving its financial targets this year.

Outcome: the Board:

- noted the levels of performance in February 2021.

Item 2020-21 (136c)

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 are 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 Child and Adolescent Mental Health Services, the third strongest was the functionality of Information Technology (IT) software and the fourth staff safety.

The Board noted changes to the risk register as follows:

- One risk that previously scored 15 (extreme) had been deescalated to a score of 12(high):
  - Coronavirus (Covid-19) increase in infection rates
- Eleven risks scoring 12 (very high)

The Trust Chair observed that it was helpful that the Committees were now evaluating

assurance by strategic risk, rather than for each paper and noted the assurance levels provided in the reports presented at Item 134b and 134c.

The Trust Chair noted the escalated risk related to Community Dental Services and asked what more could be done to mitigate the risk.

The Executive Director of Operations explained that the risk related to no ongoing access for complex children to be seen for a specialist opinion because the Trust had not been able to fill the vacancy for a consultant paediatric dental specialist. She said that following escalation further discussions were planned between the Trust, Commissioners and the Leeds Dental Institute to develop a clear plan.

Non-Executive Director (IL) said that he was concerned that more account was taken of business risk than factors around risks to clinical safety and that this needed to be better understood and described for all risks. The point was noted and recognised.

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 (137)

Discussion points:
Guardian for Safe Working Hours (GfSWH) – quarterly report
The Trust Chair welcomed Dr Nagashree Nallapetta to the meeting as the newly appointed GfSWH and invited her to present the report for 2020-21 Quarter 3. The GfSWH explained that the purpose of the report was to provide the Board with assurance that trainee doctors and dentists working within the Trust are working safely and in a manner compliant with the 2016 Terms and Conditions of Service.

The Board reviewed the report noting; there were no exceptions to report during Quarter 3, the challenges around the engagement and training experience of paediatric trainees, the work by the GfSWH to address this and the engagement of Junior Doctors in the Junior Doctors Forum.

Outcome: the Board

- agreed to support the GfSWH in her new role
- agreed to support the GfSWH and Deputy Medical Director in the work underway to understand the impact of the on-call rota on community paediatric training without reliance on exception reports
- recognised the work underway to engage trainee doctors and dentists within the Trust and to promote the role of the GfSWH.

Item 2020-21 (138)

Discussion points:
2020 Staff Survey Results
The Director of Workforce, Organisational Development and System Development (LS) presented the report which provided the Board with an update on the 2020 Staff Survey organisational results, outlined in summary what staff have said about working in the Trust and set out how the Trust proposed to use the intelligence from the results.

Associate Non-Executive Director (KR) suggested that the results in some areas, for example bullying, harassment and the data on disability required further exploration.

The Chief Executive said that these areas would be a key focus for discussion at the Trust Board workshop in May 2021.

Non-Executive Director (AL) said that it was important to recognise that the Staff Survey results did not always reflect how staff really felt. She cited as an example feedback from BAME staff at a recent Network meeting she had attended where staff clearly felt that improvements needed to be made in the area of career progression for BAME staff.

The Chief Executive said that this would be an area of focus in 2021 which would also include a review of the initiatives that had already led to improvements in BAME career progression and the next steps to further narrow the gap with the rest of the Trust' workforce.

Outcome: the Board

- noted the release of the 2020 Staff Survey results
- endorsed the proposed approach to the management and dissemination of the information and its implications.

Item 2020-21 (139)

Discussion points:

a) Digital Strategy

The Executive Director of Finance and Resources presented the report which provided an update on the implementation of the Digital Strategy. Noting that the Business Committee had received and reviewed the update report In February 2021 and concluded that reasonable progress was being made on the delivery of the strategy.

The Trust Chair sought assurance that the strategy would be responsive enough to support the reset and recovery agenda.

The Executive Director of Finance and Resources said that he believed that the strategy was flexible enough to respond and support the reset and recovery of services. He added that in the long term it was difficult to predict what would be required nationally and locally in the fast moving digital environment.

Outcome: the Board

- noted the update on the implementation of the Digital Strategy.

b) Engagement Strategy update report

The Executive Director of Nursing and Allied Health Professionals presented the six monthly update on the Trust's Engagement Strategy, highlighting that progress had been maintained on implementing the Engagement Strategy operational plan despite the difficulties presented throughout the Covid-19 pandemic. It was noted that the team had worked well with partners in the city for example Patient Voices and Healthwatch.

Associate Non-Executive Director (KR) thought that the strategy understated its positive impacts and suggested that there could be a better balance between qualitative and quantitative information in the strategy.

The Director of Nursing and Allied Health Professionals said that update had been reviewed in depth by the Quality Committee where there had been discussion about outcomes in terms of demonstrating impact and an agreement that these should be referenced more explicitly in the strategy, including the link to Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) feedback from staff.

The Board agreed that the Strategy should include more detail about the work being undertaking across different services in the Trust, what patients and families contributed and also how it connected with the Trust's other strategies. They believed that there would be benefit in a more outcome focussed piece of work.

Outcome: the Board

- noted the update report

- approved the plan to work with services to develop a two year plan to support the ongoing implementation of the Engagement Strategy.

c) Workforce Strategy

The Director of Workforce, System Development and Organisational Development (LS) presented the bi-annual update on the delivery of year two of the Workforce Strategy. She said that the update acknowledged those areas that had experienced a level of pause or reduction in pace during the Covid-19 pandemic, as well as those areas that had accelerated or undergone transformation during the same period.

The paper also set out draft plans for the development of the Trust's next Workforce Strategy including a timeline for stakeholder engagement which the Board was being asked to approve.

Non-Executive Director (RG) referred to the plan to present a new Workforce Strategy to the Board in October 2021 and asked whether this would be achievable.

The Director of Workforce, System Development and Organisational Development (LS) recognised that to develop a new plan by October 2021 might be a challenge but believed that it would be possible.

Outcome: the Board

- noted the update report
- agreed the draft plans and timeline for the development of a New Workforce Strategy.

The Trust Chair observed that the interconnection between projects and strategies across the organisation needed to be clearer and this might benefit from a further off line conversation with the Chief Executive.

Item 2020-21 (140)

Discussion points:

a) Revenue and Capital Budgets 2021/22

The Executive Director of Finance and Resources presented the report which described the Integrated Care System (ICS) and Trust's approach to the allocation distribution and setting of the Trust's revenue and capital budgets for 2021/22.

He acknowledged that there was a high level of uncertainty concerning the financial regime beyond Quarter 2 2021/22 but the Board was being asked to approve service and departmental expenditure budgets totalling £179.8m prepared on the basis described in the paper.

A Non-Executive Director (JM) queried the underlying deficit of £2.5m. The Executive Director of Finance and Resources referred to the table in page 5 of the document and said that numbers assumed that the financial system would be able to flow funds to LCH to match the commissioning decisions made by NHS Leeds CCG. However, he noted that the underlying deficit did not assume settlement of the £2.7m of issues outstanding between the Trust and the CCG when covid led to contract agreement processes being suspended. However, he said that the £2.7m would flow to the Trust in the first half of 2021/22 under the proposed continuing emergency financial regime.

The Executive Director of Finance and Resources outlined the position with backlog maintenance said that high and significant risks in 2020/21 had been addressed through the capital programme. There were now no items which were considered high risk in the estate which required immediate rectification.

Outcome: the Board

- approved a revenue expenditure budget of £179.8m and initial capital budgets of £3.7m.

b) 2020/22 Strategic framework

The Executive Director of Finance and Resources introduced the report which presented the draft 2021/22 Strategic Framework for approval. He explained that the annual planning and commissioning process for financial year 2021/22 had not taken place in accordance with national guidance issued in December 2020 to 'stand down' these processes due to Covid pressures, and extend Covid Reset and Recovery planning into Quarter 1 2021/22. The priorities would be reviewed once the national planning guidance was issued.

The framework had been reviewed at both the Business and Quality Committees.

Non-Executive Director (RG) asked how the strategic goals and priorities would be communicated to staff.

The Chief Executive said that she intended to record a vlog after the Easter break and provide a brief at the Trust's Leaders Network which would be cascaded to staff.

Non-Executive Director (HT) said that the Quality Committee had asked for the language in the report to be amended to include and refer to 'patients and citizens'.

Outcome: The Board

- approved the 2021/22 Priorities subject to any changes required following receipt of the NHS Planning Guidance.

c) Draft Key Performance Indicators for Performance Brief 2021/22

The Executive Director of Finance and Resources presented the report which proposed amendments to the 2020/21 Key Performance Indicators (KPIs) for inclusion in the Performance Brief. He said that the proposals to the Board were made following scrutiny, amendment and agreement at the Business and Quality Committees.

The Board noted that the KPIs were being proposed in the absence of the NHS planning guidance and for this reason proposals for further revision may be brought to the Board and committees as the year progressed.

Outcome: the Board

- approved the proposed initial 2021/22 KPIs.

Item 2020-21 (140d)

Discussion points:

Revisions to the Board Assurance Framework (BAF) strategic risks

The Company Secretary presented the report and led members through the suggested revisions to the strategic risks associated with the Trust's strategic objectives and priorities. She explained that the revisions had been reviewed by the Senior Management Team (SMT) following the required annual review.

Outcome: the Board

- reviewed the BAF strategic risks and approved the changes required for the 2021/22 version of the BAF.

Item 2020-21 (141)

Discussion points:

Integrated Care Partnership (ICP) in Leeds

The Chief Executive presented the paper which had been written by the Leeds Health and Care Partnership Executive Group (PEG) to seek approval of a city wide approach to the development of an ICP in Leeds. The paper contained five recommendations which Boards and executive teams across the city were being asked to agree.

The Chief Executive reminded members that the ICP development plans had been discussed in

detail at the Board workshop in January 2021 and at various informal Board member group meetings prior to this Board meeting.

Board members made the following comments and observations on the recommendations and the paper:

- Recommendation 1 - Strategic indicators related to Health Outcome Ambitions
  - A shared ambition for children between birth and 11 should be included and something specifically about 'school readiness'.
- Recommendation 4 – co-ordinating /integrating set of capabilities
  - Clearer narrative about what this means in reality
  - Clarity on who will fund the expertise and technical support required to develop these capabilities.
- Next steps – timetable – concern about whether the timetable leading up to formal sign off allowed sufficient time for boards to properly review the development of the proposals.
- ICPs are already well established in some ICSs and it would be useful to understand and benchmark proposed architectures with others.
- Where does the "primacy" lie in the various strategies and how will they align in future.

Subject to the comments and observations above the Board agreed that in principle the recommendations represented a sensible way forward.

Outcome: the Board

- agreed in principle to the five recommendations presented in the paper subject to the inclusion of the suggestion related to Recommendation 1 about Health Outcome Ambitions and consideration of the other comments made by members. The Chief Executive will formally communicate the Board's concerns to the ICP development group.

Item 2020-21 (142)

Discussion points:

a) Going concern report

The Executive Director of Finance and Resources presented the Going Concern Consideration. He explained that the matters covered in the paper had been considered by the Audit Committee at its meeting on 12 March 2021 and the paper had been updated to reflect comments made at that meeting.

Non-Executive Director (JM) as Chair of the Audit Committee confirmed that she had reviewed the changes made to the statement following the discussion on 12 March 2021 and she was content to support that the Board agreed the recommendation in the paper.

Outcome: the Board

- agreed the preparation of the annual accounts for 2020/21 on a going concern basis.

b) Declarations of interest and compliance with the fit and proper person requirements made by the directors for 2020/21

The Chief Executive presented the report which contained the director's declarations of interest schedule of disclosures for 2020/21, confirmation that 'fit and proper person test' declarations had been made and other additional annual background checks completed.

Outcome: the Board

- noted the declarations made by for 2020/21 (in draft) with no amendments offered

Item 2020-21 (143)

Discussion points:

Charitable Funds – application for funding

The Executive Director of Nursing and Allied Health Professionals presented the application for funding and explained that the Charitable Funds Committee could approve bids for funds up to a

value of £25,000. The total value of the bid set out in the application was £26,700 for wellbeing hampers, lunches and fruit for staff and required approval by the Trust Board.

The Board noted that the bid had been discussed and recommended for approval by the Charitable Funds Committee.

Outcome: the Board

- approved the bid for £26,700 for wellbeing hampers, lunches and fruit for staff.

Item 2020-21 (144)

Discussion points:
West Yorkshire Mental Health and Learning Disabilities and Autism Committee review of the Memorandum of Understanding (MoU)
The Chief Executive presented the refreshed MoU for approval following discussions at the Committees-in-Common (CinC) meeting of Chairs and Chief Executives held on 21 January 2021.

The changes recommended for agreement further strengthened the governance arrangements for the CinC meetings.

Outcome: the Board

- received and approved the refreshed MoU
- noted the use of the 'Triple A' assurance report which will be used to summarise CinC meetings to Trust Boards; and
- noted that a more substantial review of the MoU would be commissioned by the CinC when appropriate.

Item 2020-21 (145)

Discussion points:
The Executive Director of Finance and Resources shared a visual presentation which briefed the Board on the proposal for a new telephony contract arranged with Virgin Media for the provision of a cloud based telephony service across the Trust for five years.

The contract value was £962,350 over five years with a total saving of £172K over the term of the contract.

He asked the Board to agree to formal approval of the contract being made by the Trust Chair and Chief Executive under 'Urgent Decision' Powers.

Outcome: the Board

- received and noted the information in the briefing and agreed that formal approval of the contract could be made by the Trust Chair and Chief Executive under the 'Urgent Decisions'procedure.

Item 2020-21 (146)

Discussion points:
Review of interim governance arrangements
The Trust Chair reminded members that in December 2020 the Board had agreed to a temporary amendment to the governance arrangement in order that the Trust could achieve its strategic objectives, comply with its statutory duties and maintain good governance whilst faced with challenging circumstances resulting from the pandemic.

The agreement was that the amended governance arrangements would be reviewed no later than the 31 March 2021.

The Board discussed the current pressures on the Trust and the wider health system and agreed that these had reduced sufficiently for the Trust to revert to its usual governance framework.

Outcome: the Board

- agreed that the current pressures and on the Trust and the wider health system had reduced sufficiently for the Trust to revert to its usual governance framework.

Item 2020-21 (147)

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

a. Audit Committee: 15 January 2021
b. Quality Committee: 25 January 2021
c. Business Committee: 27 January 2021
d. West Yorkshire and Harrogate Health and Care Partnership – Committees in Common (CiC)
    - Update to Boards 21 January 2021
    - Minutes 21 January 2021
    - Escalation and assurance report 21 January 2021
    - Briefing note West Yorkshire Adult Secure Provider Collaborative
e. Scrutiny Board Adults Health Active Lifestyles: 9 February 2021
f. Non-Executive Director/CEO Update meeting notes 17 February 2021

Outcome: the Board

- noted the minutes and reports.

Item 2020-21 (148)

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 (149)

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 12.09pm

Date and time of next meeting
Friday 28 May 2021, 9.00am – 12.00noon
Virtual meeting and live streamed

AGENDA ITEM 2021-22 (4b

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 28 May 2021

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting 26 March 2021				
	None to note			

Actions on log completed since last Board meeting on 26 March 2021	
Actions not due for completion before 28 May 2021; progressing to timescale	
Actions not due for completion before 28 May 2021; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 28 May 2021; not having met agreed timescales and/or requirements	

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (6)

Title: Chief Executive's Report

Category of paper: For assurance

History: Not applicable

Responsible director: Chief Executive
Report author: Chief Executive

Executive summary (Purpose and main points)

This report updates the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest.

This month's report focusses on:

- Covid response
- Health and Safety Executive spot-check
- Funding for research in the community
- Returning to work – developing a hybrid model

A further verbal update will be provided at the Board meeting, including the most up to date figures on infection rates.

Recommendations

Note the contents of this report and the work undertaken to drive forward our strategic goals

1 Introduction

This report updates the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest. The report, which aims to highlight areas where the Chief Executive and senior team are involved in work to support the achievement of the Trust's strategic goals and priorities: delivering outstanding care in all our communities, staff engagement and support, using our resources efficiently and effectively, and ensuring we are working with key stakeholders both locally and nationally.

2 Current position on the key areas of Trust's involvement in managing the Covid pandemic:

A verbal update will be provided at the Board meeting.

3 Health and Safety Executive COVID-secure spot check

The Trust is committed to ensuring that staff, patients and visitors are as safe as possible. Throughout the pandemic the Trust has continued to adapt its working environment to manage the risk posed by coronavirus. The Trust has a dedicated Safe Working Environment Group, which is supported by the Risk and Safety Team, and the Group has been responsible for ensuring the Trust has the right measures in place to keep staff safe whilst they work, and to remind staff and managers of the need to observe these measures.

The Health and Safety Executive (HSE) is currently carrying out spot checks and inspections on businesses to ensure they are COVID-secure. They are doing this by calling, visiting and inspecting all types of businesses, in all areas, to check the measures they've put in place are in line with the current guidance.

The HSE completed a Covid-19 spot check of the Trust on 17 May 2021 and confirmed that it was satisfied the Trust has put suitable and sufficient measures in place and the HSE will be taking no further action.

4 Returning to work – developing a hybrid working model.

Work is underway to formulate the Trust's approach to ways of working beyond the pandemic. It follows the successful implementation of remote working and virtual practices in many areas of the organisation during the past 15 months. Titled 'Hybrid Working', this work is bringing together international research with feedback and experiences shared by the Trust's workforce. Initial indications are that a blended model incorporating remote working and in-base working is likely to be adopted. Approaches are expected to vary according to the individual nature of roles and services; and it is likely that many areas of the organisation will not return exactly to pre-pandemic ways of working.

5 Integrated Care System / Integrated Care Partnership

The ICP and ICS both continue to develop. Myself and the Chair continue to play full roles in their development as part of the ICS steering groups, executive groups and the ICP development board. Others across the Trust are involved in particular aspects of the work related to the development of governance, financial models, clinical leadership and the role of community services and flow. Papers have been shared with Non-Executive Directors throughout this period and they are engaged in groups in the ICS. We continue to work to have an ICP Board in place by the autumn and the ICS fully established for April 2022 with all processes and structures to support both in place. As key decisions need to be made the Board will, of course, be fully involved in this. Both are exciting and important developments to ensure that we can work in an even more integrated way in the future and better serve our communities

6 Funding for research in the community

The Trust successfully completed a 12 month scoping project to determine the feasibility of an integrated research governance, management and delivery system in Leeds which would support research in the community. This was undertaken in response to recognition of the importance of the impact of left shift in research delivery and, despite a clear desire, low research engagement in primary care in the Leeds area. The Trust has now been awarded a further £87k of Clinical Research Network strategic funding for the continuance of work towards an integrated place based research delivery model in Leeds that is feasible for adoption by other place based health systems.

The National Institute for Health Research (NIHR) Clinical Research Network has committed to revising the model for Leeds as vanguard for the region, and has presented to both national and regional forums the intention for this revision to be influenced by the LCH led project. The NIHR have also accepted our recommendation that the Trust focussed performance metrics on which funding allocations are based poses barriers to collaboration and integration, and will work with us to develop a performance framework that will remove these barriers, and actively encourage integration.

7 Board development workshop

Our May 2021 Board development workshop was led by the Director(s) of Workforce, and focussed on organisational culture and engagement, as the Trust strives to bring about the best working circumstances for its workforce. As part of developing the Trust's new Workforce Strategy, due for launch in late autumn 2021, the workshop sought the input and influence of the Board and organisational leaders for its direction of travel. The two main topics: Staff Survey 2020 and Cultural Change gave the workshop attendees an opportunity to consider more broadly our approach to leadership, protected characteristics and employee voice and the output of the workshop will strongly influence our new workforce strategy.

8 Black Inclusion Week

Black Inclusion Week raises awareness of the importance of Black inclusion and creates a platform for change to enable true equality for people of African and Caribbean descent. To raise awareness of Black Inclusion Week, the Trust invited Race Equality Network members and allies to reflect on inclusion at Leeds Community Healthcare NHS Trust. A series of blogs called '5 reflections, 5 days' offered individual reflections from five members of staff as a black person working for the NHS.

9 Website Accessibility Compliance

All 210 NHS Trust websites are audited monthly by Silktide Index, with the aim of understanding the degree of compliance by each trust with legislation such as: *Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018.* The audit focuses on accessibility criteria such as colour contrast, PDF accessibility and mobile accessibility.

In May 2021 Leeds Community Healthcare NHS Trust's website received a rating of 70 (Good), a vast improvement of the Trust website rating of 45 (Poor), in November 2020. The Trust is performing well in comparison to other Trusts that have been audited, although it is not yet in the top 30 trusts.

This improvement comes as a direct result of the Communication Team actively working to implement changes to increase accessibility, working alongside the Trusts website provider, and services working together with the Communications Team to make sure that their content is accessible.

10 Infection Prevention Control (IPC) Clinical Fellow with NHSE/I

Liz Grogan, our Head of Infection Prevention Control, has attained a 12 month part time secondment as an Infection Prevention and Control (IPC) Clinical Fellow with NHSE/I. This opportunity will bring some great value back in to the Trust as well as across national Infection Prevention and Control.

11 Steph Lawrence appointed National Professional Advisor for Adult Community Services at CQC

Steph Lawrence (Executive Director of Nursing and Allied Health Professionals) has been appointed to work with the CQC as the National Professional Advisor for Adult Community Services on a part time basis from April 2021. She will do this alongside her Director of Nursing and Allied Health Professionals role within the Trust. This is a great opportunity to help shape how CQC inspect and monitor community services now and in the future.

12 Recommendations

The Board is recommended to note the contents of this report and the work undertaken to drive forward our strategic goals.

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (7a)

Title: Audit Committee Chair's Assurance Report 16 April 2021

Category of paper: for assurance
History: Not applicable

Responsible director: Audit Committee Chair
Report author: Audit Committee Chair

Meeting summary

Internal audit

The Committee noted progress with the 2020/21 internal audit plan. The Committee discussed the executive summary and strategic findings for the three audits completed since the last Committee meeting. The Payroll audit had been determined reasonable assurance with two important recommendations relating to the storing of electronic starter and leaver forms and the timely completion of payroll related forms by managers. The Patient Engagement audit had been determined substantial assurance with two routine recommendations related to information published on the Trust's website including promoting news of improvements following feedback from service users. For the Waiting Lists audit, the Committee noted that this was an operational rather than an assurance review therefore no assurance assessment was provided. The Committee reviewed the findings from the review and agreed that they did not provide sufficient information or assurance that the Trust was managing waiting lists diligently enough to mitigate the risks to patients.

The Head of Internal Audit reported that they anticipated being able to provide an overall opinion of reasonable assurance once two final audits had concluded and they were committed to having all the outstanding audits completed and presented to the Committee by 7 June 2021 with the audit opinion being confirmed at that meeting.

Annual report and accounts 2020/21

The Committee was advised of the Trust's progress with the finalisation of the Trust's annual report, accounts and associated activities. The Committee noted the revised timescales for completion of the annual report and accounts. The external auditors confirmed that they had completed some interim audit work and there were no concerns.

Board sub-committees' annual reports 2020/21

The Audit Committee's draft annual report was received and agreed that it accurately reflected the Committee's activities for the year. The Committee's terms of reference were reviewed, and it was agreed that some minor changes needed to be made to reflect the Committee's role in providing assurance to the Board on information governance and data security matters.

The Committee also received the annual reports of the Board's other sub-committees as part of the Committee's role in reviewing the effectiveness of governance. The annual reports were approved.

Counter fraud risk assessment and annual work plan

The Counter Fraud Specialist presented the plan, which provided details of the proposed provision of counter fraud work across the Trust for 2021/22. The work plan was risk-based but was also aligned to the Government functional standard, which replaces the NHS Standards for Providers from April 2021. The assessment did not identify any high risks to the Trust.

Information Governance Group meeting minutes

The Committee noted the minutes from 14 January 2021 and requested further information when the implications are known for the flow of personal data between the EU and the UK after the extended deadline of 30/06/2021 and how compliance will be maintained after this date**.**

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (7b)

Title: Quality Committee Chair's Assurance Report 26 April 2021

Category of paper: For Assurance

History: N/A

Responsible director: Executive Director of Nursing and Allied Health Professionals (AHPs)

Report author: Assistant Director of Nursing and Clinical Governance

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Executive summary:

This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 26th April 2021, and it indicates the level of assurance based on the evidence received by the Committee. This meeting was held by MS teams.

Items discussed:

Covid-19 update
An update was provided by the Executive Director of Nursing and AHPs and the Executive Director of Operations. It was reported for the first time since the start of Covid-19 there are no care homes reporting outbreaks. A positive picture in relation to vaccines was reported with 50% of the population having had their first dose and 20% having had both doses.

Reset and recovery
The Committee received a verbal update from the March position from the Executive Director of Operations. Key points to note were:

- Increasing waits for therapy across tow Neighbourhood Teams, related to prioritisation issues rather than capacity and is being addressed within the transformation project
- The data reflecting 0-19 service waits are not true waits and are as a result of delays in data validation
- Podiatry waits remains a concern however additional clinics are in place to increase capacity and following clinical prioritisation of referrals all waiters are low priority with plans to promote self-management and involvement of third sector support following next appointments.

Learning Disability (LD) update
The report was presented by the LCH LD Lead. The report provided a highlight of the key areas acknowledging pockets of excellent practice both in LCH and across organisational boundaries. It was reported that the Trust is not yet meeting the requirements of the LD standards which have to be embedded by 2023. Once full findings are received from the national audit an improvement plan will be developed to address shortfalls. It is expected this will require some significant improvement activity, specifically around autism.

0-19 update
The paper was presented by the Executive Director of Nursing and AHP's. A Public Health England endorsed approach to recovery of the gaps in the current vaccination regime due to school closures related to Covid-19 was acknowledged. The aim is to be caught back up to the regular schedule by the summer of 2022.
This noted the delay in second HPV vaccinations and the requirement to administer three vaccinations at one visit to young people. The latter will be supported with appropriate communications for parents and the young people.

In relation to the Health Visitor vacancies it was confirmed that work is underway to address this by exploring substantive and CLASS staff with Health Visitor qualifications to support the service; a review of skill mix in the service and successful recruitment which is to be expedited where possible. Conversations with the third sector will be considered. The revised 0-19 offer with the removal of ante-

natal visits is being worked through with partners. It was agreed that the service is data rich and this will be used to agree the offer / revised offer.

WYOI update
A verbal update was presented by the Executive Director of Nursing and AHPs who reported a de-escalation of behaviours and the movement of 1 young person since last Committee, however the young person at greatest risk remains in WYOI. This has continued to be escalated nationally and clinical decisions regarding the appropriate placement for this young person are being challenged by the Trust. The Executive Medical Director reported that following the STEIS reporting this has been picked up nationally by the Healthcare Safety Investigation Bureau (HSIB) who will not pursue this however they have discussed this with the national GIRFT lead for Children and Young Persons Mental Health as a wider, and known, issue.

Service spotlight: LMWS
The spotlight was delivered by three LMWS head of service colleagues, reflecting the service which has been fully operational for a year. Below captures the headlines of the current service acknowledging a model review is underway.

- **IAPT**: It was reported that referrals have increased significantly through autumn with 18% of people accessing from the most deprived fifth of Leeds. Health inequalities are being monitored and addressed as this is slightly below the target of 20%
  Significant improvement in access rates and waiting times were noted, against both the contractual target and previous access associated with the former IAPT service, specifically with regards the initial assessment. The exception to this is the wait for CBT, which is currently at 9 months. This is due to a combination of increased demand; some pause of service related to Covid-19 and an increasing length and complexity of the client group. Actions are in place to address these waits, and this includes additional recruitment and contract planning conversations.
- **The Primary Care Mental Health service** has been fully rolled out since August 2020 with a notable increase in referrals, particularly in 17-21 year olds, which is being factored in to the 2020/21 contract planning. The referrals reflect 34% of service users accessing from the most deprived fifth of Leeds and 14% identified as Black and Minority Ethnic (BME) groups.
- An update was provided on **Incidents and unexpected deaths** providing assurance that unexpected deaths over the last 12 months have been reviewed. An increase in deaths (10 from 6 in 2019/20 and 2018/19) have been reported however it is to be noted this is also reflective of the increase in the service population and therefore proportionate. Whilst there is a West Yorkshire and Harrogate target to reduce suicides by 10%, which is not being met across the system, it was also noted that there has not been an increase in suicides over the last 3 years, including during the pandemic.

Digital strategy
The paper was presented by the Executive Medical Director and received positively by the Committee as a means of keeping abreast of the priorities within this strategy.

Risk Register report
The paper was presented by the Chief Executive. The mobile device management was clarified as this is different to the lone worker safety app. It was confirmed this is the process for quality assuring the use and roll out of apps and restricting the downloading of any unapproved apps to phones.

Pressure Ulcer annual report
The paper was presented by the Executive Director of Nursing and AHP's. The paper was well received as an update of work over the last 12 months. It was agreed that capacity in the Neighbourhood Teams was not reflected within the report despite being an identified challenge in wider conversations. It was confirmed this is being addressed in the wider Neighbourhoods transformation work and this will be reflected in the report.

Health Equity strategy
The Executive Medical Director presented the report and was joined by the Health Equalities Lead providing an updated iteration following discussion at Business Committee and Board. Comprehensive feedback was provided by Committee members to inform the next iteration, including consideration of a Trust Programme Board.

Declarations of interest
The paper was presented by the Company Secretary and a couple of errors were noted for correction.

Board Assurance Framework
The paper was presented by the Chief Executive and Company Secretary and noted the addition of one strategic risk around health inequalities. This was accepted by Committee.

Recommendations
The Board is recommended to note this information.

The Quality 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 1.1 Does the Trust have **effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards?**	• Clinical Audit • Risk register • Pressure Ulcer annual report • Deep dive in to LMWS deaths	Reasonable assurance	Data provided in relation to the current picture of LMWS deaths provided reasonable assurance however the wider reduction of suicides across the system remains a concern
Risk 1.2 Are there **sufficient clinical governance arrangements in place for new care models?**	• LMWS progress and learning • Digital strategy	Reasonable assurance	
RISK 1.3 Is the Trust maintaining **and continuing to improve service quality**?	• Reset and Recovery update • Covid update • 0-19 Service: Immunisation programme update • WYOI / Adel Beck update • Pressure Ulcer annual report	Limited / Reasonable assurance	WYOI/Adel Beck issue remains a concern despite reasonable assurance that appropriate actions have been taken within the Trust. Committee agreed until greater assurance regarding appropriate placements this would remain limited assurance. Some uncertainty remains in relation to the 0-19 revised offer and therefore currently limited assurance
RISK 1.4 Is the Trust **engaging patients and the public effectively?**	• Learning Disability Update • Service spotlight: LMWS	Reasonable assurance	
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 update • 0-19 service offer	Reasonable assurance	

RISK 1.6 Is the Trust **optimising its services to reduce the impact of health inequalities**, and has it appropriate data to understand and address this?	• Health Equity Strategy • Reset and Recovery update • Learning Disability report • Digital strategy	Reasonable assurance	

Leeds Community Healthcare NHS Trust

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (7c)

Title: Business Committee Chair's assurance report 28 April 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 28 April 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 and the latest information on the vaccination programme.

Health Equity
The Committee reviewed the current draft of the Health Equity Strategy. The Committee agreed that it was a well written document and that having year by year implementation plans would help the Trust stay focussed. The Committee agreed that the oversight arrangements for the strategy would need to be agreed by the Board to avoid repetitious conversations in committees. It was suggested that a baseline and targets were needed to acknowledge the current position and where improvements were required. There was concern expressed about how this strategy may be perceived by non-priority groups.

Reset and Recovery: Wait lists
The Committee received an overview of the current waiting list position by business unit, a summary of the waiting list assurance work undertaken by the Reset Programme Team, an introduction to the Improving Patient Flow and Prioritisation Programme, and a case study (a patient 'walk through' of the Musculoskeletal Service (MSK) opt-in process conducted by the Reset Programme Team). The services with a current upward trajectory included neighbourhood teams, Child Development Centres, Paediatric Neuro-disability, Children's Speech and Language Therapy, Adult Speech and Language Therapy, and Podiatry. The reasons for the waits were given as well as the actions being taken to improve the situation.

Leeds Mental Wellbeing Service (LMWS)
The Committee was presented with a report that provided information on the performance of the Leeds Mental Wellbeing Service particularly in relation to promoting health equity. It also provided a snapshot of the work being undertaken with people who use/have used the service. The performance information showed the significant improvement in access over the last year despite the challenges brought about by the pandemic. The service remained open to referrals throughout the year whilst swiftly moving to a digital first model. Face to face consultation where indicated continued to be available. Recovery rates were slightly under target (target was 50%, actual rate was 48.8%). Waiting times had shown a significant improvement. The service has developed a health inequalities plan focused on improving access, experience and outcomes for clients, in particular those affected by health inequalities. The Committee was concerned about the low level of older people accessing the service, in comparison to other age groups and learned that the service was exploring the barriers to access.

Virtual Ward (Frailty)
The Committee was presented with progress against the agreed milestones, the service's development plan and a summary of its performance to date. There had been 758 patients admitted to the service and bed days saved equated to 3696. The admission rate to hospital was 15%. The cost per intervention was currently lower than the average cost of a hospital admission and there was a positive return on investment (for every £1 spent, approximately £2.22 was being saved). Areas that still required improvement were meeting the 2 hour response time (currently 74%) and data quality. There was also an increase in the complexity of patients being referred to the service and some mitigation was being planned to manage this.

Health and Safety Compliance Report
The Committee received an update on the progress with the Health and Safety executive action plan. The plan is regularly monitored by the Health and Safety Group and there has been significant progress made. There were however a few areas that were not progressing as quickly as planned. This was in part because of the effect of the pandemic. It was recognised that there had been a cultural shift in managers' attitudes to health and safety over the last year, with managers more involved in creating and monitoring safe working environments for their staff, assessing the Covid risks to staff who were extremely clinically vulnerable and supporting them to work safely, and providing safe home-working environments. The Committee was advised that a business case was being developed regarding Moving and Handling training to progress some of the actions further.

Performance Brief
The Committee noted that in the responsive domain there had been two 52 week breaches, which had been an administrative oversight and the process had been improved to avoid such mistakes in future. In the Well led domain, overall sickness levels were positive, but there were some teams with levels of sickness that were a cause for concern.

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 • Operational and non-clinical risks register • Reset and Recovery • Report on LMWS service take-up • Virtual Ward (Frailty) update • Internal Audit- wait lists	Reasonable	The Committee received assurance that the Trust was delivering against its obligations for the Leeds Mental Wellbeing Service (LMWS) contract.
RISK 2.5 Is the Trust delivering on its agreed **income and expenditure** position?	• Performance brief and domain reports (Finance) • Internal Audit – COVID Financial Governance • Quarterly finance report	Substantial	The Committee reviewed the likely year-end financial position and the strong likelihood of achieving the targets set
RISK 3.1 Does the Trust have **suitable and sufficient staff capacity and capability** and is it maintaining a low level of **sickness absence**	• Performance brief and domain reports (turnover and sickness) • Covid update • Reset and Recovery • Update on Statutory Mandatory Training audit actions	Reasonable	This was a mixed picture – there were service areas with reduced capacity and some with increased referral rates. Overall the risk was being managed well.
RISK 3.5 Has the Trust developed and embedded a suitable **health and safety management system**?	• Health and Safety Executive compliance report • Performance brief and domain reports (staff RIDDOR incidents)	Reasonable	
RISK 3.6 Is the Trust maintaining **business continuity** in the event of significant disruption?	• Reset and recovery • Covid update	Reasonable	Useful analysis provided that indicated an improving position within the City.

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (8)

Title: Performance Brief

Category of paper: for assurance
History:
Senior Management Team 19 May 2021
Quality Committee 24 May 2021
Business Committee 26 May 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 on performance against the KPIs for the year agreed by the Board. The Board was, and remains, aware that performance against the KPIs will continue to be impacted by the Covid-19 pandemic but anticipates that where performance against KPIs has been adversely impacted, improvement towards targets will improve during the year. The report seeks to explain where there has been an adverse impact.

In the 'safe' section the report highlights the Trust's responses to analysis of incident reporting that had identified potential issues concerning medications in one Neighbourhood Team, meatal tears following a change of practice in another Trust and discharges from Leeds Teaching Hospitals.

An Improvement Plan is being initiated for Podiatry following reporting of a relatively high number of incidents related to foot ulcers

Key learning from 3 Serious Incidents is highlighted. Learning and good practice identified from other incident reviews is noted.

This month the 'caring' section discusses the action a number of services are taking in response to feedback received. Good practice from some services' engagement with their patients is noted. MSK and the Stroke Team are developing focus groups and semi-structured telephone interviews to inform service improvement. Engagement Champions are mapping the current patient and carer groups across the organisation.

There are no 'effective' issue to highlight as these are only reported quarterly.

In the 'responsive' section, issues on waiting times are highlighted with explanations as to the recovery actions being taken. Details of the Improving Patient Flow and Prioritisation (IPFP) programme that has been initiated are presented. A case study from MSK shows one way a service with waiting pressures caused by Covid has responded with learning that can be applied in other areas of the Trust.

Overall, the 'well-led' KPIs show a good and improving story which is encouraging given the pressure many staff have been under and continue to be so. The continued under-performance on appraisals reflects the position that was consciously permitted during the height of the pandemic. All teams have now been encouraged to restart appraisals were they were paused in response to service pressures.

No formal summary financial report has been produced for April due to the late agreement of the financial regime for the first half of 2021/22 and the subsequent allocation of resources. An overview of financial performance suggests no cause for concern under the current financial regime for the first 6 months.

Recommendations

The Board is recommended to note the performance against KPIs

Performance Brief – April 2021

Leeds Community Healthcare NHS Trust

This report seeks to provide assurance to the Senior Management Team, Business Committee, the Quality Committee and the Trust Board on performance against the KPIs for the year agreed by the Board.

The Board is aware that performance against the KPIs will continue to be impacted by the Covid-19 pandemic throughout the year but anticipates that where performance against KPIs has been adversely impacted, improvement towards targets will improve during the year. Where there has been an adverse impact the report seeks to explain.

Main Issues for Consideration

The report highlights the Trust's responses to analysis of incident reporting that had identified potential issues concerning medications in one Neighbourhood Team, meatal tears following a change of practice in another Trust and discharges from Leeds Teaching Hospitals.

An Improvement Plan is being initiated for Podiatry following reporting of a relatively high number of incidents related to foot ulcers

Key learning from 3 Serious Incidents is highlighted. Learning and good practice identified from other incident reviews is noted.

The Patient Safety Team are now attending the Preceptorship Training to embed the LCH safety and learning culture.

This month the Performance Brief discussed the action a number of services are taking in response to feedback received. Good practice from some services engagement with their patients is noted. MSK and the Stroke Team are developing focus groups and semi-structured telephone interviews to inform service improvement. Engagement Champions are mapping the current patient and carer groups across the organisation. 4 tablets have now been awarded to carers supporting someone to access LCH services/accessing LCH services

The Patient Experience Team continue to attend the Preceptorship Training to embed the LCH engagement and learning culture.

There are no 'effective' issue to highlight as these are only reported quarterly.

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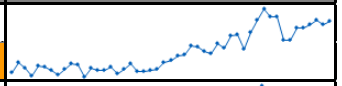
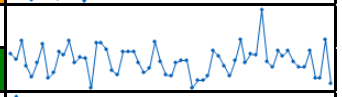
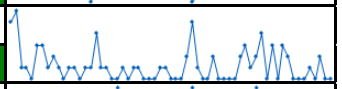
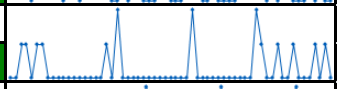
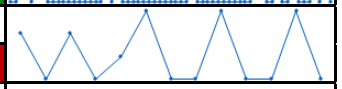
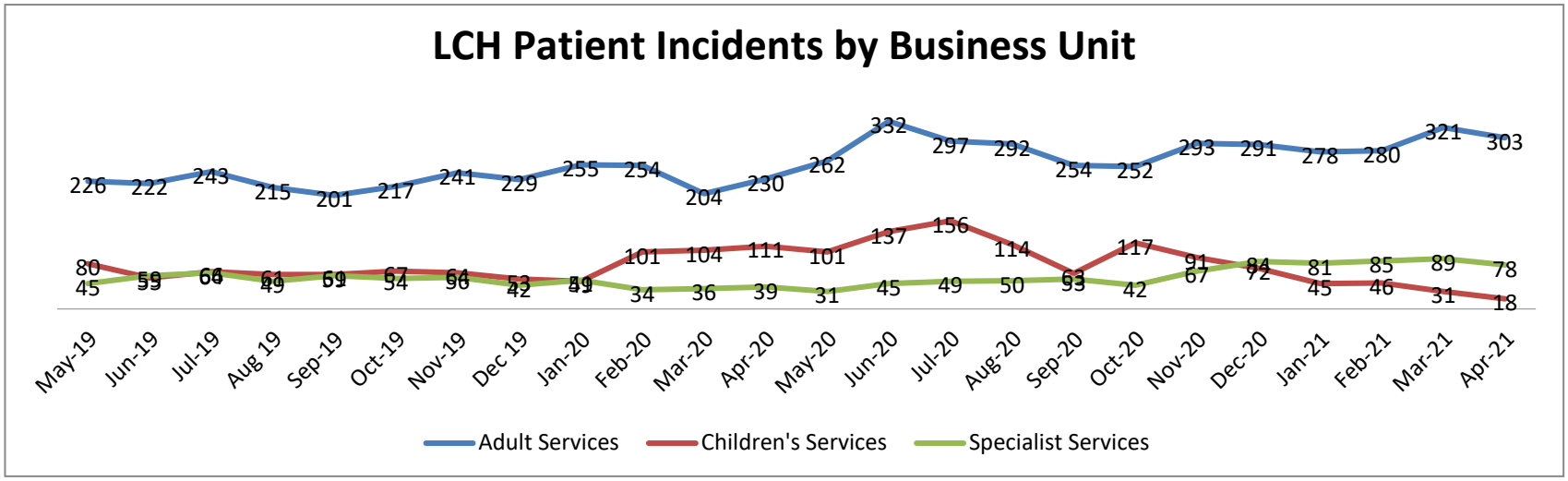
No formal summary financial report has been produced for April. An overview of financial performance suggests no cause for concern under the current financial regime for the first 6 months.

Safe – April 2021

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

Safe - people are protected from abuse and avoidable harm	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Apr	Time Series
Patient Safety Incidents Reported in Month Reported as Harmful	SL	1.06 to 1.73	2.07	●	2021/22 2020/21	2.07 1.80	
Serious Incident Rate	SL	0 to 0.1	0.01	●	2021/22 2020/21	0.01 0.05	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	TBC	0	●	2021/22 2020/21	0 0	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	0	●	2021/22 2020/21	0 0	
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	TBC	0	●	2021/22 2020/21	0 2	
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	RB	No Target	50%	●	2021/22	0%	

Trend of LCH Patient Safety Incidents by Month and Business Unit



There is a clear reduction in reports from the Children's Business Unit due to the transfer of the CAMHS Inpatient service at Little Woodhouse Hall to Leeds and York Foundation Trust (LYPFT). A reduction in SBU incidents is explained by the reduction in incidents in Wetherby Young Offenders Institute (HMWYOI) from 40 in March to 20 in April.

Adult Business Unit (ABU) - Themes

Medications

Following on from the increase in medicines incidents in Seacroft Neighbourhood Team reported last month, support has been provided to the team from the medicines management service. Weekly medication incident supervision sessions for staff have been instigated. A dedicated team Pharmacy Technician has been introduced who has focused on establishing more robust processes for ordering medications for patients. This has resulted in a reduction in medication incidents from 30 in March to 7 in April, only 2 resulted in harm, which was minimal.

Meatal Tears

A deep dive is being completed and is expected to be completed in the next month to consider any correlation in an increase in meatal tears to the change in catheter type being prescribed in LTHT to a more rigid silicone catheter. Following discussion with LTHT, they are also reviewing their own data to identify any upward trend in reporting and to identify any product changes within urology which may be contributing to the rise in meatal tears.

Continence Specialist Nurses are continuing to raise awareness of the occurrence of meatal tears within the community and are reporting any cases they identify from their specialist assessments. This is thought to contribute to the increased trend in positive reporting for meatal tears.

An education leaflet has been developed and shared with LTHT with a request that this is issued to patients in hospital who have a new urinary catheter inserted. This will promote care to avoid meatal tears immediately post discharge.

A revised care pathway is to be introduced. Patients will be seen by a registered Nurse and self-management facilitator when the catheter referral is received. The self-management facilitator will continue to work with, and support the patient to provide proactive care.

Hospital Discharge

Following an escalation to LTHT of an increase in hospital discharge related incidents in January 2021, a deep dive and review of the data has been completed over quarter 4. This did not highlight a sustained increase in reporting over the past 2 years or significant increase in the harm level for these incidents. However, LTHT reviewed the 16 incidents escalated in January and all were assessed to have significant learning for LTHT.

The Quality Lead has re instigated meetings with the Director of Nursing (operations) in LTHT monthly to review all moderate and above harm hospital discharge incidents. LTHT will now contribute to the rapid review/SI process as appropriate. Learning will be shared by LTHT to ensure that feedback and learning reaches the hospital ward. This will be reviewed in 3 months to ensure the learning is embedded.

Due to some data accuracy issues within the discharge incident reports the Quality Lead will provide education and training within ABU to support improved data accuracy within LCH.

The above trends have led to the establishment of quarterly meetings between the Quality Lead and LTHT to monitor trends which will be shared across both organisations.

Category 4 Pressure Ulcer update

There were no LCH acquired category 4 pressure ulcers recorded in April 2021.

Summary of Major Harm Incidents

There were 3 major harm incidents reported in April; all were falls related. This is not significantly different from the average numbers reported over the last year.

One of the 3 has been reviewed at the Rapid Response Review Meeting (RRRM) and has concluded no lapses in care identified and 2 remain in the review meeting process and are awaiting the return of a completed Rapid Response (RR) template

Specialist Business Unit (SBU) – Themes

Neuro falls

Non completion of postural blood pressure assessment, which is part of the Tier 2 falls assessment was identified as a theme last year and an action plan was formulated to improve adherence. There has been a recent recurrence of this theme and assurance has been sought from the service to evaluate whether the action plan has been embedded in practice. The Clinical Lead and Clinical Head of Service are due to meet to

discuss this further in May 2021. The Service is currently performing an audit for assurance and formulating an action plan. The outcome will be reported in the June Performance Brief

Podiatry
The service continues to report high incidents related to foot ulcers. An Improvement Plan is being developed to deliver improvements and to provide assurance.

HMWYOI
There were fewer incidents at the YOI in April as there are less children with self-harming behaviour and extra care support has been funded by NHS England.

CIVAS
Following 3 reported incidents, a risk assessment tool for the prevention and management of deep vein thrombosis for patients with long term arm lines in situ has been developed and shared across the Community Intravenous Antibiotic Service, Hospital Line Team, Anaesthetists LTHT and Emergency Department Team via the LTHT/LCH incident meetings noted above.

Children's Business Unit – Themes

Little Woodhouse Hall (LWH)
There has been a significant reduction in incident reporting within the Children's Business Unit (CBU) due to the LWH service moving to LYPFT, although as previously reported the number of incidents in the unit had been decreasing anyway as the mix of young people changed.

Incident Reports Numbers – Deep Dive
A recent deep dive of activity identified that 23/27 services reported less than 5 LCH patient safety incidents in Q4. Training is ongoing to support the recognition of near miss incidents to ensure early learning is implemented to reduce the risk of future harm incidents.

LCH Patient Safety Incidents Occurring in April 2021

There were 687 incidents recorded in Datix in the month, of these 399 (58.1%) were recorded as LCH patient safety incidents.

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

Month	LCH Patient Safety Incidents by Severity			Total
	Low and No Harm	Moderate Harm	Major Harm	
April 2021 *	358 (89.7%)	38 (9.5%)	3 (0.8%)	399*
March 2021	402 (91.2%)	34 (7.7%)	5 (1.1%)	441
February 2021	395 (85.9%)	56 (12.2%)	6 (1.3%)	460
January 2021	361 (90.6%)	27 (7.4%)	8 (2.0%)	396
December 2020	381 (88.4%)	35 (8.1%)	15 (3.5%)	431
November 2020	389 (89.8%)	37 (8.5%)	7 (1.6%)	433
October 2020	383 (93.2%)	23 (5.6%)	5 (1.2%)	411
September 2020	334 (88.1%)	36 (9.5%)	9 (2.4%)	379
August 2020	421 (90.1%)	41 (8.8%)	5 (1.1%)	435
July 2020	443 (90.6%)	37 (7.6%)	9 (1.8%)	489
June 2020	433 (87%)	53 (11%)	9 (2%)	495
May 2020	354 (91%)	30 (8%)	4 (1%)	388

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

Summary of Moderate Harm Incidents (occurring in April 2021)

There were 38 moderate harm incidents reported. Incident categories are broken down below:

- 26 x Skin Damage (23 x Pressure Ulcers and 3 x Traumatic Skin Damage)
- 11 x Falls
- 1 x Failure to act on adverse symptoms

SIDM Outcomes in April 2021

52 incidents were heard at SIDM, chaired by the Assistant Director of Nursing, Assistant Director of AHPs, Head of Clinical Governance or Quality Leads; the outcome of those incidents is shown below.

Total no.	No lapses in care & no further investigation required	No lapses in care, learning identified	Progressed to Internal Investigation	Progressed to comprehensive RCA as potential lapses in care (SI)	Further details required	Not a reportable incident or rejected
52	23 (44.2%)	9 (17.3%)	1 (1.9%)	3 (5.8%)	13 (25.0%)	3 (5.8%)

The Incident and Assurance Manager continues to provide an overview at the Trust's induction and from May 2021 will be delivering training at the preceptorship programme to ensure staff have an early introduction to incident management from the outset.

The learning from the concluded reviews have been shared with the reporting teams, these are:

- A contributing factor to a number of reports was the lack of laying and standing blood pressure assessments to assess any postural drop in blood pressure
- The need for timely completion of falls risk assessments
- Clearer communication to be fully evidenced within clinical records.

There was good practice identified as well and this includes:

- Osteoporosis and postural drop risks identified and communicated to the GP in a timely manner by the Stroke Service.
- Recognition of positive steps and amount of effort to try to contact patient in a difficult situation.
- Shared learning with Adult Social Care re diabetic foot ulcers and daily skin inspections
- Consistent completion of Tier 1 falls risk screening and Tier 2 falls risk assessment on initial assessment.
- Evidencing risk assessment and rationale for delayed visit within the clinical record.

Serious Incidents (SI) Investigations

In April, 4 incidents progressed to serious incidents and were reported on StEIS, one was subsequently de-logged as not meeting the SI criteria. The 3 ongoing incidents are below. The learning will be shared in the quarterly SI report

- 1 fall resulting in a femoral mid-shaft fracture reported by Woodsley Neighbourhood Team. Contributing factors included missed opportunities to re-assess following earlier similar falls; being removed from physio waiting list when assistance was still required and laying/standing blood pressure not being assessed.
- 1 fall resulting in a cervical spine fracture reported by Armley Neighbourhood Team following an unwitnessed fall. Contributing factors included delay in physio assessment, identified as being weak and unsteady but not escalated and not re-prioritised following earlier fall with fracture.
- 1 unexpected death occurred in a patient who was approaching the end of life in the Armley Neighbourhood Team. The initial review concluded there were potential missed opportunities to recognise the patient was at risk of developing urosepsis from a possible urinary tract infection and complete full clinical observations. Immediate actions are progressing with involvement of the CUCS and the IPC team in relation to both of these initial concerns.

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

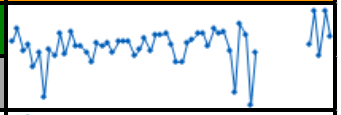
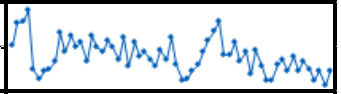
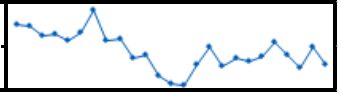
LCH was compliant with two of the three incidents identified for Duty of Candour. For the remaining incident, contact was attempted within the 10 day timescale but due to a hospital admission LCH were unable to complete Duty of Candour until the patient was discharged after the 10 day period. LCH would assess that compliance was achieved for this incident in addition.

The Serious Incident management process is being reviewed within the Clinical Governance Team with the support of the Organisational Development Team.

StEIS reporting has been completed for all incidents within the statutory 48 hours.

Caring – April 2021

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

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Apr	Time Series
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%		●	2021/22	96.7%	
					2020/21		
Total Number of Formal Complaints Received	SL	No Target	8		2021/22	8	
					2020/21	4	
Number of Compliments Received	SL	No Target	69		2021/22	69	
					2020/21	40	

Friends and Family Test

96.65% of 418 respondents to the Friends and Family Test rated their experience as "Very Good" or "Good" in Community Care (FFT).

In March feedback was shared with Specialist Weight Management Service and Children's Speech and Language Therapy. These services have provided the following updates;

Specialist Weight Management Service – feedback related to inconsistencies in clinicians leading appointments, there was some confusion around appointment changes and cancellations, and people feeling support is generally lacking. There were considerable pressures during the last quarter of 20/21 due to staff sickness and reduced capacity. Further restrictions due to Covid-19 in January resulted in non-essential face to face clinics being suspended and some appointments were cancelled or re-arranged. The Service now has a full complement of staff, appointment cancellations and changes are expected to be minimal going forward. The service has identified the following engagement with their service users to ensure improvements can be made following this feedback and the Patient Experience Team (PET) will support the completion of the feedback;

- *Seeking feedback from patients regarding their communication and appointment method preferences once Covid-19 restrictions are eased further.*
- *The production of a Service video that can be readily accessed by patients to provide more details about the service, staff and the types of support we can offer to people.*
- *Options for interim support for patients between scheduled clinical consultations including providing resources for supported self-management.*

Children's Speech & Language Therapy Service - received feedback relating to waiting times for appointments and continuity of care. The service are using this feedback in their up-coming service planning day to ensure the patient and carer voice is part of our decision making process. The team plan to review and simplify the clinical triage process to improve waiting times and reduce the number of patients waiting on Speech and Language Therapy pathway.

Feedback received in April

Musculoskeletal Service - Feedback related to the short length of appointments, lack of opportunity to explore symptoms and ask questions, no further treatment and the clinician not listening to the patient. This feedback has been shared with the Business Unit Quality Lead relevant teams and an update on action/learning will be shared in this report next month.

Morley Neighbourhood Team – Poor communication with patients and carers; including lack of communication when staff are running late to appointments. This feedback has been shared with the Business Unit Quality Lead relevant teams and an update on action/learning will be shared in this report next month.

Health Visiting - In March we shared a comment from the FFT for Health Visiting Outer West Team related to lack of support from the service. In response the service have reiterated their offer of support to parents and this will be shared externally. However in April there have been further negative responses to FFT for the 0-19 PHINS Health relating to a feeling of lack of support and communication, particularly with new parents. PET will feed back again to the service and offer support around engaging and communicating the service offers available with parents and carers. This has been escalated to the CBU Quality Lead to further support and ensure the appropriate improvement actions are taken.

Engagement

Community Stroke Team- are developing semi-structured telephone interviews with a small cohort of Stroke patients who were placed on a waiting list during the height of the COVID-pandemic. Now the service is beginning to offer these patients therapy and open up this waiting list, it seems some patients have already improved and no longer require input from the service. The service want to speak to these patients to find out more about their experience of waiting, what the impact of this wait was, what other support they may have accessed during this time and to consider which of these patients would have benefitted from the service being involved earlier to help inform future planning and service delivery.

Musculoskeletal Service (MSK)- PET have provided support in planning a Focus Group to review the MSK website; the aim is to ask for feedback on the website layout, button headings, and ease of accessing appropriate information from the site. This will also support the application of the Accessible Information Standard. MSK have also sought feedback from service users around a number of service leaflets and literature. This work is ongoing.

Engagement Champions- Engagement Champions are currently developing a patient/carer group matrix across the organisation to map these groups; the Youth Board, CAMHS Eating Disorders, 0-19 Parents group, ADHD CAMHS group, Neurology User Carer Forum and the LEEDS programme – Structured Education programme, Community Diabetes.

ICAN shared that they are working with the CBU Involvement lead to develop a Parent Group to empower families, to create peer support network for parents and to link with existing community group such as Sunshine and Smiles. The wider Children's Business Unit is now being included in this work and a working group is booked for May to progress the development of a parent network across children's services.

Digital Inclusion for Carers- 4 tablets have now been awarded to carers supporting someone to access LCH services/accessing LCH services themselves. This has included an application from the Homeless and Health Inclusion Team with a tablet being gifted with screen reading software downloaded to support the user.

Accessible Information Standards- PET has been supporting the update of the SystmOne communication template to embed the Accessible Information Standards across the Organisation and to include digital literacy. Intranet pages have been developed to link to the template to provide signposting and resources for staff to allow for the provision of accessible information to all patients and this will become mandatory. The template is due to be launch at the end of May.

Complaints, Concerns and Claims

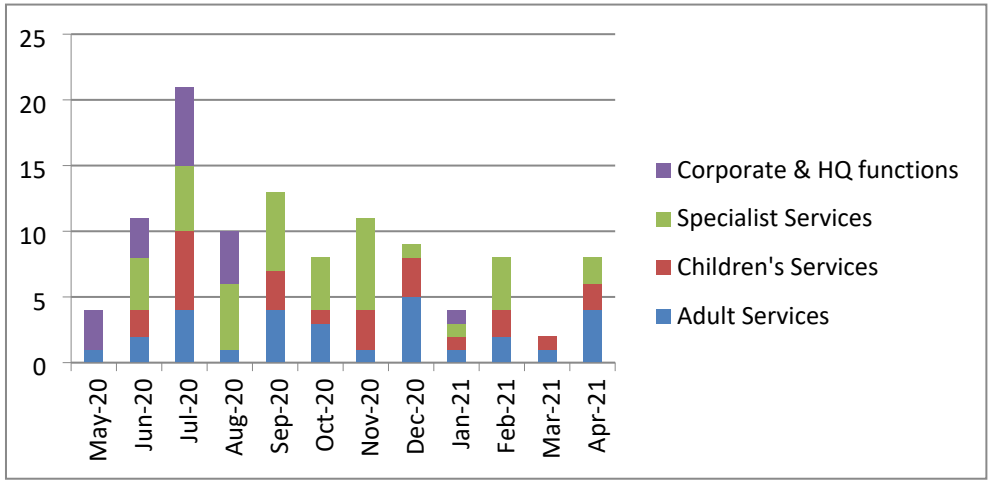
There were 8 complaints received in April 2021. Those for consideration include:

Leeds Sexual Health Service received one complaint in April, this was related to issues with appointment time communication and is not linked to trends in concerns raised on the service telephone system.

A complaint received by the Dental service (Reginald Centre) has potential to progress to a future claim following a statement made by the complainant. PET will oversee the response and are liaising with the complainant to arrange a resolution meeting. The complaint is under investigation and is related to clinical judgement at initial review.

A complaint has been received by the Yeadon Neighbourhood Team and passed to PET for processing; this has also been received via the Trust Chief Executive directly from the Complainant. The complainant has raised ongoing concerns around a hospital discharge and the continued care and treatment of her Father. Due to the content of the complaint this has been escalated to the Executive Director of Nursing and AHPs via the ABU Quality Lead and the Safeguarding Team have been contacted for advice. Following immediate review by the Safeguarding Team there are no current safeguarding concerns.

The graph on the following page highlights the number of complaints that have been received by the Organisation over the last 12 months.



7 complaints were closed in April. Learning and actions identified from these complaints:

Armley NT closed a complaint related to Clinical Judgement/Treatment. Learning has been shared with the nurses in the Neighbourhood Team around communication with GPs and proper recording of Covid-19 symptoms and positivity. It has been recommended that Nurses now carry a supply of swabs and urine containers to ensure that equipment is readily available to carry out swab testing when required and this element of care is not missed again. The nurses now carry these supplies routinely.

ICAN East Appointment has ensured that all school appointments are communicated with parents / carers – this has been recommunicated to all therapists and therapy administrative staff to ensure this standard is adhered to in the future.

There were 37 concerns received in April 2021. 10 of the concerns received were for Leeds Sexual Health service; 7 of these concerns are around difficulty in accessing the service via telephone, similar to the concerns reported in March 2021 and raised via the FFT in March and April and relates to the work ongoing to improve the system.

Complaint Responses

Three were shared later than the 40 day internal timeframe for responses in April; all of these responses were extended due to issues with consent to share the information. Internal processes for ascertaining consent are being reviewed as part of the Patient Experience policy review to ensure that these are fit for purpose and do not impact on timeframes. The review will be finalised in May.

Claims: There have been 0 clinical claims received. There have been 0 non-clinical claims received in April.

Covid-19: We have received 0 Covid-19 related complaints or concerns in April.

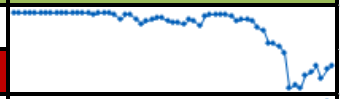
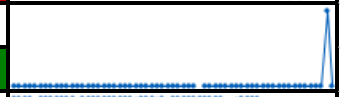
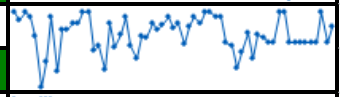
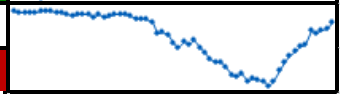
Effective

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.

The measures in the effective domain are reported on a quarterly basis and hence are not included in this report.

Responsive – April 2021

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

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	Apr	Time Series
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	83.1%	●	2021/22 2020/21	83.1% 89.6%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	0	●	2021/22 2020/21	0 0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	39.2%	●	2021/22 2020/21	39.2% 55.3%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	74.8%	●	2021/22 2020/21	74.8% 93.2%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	99.5%	●	2021/22 2020/21	99.5% 99.1%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	88.7%	●	2021/22 2020/21	88.7% 31.5%	

Consultant-Led Waiting Times

Performance against the 18-week referral to treatment standard is below expectations. There are now 288 patients waiting more than 18 weeks. The table below provides details on the number of patients waiting on each consultant-led pathway.

	Mar 2021						Apr 2021					
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	90.1%	872	86	9.8	8.9	19.9	92.3%	939	72	8.4	8.0	19.0
CPC (CHICS)	84.3%	210	33	8.9	5.9	23.7	83.0%	235	40	9.3	6.6	27.0
GAN	100.0%	4	0	7.2	5.0	15.2	100.0%	4	0	1.0	0.7	2.1
Gynaecology	14.8%	128	109	20.3	21.3	25.7	10.7%	103	92	21.0	20.6	27.3
MSK												
PND	85.0%	373	56	10.1	9.0	22.3	80.0%	420	84	10.7	9.6	23.6
Total	82.1%	**1587**	**284**				83.1%	**1701**	**288**			

Current Waiting List Position – Reset and Back Log

Adult Business Unit

Neighbourhood Teams – There are capacity issues within wider Neighbourhood team for all therapy waits. All patients have been clinically prioritised virtually by a Senior AHP. There is an ongoing project to enhance approach to waiters led by Clinical Pathway Leads which will become part of Transformation Programme with plan to manage and prioritise patients so a waiting list is not operated and reduce the amount of unwarranted internal referrals.

Childrens Business Unit

0-19 PHINs – Reported delays are due to waiting list validation; not true waiters.

Audiology – A recruitment plan now underway to increase capacity in service

PND - Recruitment of new doctor to service is ongoing. Other parts of service providing some cross cover to manage gaps.

Specialist Business Unit

CNRS – The service are currently reviewing service with commissioners.

Adult SLT – The service are currently ensuring highest need seen first. The waiting list backlog linked to capacity of very specialist roles. A capacity and demand project has been started with BCDS project resource.

Diabetes – A new service model implemented. Self-management continues to support capacity and improve independence. Caseloads have been reviewed and groups have restarted virtually.

MSK – The service have brought waiters down using an opt in/ opt out process. More information on this is provided in the case study below.

Podiatry – Here all referrals have been clinically assessed and prioritised. Capacity has been limited by Covid-safe requirements and digital contacts taking longer. Additional clinics have been arranged to increase capacity. All current waiters are low risk and the service is using an opt in process.

Respiratory - Waiters are mainly for the lung screening service which is not currently operating.

Assuring through Reset

Robust waiting list assurance work has been completed with all services with a waiting list. This work has been led by Executive Director of Nursing and Clinical Lead Reset. There is assurance that all people waiting have been appropriately prioritised and reviewed regularly.Clinically led validation of lists was not being completed by all services, and this will be addressed when a revised wait list validation exercise it launched. Data quality issues and gaps identified in admin processes have been artificially identifying waiters. Ongoing assurance work will become part of the new Improving Patient Flow and Prioritisation (IPFP) programme. Bespoke waiting list meetings within Business Units to be commenced to ensure oversight and understand risks and develop mitigations

Improving patient flow and prioritisation (IPFP) programme

This programme is currently in its initiation stage. Its aim is to ensure robust operational and clinical processes and capabilities that enable effective management of patient pathways and flow, leading to a sustainable and safe way of managing people waiting. The programme will be organised into the following work streams:

- Reducing Covid related backlogs
- Improving clinical prioritisation
- Improving waiting list management
- Developing capacity and demand capabilities
- Programme currently in initiation stage

MSK 'opt in' case study

Reset programme team undertook patient walk through of MSK opt in process to provide assurance and put health inequalities lens on decisions taken. At the start of reset 15000 referrals on waiting list; 30% of which had opted in. All patients were contacted to either opt in or opt out. Phone and email used where these contact details were available, everyone else received letter. The patients were then followed up by all contact methods until a response received. The letter didn't initially have instructions around other accessibility formats, but this was soon rectified.

All patients opting out were given a 'passport' and can still re-enter service now without a new referral from primary care. Rotas set 3 weeks in advance so those re-entering don't have a long wait time for treatment. Treatment was offered by phone, digital, face to face and self-management. The format was based on need initially and is now based on preference too. Face to face appointments were offered at limited range of venues but with geographical spread across Leeds. Feedback about virtual contacts has been positive in relation to flexibility and cost.

The recommendations from MSK case study were as follows:

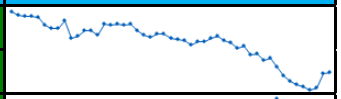
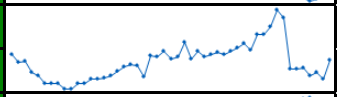
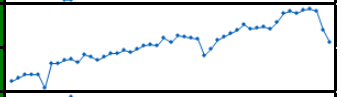
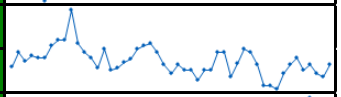
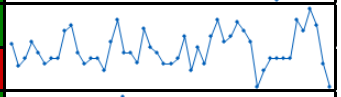
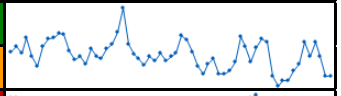
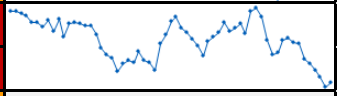
- Ensure patient actively opts in or opts out with reasons why for opting out
- Give those who have opted out a passport to easily access the service should their condition decrease over time
- Utilise a range of communication mechanisms and approaches to meet different needs
- Firm up admin process around getting response from patients – and don't just have one opportunity for this
- Have standard approach to how we opt in – work now underway as part of IPFP programme

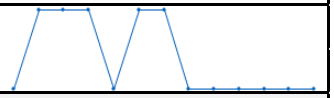
Health inequalities findings included:

- Range of communication mechanisms used – telephone, email, letter, SMS
- Letter now includes information in other formats
- I-pads available to loan to patients for treatment
- F2F venues – geographically spread around the city with a focus on deprived areas (e.g. Beeston, Armley, Meanwood, East Leeds)
- More patient engagement could have been undertaken to understand views and needs of different community groups

Well-Led – April 2021

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.

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	Apr	Time Series
Staff Turnover	LS/JA	<=14.5%	-	●	2021/22	10.3%	
					2020/21	11.8%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	-	●	2021/22	16.5%	
					2020/21	18.6%	
Stability Index	LS/JA	>=85%	-	●	2021/22	87.0%	
					2020/21	88.4%	
Short term sickness absence rate (%)	LS/JA	<=2.2%	-	●	2021/22	1.7%	
					2020/21	2.1%	
Long term sickness absence rate (%)	LS/JA	<=3.6%	-	●	2021/22	3.0%	
					2020/21	3.8%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=5.8%	-	●	2021/22	4.7%	
					2020/21	6.1%	
AfC Staff Appraisal Rate	LS/JA	>=90%	-	●	2021/22	76.2%	
					2020/21	84.0%	
Competency structure - 13 training requirements	LS/JA	>=90%	-	●	2021/22	89.9%	
					2020/21		

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	Apr	Time Series
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	LS/JA	>=52.0%	-		2021/22		
					2020/21		
Percentage of staff who are satisfied with the support they received from their immediate line manager	LS/JA	>=52.0%	-		2021/22		
					2020/21		
'RIDDOR' incidents reported to Health and Safety Executive	BM	No Target	0		2021/22		
					2020/21	0	
Percentage of staff in each of the AfC bands 1-9 and VSM (including exec. board members)	LS/JA	No Target	-		2021/22	**11.3%**	
					2020/21	10.5%	

Retention

The overall trend continues to be positive with turnover reporting at 10.3% which is below the 2020/21outturn target of 14.5%. The stability rate has decreased from 88.2% to 87% which is above the target of 85%. This decrease is due to the impact of a recent TUPE transfer out of staff from the Child and Adolescent Mental Health service.

Staff leaving within the first 12 months of employment has increased this month to 16.5% but is below the target of 20%. This figure represents a total of 6.3 full time equivalents. 4 full time equivalents left from across the Children's Business Unit due to a variety of reasons this included 2 nurses (1 from 0-19 service and 1 from Children's Continuing Care)

The highest reason for leaving across all the staff groups and business units was due to promotion. The Children's Business Unit accounts for 40% (10.1 FTE's) of April's leavers followed by 27.6% (6.9 FTE's) from the Adult Business Unit.

Further work is underway to understand the recent increase in turnover in the Children's Business Unit. Work to maintain workforce stability will continue with a focus on areas with high turnover, development of career pathways, exit interviews and processes, apprenticeships, recruitment, health and wellbeing with increasing support to leaders and flexible approaches to staff engagement.

Background detail associated with retention was included in the Performance Brief considered at the Quality and Business Committees this month.

Sickness absence

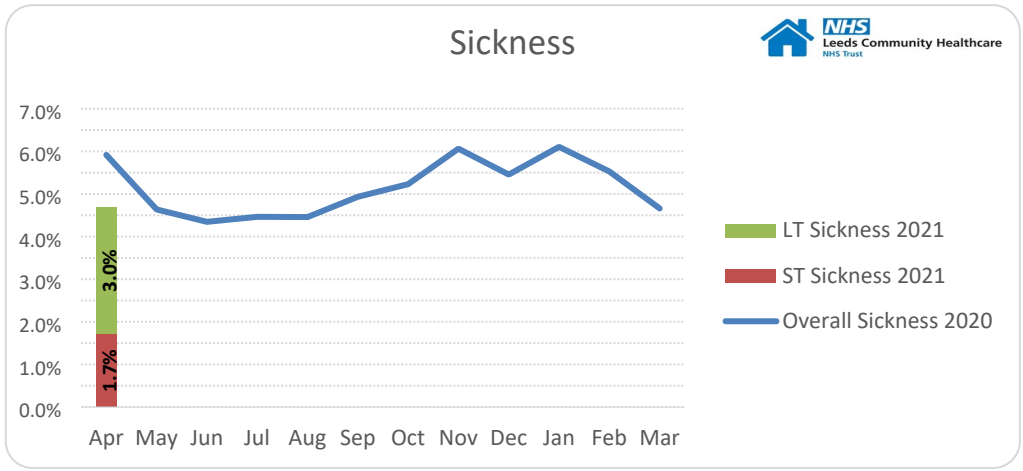
Throughout 2020/2021 and during the pandemic we have seen sustained improvements in a reduction in sickness absence levels in comparison with the previous year. The general downward trend continues across all Business Units and Corporate Teams, with April being no exception. The overall Sickness absence remains at 4.7%, which is significantly below the same period last year. The main reason for long term absence continues to be due to anxiety, stress and depression and short-term sickness due to infectious diseases, which is not unexpected during the pandemic.

ABU continues to have comparatively higher sickness absence overall currently 6.4% or 5.97% over the year which we are continuing to monitor. Support is being provided to Operational Leads and their teams and absences are discussed and reviewed on a monthly basis with their HR Business Partner. Sickness absence cases continue to be actively managed with the appropriate support being provided either through the management chain in addition to occupational health advice and/or via additional health and well-being interventions, such as the Employee Assistance Programme, the Long COVID Pathway and access to Leeds Mental Wellbeing Service. Anxiety/Stress/Depression remains the highest cause for absence followed by COVID absence. Combined, these top two reasons for absence equate to almost half of all ABU absence and is impacting at all levels in the business unit.

To support staff, work continues to refine the general HWB support that staff can access, as well as offering Targeted support for specific staff communities. Specific activity last month included a Hypnotherapy session provided by our psychiatrist and scoping stage to implement Schwartz rounds, to link in with the wider strategy of staff support around social and emotional support.

Overall Sickness Absence 2021

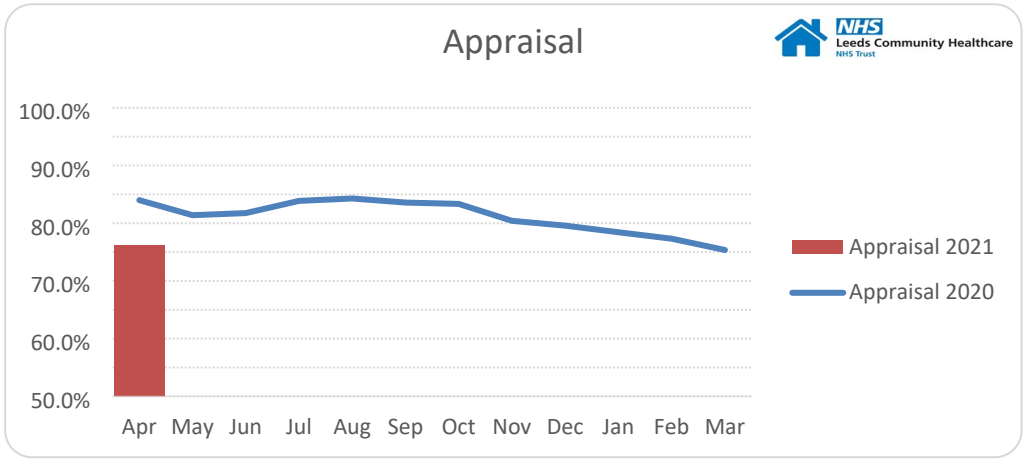
	Target	Apr
Overall Sickness 2021	(5.8%)	4.7%
833 Adult Business unit		6.4%
833 Children's Business Unit		4.0%
833 Corporate Directorate		2.3%
833 Operations		3.9%
833 Specialist Business Unit		4.0%



Appraisal

The Appraisal position for April has improved by +0.8% from March to an overall compliance rate of 76.2%

	Target	Apr
Appraisal 2021	90%	76.2%
833 Adult Business unit		63.2%
833 Children's Business Unit		87.6%
833 Corporate Directorate		88.1%
833 Operations		89.1%
833 Specialist Business Unit		75.3%



Compliance across the Children's Business Unit (87.6%). Corporate Directorate (88.1%) and Operations (89.1%) remains strong and close to the 90% KPI. The overall rate is being impacted by compliance across the Adult and Specialist Business Units where some services were given authorisation to suspend appraisals.

In the current context of services coming out of escalation some Adult Business Unit and Specialist Business Unit services will need to focus on appraisal compliance in the coming months to recover their appraisal position. Hotspots include Neighbourhood Services, City Wide Services and Podiatry and Dental which represent 58.7% of all outstanding appraisals.

To support all services with appraisals an Online Appraisal toolkit was launched in April and will continue to develop as a hub for all aspects of appraisal.

Our work on this agenda continues with the overall aim of improving appraisal compliance and the quality of appraisal conversations across the Trust. This includes:

- Supporting Adult and Specialist Business Units to recover their appraisal compliance positions where necessary.
- Reviewing the appraisal KPI and reporting parameters.
- Designing and launching an Appraisal evaluation and quality assurance survey.
- A review of the support and guidance we provide to our staff. This includes further development of the online toolkit, training, and guidance, and looking at ways we can enhance the appraisal conversations around wellbeing and career development.

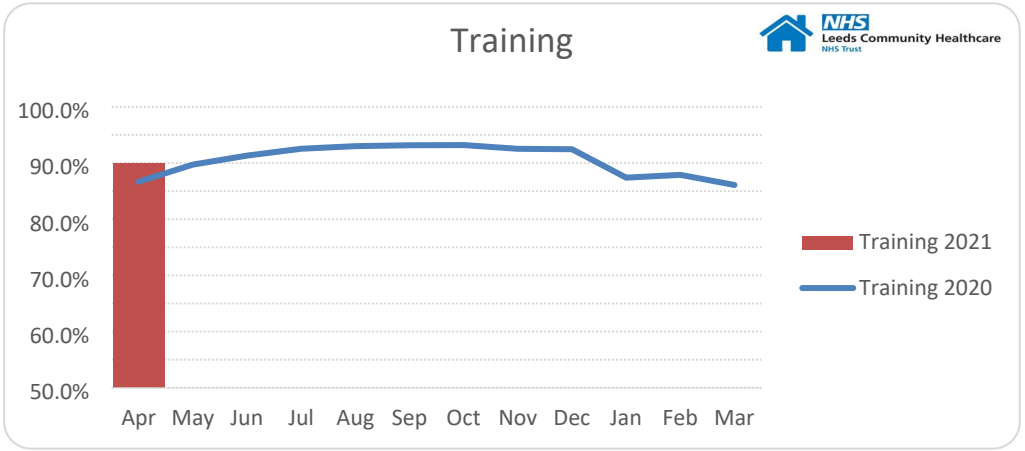
Although not covered in the data above we have worked with the PCN HR Business Partner to update Appraisal data in ESR for all PCN colleagues and it now stands at 100%.

Statutory and Mandatory Training

The overall Statutory and Mandatory position has increased by **+3.8%** from March to an overall compliance rate of **89.9%**

We are now reporting on 11 of the 13 Statutory and Mandatory training subjects as defined by the Trust (previously 6). This will increase to all subjects 13 from June.

	Target	Apr
Training 2021	90%	89.9%
833 Adult Business unit		84.2%
833 Children's Business Unit		92.1%
833 Corporate Directorate		93.5%
833 Operations		94.0%
833 Specialist Business Unit		93.3%



Performance across the board is strong with Children's Business Unit (92.1%), Corporate Directorate (93.5%), Operations (94%) and Specialist Business Unit (93.3%) all performing above our 90% KPI.

Adults Business Unit is performing is good (84.2%) given the pressures and priorities faced over the last 12 months. It is anticipated this performance will improve over coming months.

Workforce Racial Equality Standard (WRES indicator 1)

From April 2021 onwards, new aspirational goals have been set, to increase our overall number of BME staff within the workforce to 14% by 2023 and 18% by 2028 (Figures based on the 2011 Census data).

The percentage of BME staff employed in the overall workforce at the end of April 2021 is 11.3%. Granular detail of staff in post (by pay band) is contained in the table below, which will be used to monitor progress.

AFC Band	Target	1	2	3	4	5	6	7	8a	8b	8c	8d	Medical & Dental
Total White		13 (19)	142 (165)	457 (472)	240 (234)	425 (371)	760 (748)	378 (346)	147 (137)	26 (24)	15 (14)	2 (1)	26 (55)
Total BME		10 (4)	42 (36)	86 (104)	33 (52)	62 (159)	78 (165)	25 (76)	8 (30)	2 (6)	1 (3)	0 (1)	20 (13)
Total Not stated/given		0	17 (0)	33 (0)	13 (0)	43 (0)	75(0)	19 (0)	12 (0)	2 (0)	1 (0)	0 (0)	22 (0)
Total % White	**82%**	56.52%	70.65%	79.34%	83.92%	80.19%	83.24%	89.57%	88.02%	86.67%	88.24%	100.00%	38.23%
Total % BME	**18%**	43.48%	20.90%	14.93%	11.54%	11.70%	8.54%	5.92%	4.79%	6.67%	5.88%	0.00%	29.41%
Total % Not stated/given	**0%**	0	8.46%	5.73%	4.55%	8.11%	8.21%	4.50%	7.19%	6.67%	5.88%	0.00%	32.36%

(Figures in brackets are the number of staff required to achieve the goal set for 2028)

Work will continue, in partnership with the Race Equality Network group on a range of initiatives towards increasing representation of BME Staff at all levels of the organisation.

Finance – April 2021

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

No formal summary financial report has been produced for April. Due to the late agreement of the financial regime for the first half of 2021/22 and the subsequent allocation of resources there is no requirement for a national collection of financial monitoring information for April. Accordingly, the finance team has concentrated on supporting service managers with their budget management and completion of the 2020/21 Annual Accounts. . The Business Committee discussed the overall financial outlook for the first 6 months at its meeting and this will be shared with the Board. There is no cause for concern about the financial position in the first 6 months.

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (9)

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

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Category of paper: for assurance
History: Senior Management Team 19 May 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 Board Assurance Framework (BAF) summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by the committees. This informs the Board about the likelihood of delivery on its strategic objectives, as do the risk register themes.

The strongest theme found across the whole risk register is staff capacity, the second strongest theme is the functionality of Information Technology (IT) software.

There is one extreme risk scoring 16 (extreme) that has been added to the risk register

- Delayed transfer of children/young people from WYOI who require medium secure CAMHS hospital beds

There are 12 risks scoring 12 (very high). One of these has been recently added to the risk register and details are given in this report:

- Connection issues to the WIFI at Stockdale House

Two newly identified risks are currently being assessed:

- PCMIS (patient information system) used by LMWS does not have the functionality to run a system capture of all safeguarding cases

- As a result of both LCES budget limitations and a current supply delay there is a risk that patients being cared for in community may not receive prescribed equipment in a timely manner.

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

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 (March 2021), 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

2.1 This paper has previously been considered by the Senior Management Team (SMT) at its meeting on 19 May 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 Levels of assurance have been provided for eleven out of the 20 strategic (BAF) risks during March and April 2021, with substantial assurance given to one risk, reasonable assurance given to nine and limited assurance given to one risk. Details of the committees commentary about specific risks is as follows (please also refer to the Chairs' assurance reports):

3.5 The Quality Committee has been assigned an additional BAF risk this year: Risk 1.6 'Is the Trust optimising its services to reduce the impact of health inequalities, and has it appropriate data to understand and address this?' The Committee agreed that it was reasonably assured by the information presented in the draft Health Equity Strategy, the Learning Disabilities Quality Report and the report it received about the Digital Strategy including digital inclusion, that the Trust is beginning to manage this newly included risk.

3.6 BAF risk 1.3 received an element of limited assurance at the Quality Committee in April 2021, as the Committee had concerns about the impact that waiting times were having on patients in terms of both physical and mental health, there was some uncertainty in relation to the 0-19 revised offer and the WYOI/Adel Beck situation remains a concern.

3.7 The Business Committee concluded in April 2021 that there was substantial assurance for BAF risk 2.5 'Is the Trust delivering on its agreed income and expenditure position?' having considered the quarterly finance report, the performance brief and an internal audit on COVID Financial Governance. It was also noted at the March meeting that there had been a significant reduction in Estate backlog maintenance.

3.8 BAF risk 3.1 achieved reasonable assurance overall in both March and April 2021 as the risk is being managed well however the Business Committee was mindful that there are service areas with reduced capacity and some with increased referral rates.

4 Risks by theme

4.1 For this report, the 57 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:

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
- vacancies including difficulties recruiting staff to posts

Specifically:
Seven 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 and increased waiting times;
Three risks concern vacancies, including difficulties recruiting staff to posts.

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

- Intermittent fault with the WIFI at Stockdale House
- Helpdesk Support Capacity
- Use of SystmOne for recording the method of patient contact
- Electronic Staff records (ESR) use across the Trust

- Electronic Patient records for Neighbourhood Teams
- Inability to printing Pathology labels

The third strongest theme is patient safety risk because of delays in providing services due to the impact of the pandemic, including:

- School hearing screens within children's audiology
- Treatment for podiatry patients
- Treatment for MSK
- Access to type 2 Diabetes structured education
- School immunisations programme

There is also a theme of staff safety risks due to COVID, transporting oxygen cylinders, working environment (LCES), lone working and violence and aggression (WYOI)

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.

Percentage of risks aligned with each strategic objective:

Deliver outstanding care: 26% (previously 19%)
Use our resources wisely and efficiently: 7% (previously 7%)
Ensure LCH's workforce is able to deliver the best possible care in all our communities 61% (previously 67%)
Work in partnership to deliver integrated care and care closer to home 6% (previously 7%)

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 one of 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.

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

Risk register theme: Staff capacity

BAF Risk 3.1 having suitable and sufficient staff capacity and capability and reduced levels of sickness
BAF Risk 2.2 delivering contractual requirements

Risk register theme: Information Technology (IT) systems

BAF Risk 1.3 maintaining and continuing to improve service quality
BAF Risk 2.4 maintaining the security of IT infrastructure

BAF Risk 2.6 investing and creating the capacity and capability to respond to the increasing dependency on digital solutions
BAF Risk 3.1 having suitable and sufficient staff capacity and capability

Risk register theme: **patient safety**
BAF Risk 1.3 maintaining and continuing to improve service quality
BAF Risk 1.5 altered capacity due to the Covid-19 pandemic, the Trust cannot deliver services in a timely and equitable manner,
BAF Risk 2.2 delivering contractual requirements

Risk register theme: Staff safety
BAF Risk 3.1 having suitable and sufficient staff capacity and capability and reduced levels of sickness
BAF Risk 3.5 developing and embedding a health and safety management system

It should be noted that most, if not all strategic risks, if not managed well will ultimately put the primary strategic objective of Delivering outstanding care at risk.

5 Risk register movement

5.1 One new risk with a current score of 15 (extreme) or above has been added to the Trust risk register since March 2021.

Risk 1033 Delayed transfer of children/young people from WYOI who require medium secure CAMHS hospital beds

(see description in section 6.1)

Risk score: 16 (extreme)
Risk score movement: None

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6 New or escalated risks (scoring 15+)

6.1 One new risk scoring 15+ has been added to the risk register since March 2021:

Risk 1033 Delayed transfer of children/young people from WYOI who require medium secure CAMHS hospital beds

Initial risk score: 20 (extreme)
Current risk score: 16 (extreme)
Target risk score: 3 (low)

Description: An increasing number of children/young people in WYOI require medium secure CAMHS beds and require 24 hour forensic CAMHS intervention. The national shortage of beds in these specialist settings means that the young persons have to remain in their current setting. The current CAMHS service is not commissioned to provide this level of service and does not have the necessary skill

set. There is a risk that the children/young people's mental health condition will deteriorate in the current setting.
This could result in increased incidences of and an escalation in the extent of self-harm. There could be a potential increase of staff verbal and physical assault due to the deterioration in the children/young people's mental health presentation and there is a potential for the wider caseload of children/young people to experience a delay in their care due to the increased demand on staff.

Controls in place:

- Constant watch / high frequency observations in place for high risk young people
- CAMHS staff offered overtime / bank shifts advertised as a short-term measure
- Joint Senior LCH & SWYFT case escalation & risk management meeting held
- All partners are attending a biweekly MDT for one young person & NHS E Commissioning Health & Justice are present and actions are monitored.
- CAMHS Tier 4 escalation process commenced for 2nd young person subject to delayed transfer
- Additional packages of care to support the young people have been commissioned at a regional level.

Risk Score Rationale:
There are four children/young people of significant concern in HMYOI Wetherby. Incidents include self-harm, suicidal ideation and attempts, assaults on staff, non-compliance and disengagement with healthcare services.

There are a further four children/young people currently registered as high risk on the 'virtual ward'. These children/young people have extensive needs but do not represent the high level of risk or require the same level of input and observation.

Actions include:
- Individual risk management plans to be completed by CAMHS Service Manager
- Escalation of second case to NHS E Commissioning Health & Justice
- LCH, SWYFT & WYOI to develop a proposal for additional dedicated staffing to support a request for additional specialist Mental Health Nursing & Physical health care nursing provision to be resourced and sourced by NHS E
- CAMHS and LCH physical health care staff offered the opportunity to raise any individual concerns re impacts for them (e.g. clinical and safeguarding supervision, record keeping/ well-being)
- Service manager to advise CAMHS staff and ensure that where a child is identified as requiring daily CAMHS visits this does not exceed 24 hours.
- SWYFT CAMHS General Manager / Head of Quality and or Head of Portfolio clinical to ensure allocation / agreement re 72-hour reviews and subsequent investigations

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6.2 No risks have been escalated to a score of 15+ since March 2021

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

7.1 No risks have been deescalated below 15 since March 2021

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)
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
994	Patients are waiting too long for Community Dental 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
1023	Potential inaccuracies when recording the method of contact on SystmOne (face to face, virtual, by phone)	12
1025	Information Technology (IT) Helpdesk Support Capacity	12
1036	Delayed delivery of immunisation programme to children and young persons (0-19 Public Health Integrated Nursing Service)	12
1040	Connection issues to the WIFI at Stockdale House affecting some services who are based there.	12

9 New or escalated risks (scoring 12)

9.1 One new risk scoring 12 has been added to the risk register since March 2021, and details of this risk have been provided to the Quality and Business Committees for scrutiny:

Risk 1040 Connection issues to the WIFI at Stockdale House

Initial risk score 25 (extreme)
Current risk score 12 (high)
Target risk score 2 (low)

Description:
Due to an intermittent fault with WIFI connection at Stockdale House there is a risk that Police Custody staff are unable to access the network as the police contact the service via an app to arrange for healthcare attendance at the custody suites. This could result in contingency plans having to be put in place and an inability to provide a consistent and responsive healthcare service to Police Custody.

Controls in place:
Guide to restoring connection provided to staff to use should the WIFI disconnect
All staff made aware of contingency plans
Request made to temporarily move to landlines until a move can be made to permanent LCH telephony.

Actions include:
IT are exploring further options to make Stockdale more resilient
Handsets to be supplied to Police Custody staff on the LCH existing phone system so the reliance on WIFI to access the LCC phone system is by-passed
Police Custody team to become priority users of the new LCH phone system.

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

10 Risk profile - all risks

10.1 There are 15 open clinical risks on the Trust's risk register and 42 open non-clinical risks. The total number of risks on the risk register is currently 57. 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	1	1	0	4
3 - Moderate	2	13	16	12	0	43
2 - Minor	0	3	4	1	2	10
1 - Negligible	0	0	0	0	0	0
Total	2	18	21	14	2	57

11 Impact:

11.1 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.

11.2 **Resources**

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

12 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

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (10ai)

Title: Mortality Report Quarter 4 20-21

Category of paper: For assurance
History: Quality Committee 24 May 2021

Responsible director: Executive Medical Director
Report author: Executive Medical Director

Executive summary (Purpose and main points)

Purpose of this report:

To provide the Board with assurance regarding the Mortality figures and processes within LCH NHS Trust in Quarter 4 2020/21.

Main points to note:

- Quality Assurance & Improvement (QAIG) Group have met regularly and are quorate. The last meeting was the 20th April 2021.
- The Adult Business Unit mortality review meetings, combined with the Specialist Business Unit, and the Children's Business Unit learning from deaths meetings have taken place regularly, and have been quorate throughout the quarter.
- The PL368 Mortality Review and Responding to Deaths Policy was ratified in January 2021.

Adults

- The rise in deaths during Q3 attributable that occurred during a period of increased Covid19 prevalence in the region has not been sustained during Q4
- Holt Park neighbourhood team noted to breach their upper control total limit during Q3 and more significantly than during Q1, has returned to within control total during Q4 and maintained this.
- In addition to the routine Mortality Review meetings for Adults, a table top review was conducted in response to the increase in CCB deaths during Q4, which found no concerns relating to clinical care or omission. The Q4 CCB admissions were identified to be of a higher frailty level, with less potential to improve their health status or rehabilitation potential.

Children

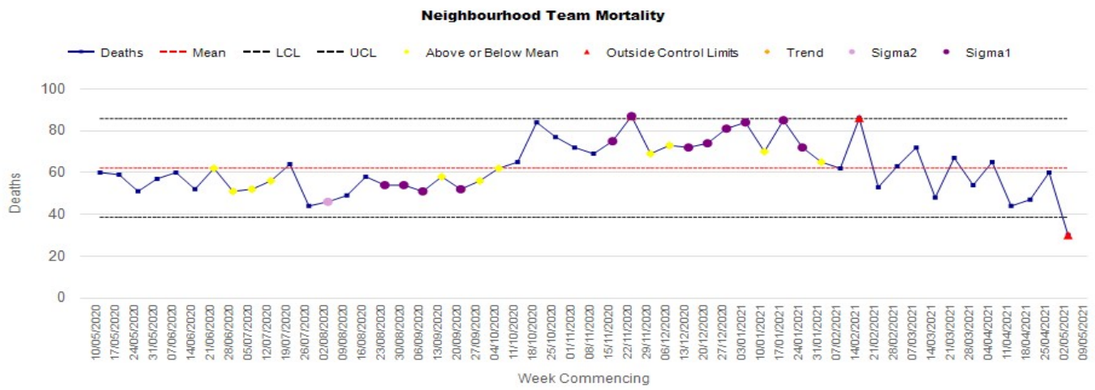
- Mortality in children has not shown any significant deviation from numbers expected over the course of Q4 or the preceding year
- LCH NHS Trust remains actively involved in the Child Death Overview Panel (CDOP) and Sudden Unexpected Death in Children (SUDIC) process
- Work has been undertaken during Q4 to standardise and improve communication between SUDIC and Child Health, in order to better facilitate rapid identification of learning due to the length of time child death review processes can take
- The database of Child Death in Leeds has now been merged to ensure it contains all deaths from all sources of information

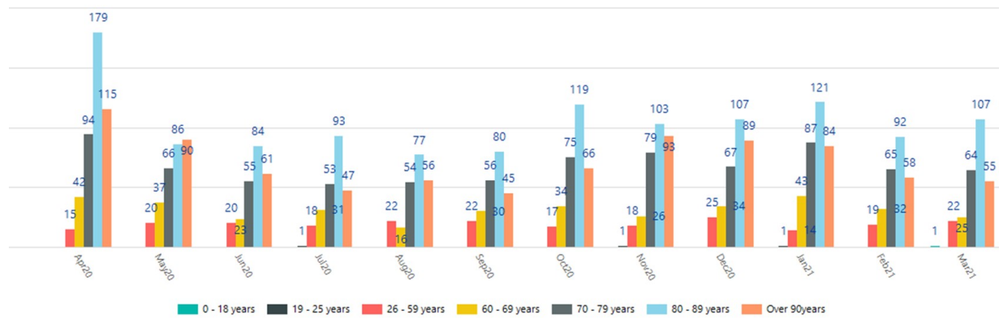
Recommendations:

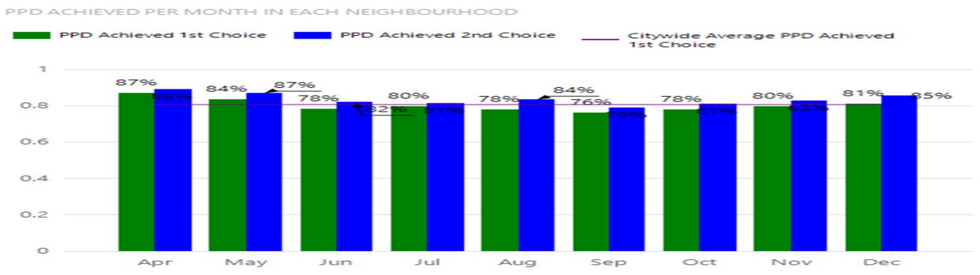
- The Board is recommended to receive this assurance regarding Trust mortality processes during Q4 of 20.21
- Note the ongoing contribution to improving data quality within the Trust and city, and the continuous work to ensure surveillance and learning is optimal.

Q4 ABU Mortality Review January to March 2021

Leeds Community Healthcare NHS Trust







Data	Q1	Q2	Q3	Q4
Level 1	670	426	392 (2019=275)	**475**
Level 2	137	129	136 (2019= 43)	**140**
Unexpected deaths	77	50	71	**59**
Expected deaths	593	376	433	**420**
Alliance CCB deaths (all cases reviewed in the MR Meeting)	3	2 (both expected deaths)	4 (1 expected & 3 unexpected deaths)	**14 (2 unexpected deaths)**
Non-Alliance CCB Deaths (a/a)	5	2	9	**3**
Virtual Ward deaths (commenced reporting in Q3)	N/A	N/A	2	**3 (5 in 20/21 year out of case-load of 549)**
LeDeR	1	0	1	**0**
Serious Mental Health	1	0	0	**0**
Death with 30 days of Hospital discharge	New in Q2	3 but TBC	11	**Tbc, nominally 13**

Themes

The numbers of deaths occurring on an ABU caseload decreased month on month in Q4 and the numbers of confirmed COVID-19 related deaths dropped considerably in both domiciliary and increased frail older adults choosing not to go into care homes or / acute trust settings and hospices, favouring returning or remaining at home continues; impacting on Neighbourhood Team capacity and pressures.

The numbers of fast-track patients supported by the Health Case Management team has returned to within normal levels in Q4

Care home deaths, the number of deaths continues to fall below the average SPC line during Q4

The historic increase in the number of deaths occurring earlier in year 2020/21 led to an increased workload required to undertake the volume of level 1 and level 2 mortality reviews within the teams and also for the subsequent monitoring and selection of mortality cases for formal review. An additional extraordinary mortality case review meeting was held in March to ensure we are keeping track on reviewing cases in a timely basis. In total 27 deaths were formally case reviewed in Q4. (usually 12-15 cases)

1 unexpected and 3 expected deaths occurred in the Alliance CCB Recovery Hubs in Q3, no concerns with the 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 once submitted and verified.

1 unexpected death occurring on the Virtual Ward is being investigated as a potential serious incident, the patients died before being seen by VW Clinicians but after referral was accepted.

In Q4 the cohort of CCB Recovery Hub admissions presented with a higher level of frailty with less potential to improve their health status and be rehabilitated. No clinical care concerns or failures in care resulting in patient harm were raised during the Q4 CCB Mortality Reviews.

Learning

The ongoing impact upon clinical staff providing the EoL care in 2020/21 is now well understood and support and individual clinical supervision continues to be provided . The opportunity to undertake Schwartz Rounds in the future will be equally beneficial.

Actions

In addition to the monthly mortality review a table top mortality review also took place in Q4 to review the increase in CCB deaths

Covid-19 related deaths will be recorded from December 2020 on the Neighbourhood Team mortality trackers, however due to timing of reporting this will be updated in the Q1 2021 report.

RISKS

- Managing to review on a timely basis the increased volume of 2020/21 deaths (reporting of at level 1, 2 and those selected for full case review.
- Maintaining the resilience and health and wellbeing of clinical staff, affected by the high volume of EoL care related to COVID-19. Immediate debrief, group and 1:1 support is offered to staff in addition to the trust health and wellbeing

Contribution to Making Stuff Better

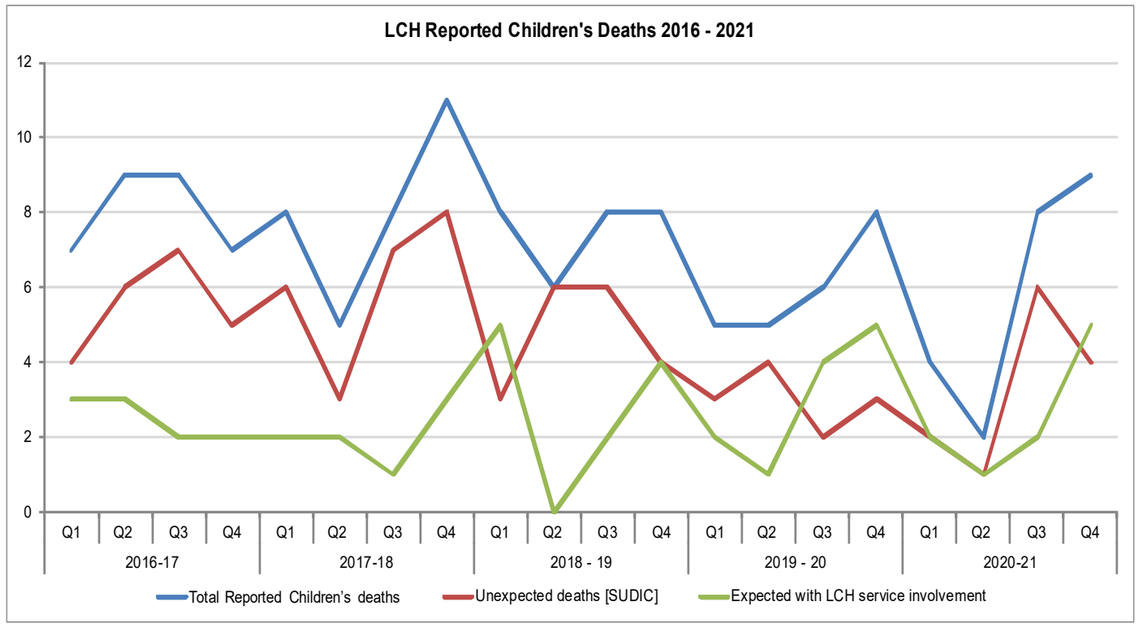
- The GP lead for End of Life Care now attends the LCH Adult Mortality Review meetings.
- Primary Care input into the Mortality Review Process is being explored with the support of Dr R Arnold and Dr G Pottinger
- BI are developing a new report to combine all adult deaths occurring on ABU and SBU caseloads, development of the report planned for Q4 has been delayed. Further work is planned with BI to ensure the data accurately represents the total adult deaths.

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 Q4 2020/21

Leeds Community Healthcare NHS Trust



Quarter 4 2020/21	Total	Unexpected/ SUDIC	Expected with LCH service involvement
January	3	1	2
February	2	1	1
March	4	1	3

Themes

Children's Mortality Group last met on 31st March 2021 in Quarter 4. All children's deaths (eight), leading up to this date, were reviewed and discussed by all group members. On the 29th March 2021 the Leeds Child Death Overview Panel was held.

The themes from Q4 have been around systems and communication between agencies and partners. Some have highlighted the need for processes to be looked at around communicating the needs of children in their final days between differing care providers and the need to discuss the decision making in order to ensure this is best for the child. The sharing of important information has also been discussed whereby it has led to care and support not being given promptly to children and parents in a clear and coordinated way.

Learning and Actions

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

Conversations are ongoing between SUDIC Lead and Child Health to standardise and improve communication with involvement of the CBU Clinical Lead and Quality Lead.

The CBU Clinical Lead and Quality Lead have met with the SUDIC lead to share the database of Child Death in Leeds and is now merged.

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.

Contribution to Making Stuff Better - Examples from 2020/2021:

- **Following two cases of drowning public health advice was given to parents around bath times and swimming pools**
- **Following the death of a child cycling collaborative working resulted in road improvements with better markings and lighting etc.**

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

Leeds Community Healthcare NHS Trust

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (10b)

Title: Mortality Annual Report 20-21

Category of paper: For assurance
History: Quality Committee 24 May 2021

Responsible director: Executive Medical Director
Report author: Executive Medical Director

Executive summary

Purpose: To provide the Trust Board with assurance regarding the Mortality figures and processes within LCH NHS Trust during 2020/21.

Key points for consideration:

The impact of the Covid19 pandemic during 20.21 is evident in the increased number of deaths on neighbourhood team caseload, and the work required by the teams to provide care and ensure appropriate and timely review of these deaths.

Despite the increased workload**,** no lapses in care related to end of life care have been recorded during the past year and no significant issues relating to the quality of care impacting upon patients or families experience of EOL care.

The increased number of patients choosing to die out of hospital noted in 19.20 has continued and been amplified by the increased numbers of deaths during 20.21. The number of patients able to die in their first or second preferred place of death has been maintained consistently at over 75% however.

The neighbourhood teams have reviewed and developed their offer in response to the increased requirements and complexity of end of life care during the past year, and the offer now routinely includes home oxygen, sub-cutaneous fluids and enhanced clinical observations, this is delivered both by the Virtual Ward and neighbourhood teams.

The clinical team responded to the change in anticipatory care guidance and rapidly developed anticipatory care medication management over Q1 and Q2, with the support of the Medicines Management team.

Analysis of the deaths during 20.21 is presented within the constraints of the data-set available to us, and it is noted that our numbers of deaths in patients with a learning disability or severe and enduring mental illness remain far lower than expected. Work continues to improve identification of these patients, pending a city-wide solution that will enable the utilisation of primary care read codes, which would enable a robust data set.

Recommendations:

Quality Committee is recommended to:

- Receive the assurance provided regarding the Trust mortality process during 20.21
- Note the high quality of care provided during 20.21 despite the significantly increased workload for the neighbourhood teams and the additional pressures the pandemic created for the workforce and the Trust.
- Note the ongoing constraints of datasets available and that whilst work continues to improve this, it remains suboptimal for meaningful analysis at this point, particularly in regards to health equity.

Annual Mortality Report 2020.21

1.0 Background

1.1 Leeds Community Healthcare NHS Trust has contact with a significant number of patients within the city, 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 a significant amount of end of life care in peoples own homes, and many receive excellent care in the time leading up to their death.

1.2 The Francis inquiry report[1] into the care failings identified at Mid Staffordshire Hospital 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[2] 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".

1.3 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

1.4 Leeds Community Healthcare NHS Trust Mortality Review and Responding to Death Policy, renewed in January 2021 details our Trust response to both of these and clearly articulates our assurance process and governance surrounding mortality reviews and shared learning throughout the Trust and the wider system.

1.5 Deaths can broadly be categorised into unexpected and expected deaths, where an expected death results from an acute or gradual deterioration in a patient's health status, usually due to an advanced progressive incurable disease. The death is anticipated, expected and predicted.

1.6 Within Leeds Community Healthcare NHS Trust all deaths, whether expected or unexpected, whilst a patient is under the care of LCH services

and on an active caseload are reported via Datix®. Exceptions to this are noted in the policy, the main one being if the death is already recorded in the Electronic Palliative Care Coordination Systems (EPaCCs).

1.7 All deaths are reviewed using the Level 1 assessment tool, whether unexpected or expected. If this identifies that a more in depth review is required the Level 2 mortality review tool must be completed and the case reviewed at the local Mortality Governance meeting.

1.8 Any deaths that fall under the Trust's Serious Incident policy (e.g. Death in Custody) will be investigated using the Serious Incident Investigation framework and policy.

1.9 Where the unexpected death is a child the death will be reported via the sudden unexpected death in infants and children (SUDIC) route and follow that process.

1.10 Leeds Community NHS Trust is committed to ensuring any learning from deaths is shared appropriately, as widely across the organisation as required and using a variety of methods.

1.11 We are committed to ensuring the Trust's Duty of Candour policy is followed, and that families are involved in both any investigation that takes place and any subsequent learning as appropriate, including from any lapses in care.

2.0 Current position

2.1 In April 2020 the Mortality Surveillance Group ceased to become a stand-alone subcommittee within the Trust, and mortality reporting transitioned to the newly formed Quality Assurance & Improvement Group (QAIG). This new subgroup was formed with the approval of Quality Committee from the amalgamation of the previous Clinical Effectiveness, Patient Safety, Experience & Governance and Mortality Surveillance subgroups.

2.2 The Terms of Reference for QAIG were approved by Quality Committee in April 2020 and reviewed by the group in October 2020. QAIG has met regularly throughout 2020.21, and received a positive Effectiveness review from members in December 2020.

2.3 Business Unit mortality review and learning from deaths meetings have taken place regularly throughout 2020.21, and have been quorate throughout.

2.4 The Trust is compliant with the Learning Disabilities Review Programme (LeDeR) system for reporting any deaths in a patient with Learning Disabilities whilst under the Trust's care. During 2019/20 processes have been incorporated into Datix® to ensure any learning disability (LD) deaths are reported to the LeDeR program.

2.5 During 20.21 the Trust stopped reviewing deaths under the Specialist Business Unit separately, and has moved to a position where Adult (Adult and Specialist Business Unit) deaths are considered together, including joint mortality review meetings. As the majority of patients under SBU were also under ABU this has reduced duplication, but also increased the opportunity to explore areas where different services could work together better for the same patient.

2.6 The neighbourhood team control totals established during 19.20 are now well established, and enhanced surveillance and review has been instigated appropriately whenever a neighbourhood team has breached its upper control total.

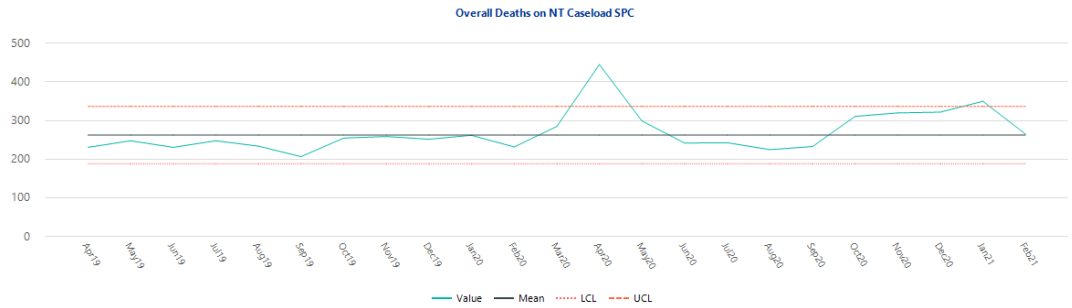
2.6.1 From Quarter 3 of 19/20, the Trust agreed to undertake the mortality reviews for the Non Alliance Community Care Bed Bases, at the request of the CCG. These deaths had not previously been being formally reviewed, and now fall under the standard Trust process.

2.7 Adult Business Unit

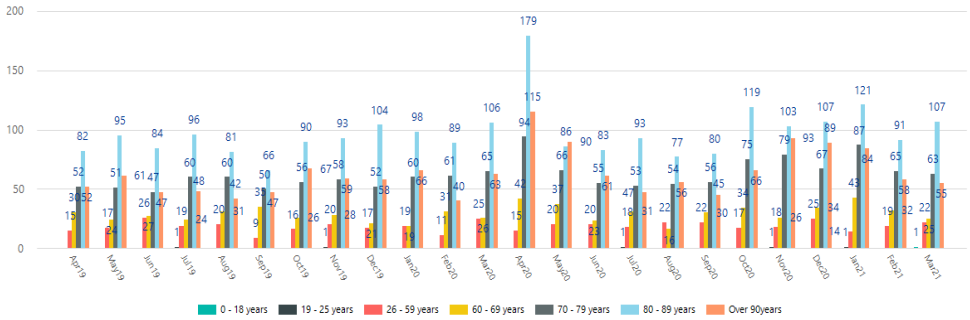
2.7.1 Mortality Data

Data	Q1	Q2	Q3	Q4	YTD	2019.20
Level 1	670	426	392	475	**1963**	1270
Level 2	137	129	136	140	**679**	206
Unexpected deaths	77	50	71	59	**257**	227
Expected deaths	593	376	433	420	**1822**	1319
Alliance CCB deaths (all reviewed in AMR Meeting)	3	2 (expected deaths)	4 (1 expected, 3 unexpected)	14 (2 unexpected)	**23**	12
Non-Alliance CCB Deaths	5	2	9	3	**19**	n/a
Virtual Ward deaths (commenced reporting in Q3)	N/A	N/A	2	3	**5 (caseload 549 over Q3/4)**	n/a
LeDeR	1	0	1	0	**2**	2
Serious Mental Health	1	0	0	0	**1**	2
Death with 30 days of Hospital discharge	New report Q2	8	11	Not yet confirmed (nominally 13)	**tbc**	n/a

2.7.2 The impact of Covid19 on the neighbourhood team caseload is evident from the table above, and comparator data for previous years shows the sustained impact over the past 12 months. The annual totals show that the Trust was involved in 36% more deaths over 20.21 than over 19.20. Overall number of deaths on caseload (expected and unexpected) was above the average SPC line for eight out of the 12 months in 20/21, falling to below average for March 21.

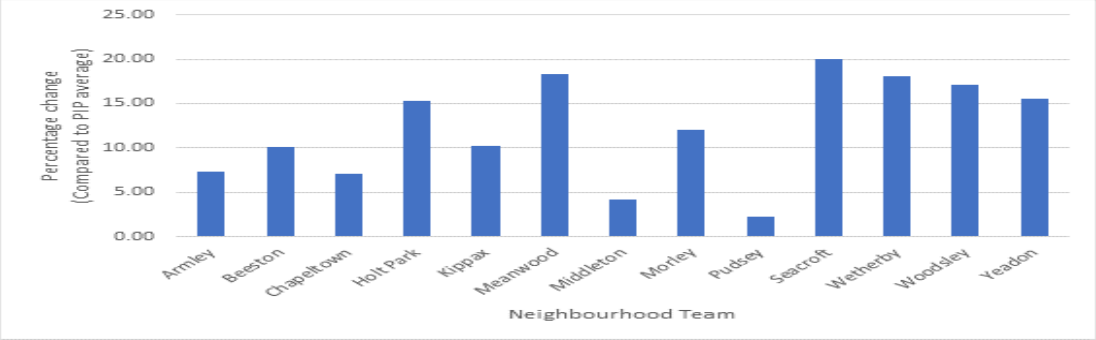


2.7.3 Demographic data shows that the greatest impact since April 2020 was on the population over the age of 60, but predominantly on the over 70s:

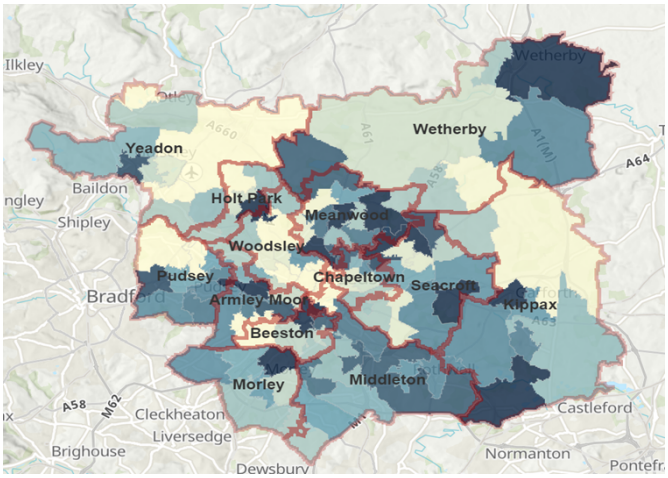


2.7.4 Analysis of deaths by gender show that these generally followed the same trajectory as non-pandemic deaths:

2.7.5 Prior to the pandemic, a higher proportion of deaths occurred in neighbourhood team caseloads for Middleton and Seacroft areas, whilst during 20.21 the greatest increase was noted in the neighbourhood teams below:

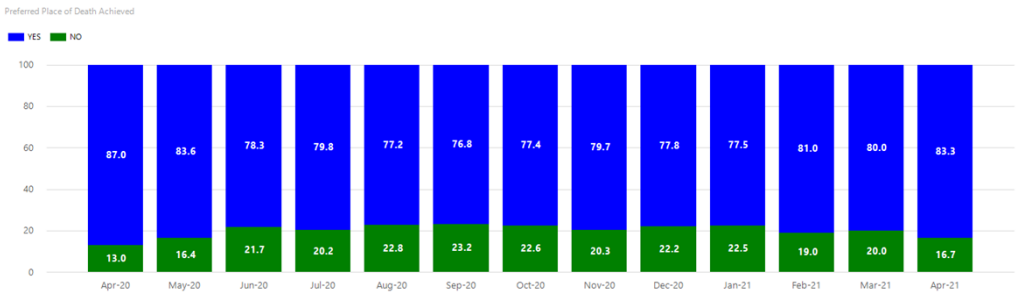


2.7.6 Comparison of Trust data with ONS mortality data (see figure below) suggests that the impact of deaths in neighbourhood teams was not always in keeping with the mortality rates seen within those areas. Whilst some neighbourhood teams (e.g. Seacroft, Wetherby and Meanwood) had large increases in deaths and relatively high rates of Covid19 mortality on ONS data, other neighbourhood teams which saw large increases in deaths (e.g. Yeadon and Woodsley) had relatively low Covid19 mortality rates on ONS data. Middleton, an NT with a relatively small increase in neighbourhood team deaths, had a relatively high Covid19 mortality rate on ONS data.



2.7.7 It has not been possible to obtain details of neighbourhood team mortality data by social deprivation or ethnicity in time for the submission of the paper, but this is anticipated to further understand the differential impact seen. At the point of writing it is therefore not possible to hypothesise whether this relates to referral rates, alternative support available in some communities, increased deaths in hospital or other factors. The Trust continues to work with colleagues in Business intelligence and the city data team to understand further and whether there is any learning for our services as a result.

2.7.8 Despite the large increase in neighbourhood team caseload, and the additional pressures on these teams from the impact of the pandemic, the Trust maintained high levels of patients accessing their first or second preferred place of death (PPD):



More than 75% were consistently supported to achieve their 1st choice PPD, and 80% to achieve their 1st or 2nd choice PPD in all but September 2020 (79.4%), comparable to 19.20.

2.7.9 The percentage of patients choosing to die out of hospital has continued to increase in line with the trend seen in 19.20. Unfortunately it has not been possible to obtain the 20.21 data in time for submission of the paper, but ABU data suggests the percentage of citizens choosing an out of hospital preferred place of death has remained similar at around 84% (45% at home) and may have risen slightly. The reasons for PPD not being achieved remain the same as in previous years, predominantly the home environment, crisis intervention or the carer being unable to cope.

The Adult Mortality Review meetings have increased the number of mortality cases reviewed per meeting from four to an average of ten per meeting to ensure a timely review was achieved. The cases selected included all deaths occurring in a CCB and the Virtual Ward and those on a NT or SBU caseload that triggered a review according to the established criteria. During the height of the Covid19 pandemic all cases involving Covid19 were subject to a Level 2 review, but with agreement from QAIG this was ceased at the end of Quarter 3.

2.8 Learning and improvements during 20.21

2.8.1 There has been an increase in the numbers of ABU registered nurses able to verify death, during 20.21 ABU RNs verified 1,858 deaths (own home and care home)

2.8.2 Supporting an increase in numbers of patients and accommodating to the level of complexity and rapid deterioration seen with Covid19 required a change in the level of care delivered to deteriorating patients. The neighbourhood team offer was enhanced and now routinely includes home oxygen, sub-cutaneous fluids and enhanced clinical observations; this is delivered both by the Virtual Ward and NTs.

2.8.3 The clinical team responded to the change in anticipatory care guidance and the rapidly developed anticipatory care medication management in Q1 and Q2.

2.8.4 Despite altering our Level 1 review forms during 19.20, identification of patients with a learning disability (LD) or severe and enduring mental illness (SMI) has remained significantly lower than the community prevalence. The Trust continues to work with partners across the city to improve this, and to better identify these patients whilst the utilisation of primary care read codes is established through improved transferability between data systems.

2.8.5 Learning from work with LTHT has resulted in us adding an extra step into the mortality review process for deaths of patients with a LD, which are now independently reviewed by a member of the West Yorks LeDeR reviewer team.

2.8.6 The Trust has progressed work with colleagues in secondary care to ensure that deaths within 30 days of discharge from hospital are reviewed in a coordinated manner, and from Quarter 4 have been able to identify these patients within our Level 1 reviews. Whilst the implementation of the Medical

Examiner system within LTHT is not yet fully established, LCH has established processes in order to ensure learning is shared between the Trusts for these deaths in order to better facilitate shared learning.

2.8.7 The Trust continues to work with colleagues in primary care to improve coordinated review of deaths in the community. Where possible NTs are present when deaths are discussed at some GP meetings and a letter has now been designed inviting primary care to attend or contribute to Level 2 review meetings when their patients are being discussed.

2.9 **Childrens Business Unit**

2.9.1 Mortality Data

Deaths within Children's Business Unit, with 2019/20 data for comparison:

	Total number of mortality reported incidents 2020/21					2019.20
Total Reported Children's deaths	Q1	Q2	Q3	Q4	**YTD**	
	4	2	3	3	**18**	24
Unexpected deaths [SUDIC]	2	1	3	3	**9**	12
Expected Deaths [CDOP]	2	1	0	6	**9**	12

2.9.2 There are established robust processes within Children's services around unexpected deaths via the sudden unexpected death in children (SUDIC) process and Child death overview panel (CDOP).

2.9.3 The Trust continues to be an integral partner in the Leeds Child Death Review Panels and processes. The Trust is an integral partner of these panels. For each possible scenario there is a designated primary organisation to arrange the Child Death Review Meeting (CDRM) and notify CDOP. LCH would organise the review meetings for those child deaths that have a chronic condition, have an expected death at home and have the death certified by the GP.

2.9.4 Following the concerns raised at Mortality Surveillance Group and in the Internal Audit report of 19.20, CBU Learning from Deaths meetings have taken place regularly and been quorate throughout 20.21. Learning from child deaths during 20.21 include providing public health advice to parents around bath times and swimming pools following two deaths by drowning. Collaborative work with the Local Authority and Police Road Safety Officers has resulted in road improvements such as better markings and lighting following the death of a cyclist, work is ongoing considering a safe cycling campaign. Work continues to ensure that appropriate reflective learning can take place at each stage of the process, in view of the prolonged nature of investigations and reports into the death of a child.

3.0 Next steps

3.1 The variation in services provided by Community Trusts and the flexibility with which a Community Trust can "carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach"[2] has to-date prevented benchmarking across Community NHS Trusts for mortality data. We continue to work with NHS Benchmarking and other community Trusts to ascertain a way to benchmark our data against comparable trusts for comparison.

3.2 Work continues with partners in the city to establish more inclusive reviews for patients whose care has cross organisational boundaries, and whilst progress has been made in this regard during 20.21 it is planned to continue to seek cross-organisational input in a more robust and reliable way. The move to an Integrated Care Partnership model for the city may provide alternative fora and processes by which this can be improved further.

3.3 The Trust database and centrally available mortality data for reporting is now reliable and robust, and enables increased surveillance of any geographical area of type of death moving outwith control totals. During 21.22 the aim is to continue to maximise the dataset available to enable meaningful analysis in line with the health equity agenda. This data can currently only be obtained through a manual search of the patient record, which is too time-consuming for the volume of patients in our dataset.

4 Recommendations

4.1 The Trust Board is recommended to:

- Receive the assurance provided regarding the Trust mortality process during 20.21
- Note the high quality of care provided during 20.21 despite the significantly increased workload for the neighbourhood teams and the additional pressures the pandemic created for the workforce and the Trust.
- Note the ongoing constraints of datasets available and that whilst work continues to improve this, it remains suboptimal for meaningful analysis at this point, particularly in regards to health equity.

5 References

5.1 The Mid Staffordshire NHS Foundation Trust Inquiry: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 to March 2009, volume 1, chaired by Robert Francis QC, published 24 February 2010.

5.2 National Guidance on Learning from Deaths, National Quality Board, First edition march 2017

Board Meeting held in public: 28 March 2021

Agenda item number: 2021-22 (11)

Title: Ageing Well

Category of paper: for update/assurance
History: none

Responsible director: Executive Director of Operations

Executive summary (Purpose and main points)

The NHS Long Term Plan (2019) outlined the Government's commitment to increase the capacity and responsiveness of community and intermediate care services as part of an Ageing Well Programme

One of the priorities in the programme is to ensure a rapid community response to enable patients to remain at home whilst receiving urgent care

The system has created a Virtual Ward (Frailty) to support the achievement of the target

This report focuses on progress to date against the urgent community response expectations and outlines the next steps towards full implementation

Recommendations

The Board is recommended to note

- the importance of this agenda and the nationally defined expectations
- the progress to date in establishing the Virtual Ward (Frailty) which enables the Trust to improve care and meet the national expectations
- the ambition to mainstream the approach through the Neighbourhood model transformation programme

Ageing Well

1 Introduction

The NHS Long Term Plan (2019) outlined the Government's commitment to increase the capacity and responsiveness of community and intermediate care services as part of an Ageing Well Programme

There are four priorities for community health providers:

- To develop an urgent community response
- To provide enhanced health in care homes
- To provide anticipatory care for complex patients
- To improve how community health services are provided

This paper focuses on priority one: developing an urgent community response.

2 Background

What is an urgent community response?

An urgent (two-hour) response is typically required when a person is at risk of admission (or re-admission) to hospital due to a 'crisis' and it is likely they will attend hospital within the following 2-to-24-hour period, without intervention to prevent further deterioration and to keep them safe at home.

What may cause a person to experience a crisis?

- A clinical condition such as a new or acute problem (eg an infection); or an exacerbation of a chronic condition, where the condition can be safely treated out of hospital, but where the functional consequences may mean that the individual is at risk of hospital admission

- Serious illness, where treatment at home is in keeping with the person's wishes as part of a pre-agreed treatment escalation plan, advance care plan, advanced decision to refuse treatment. The patient will likely be in receipt of palliative care and wish to be treated at home or their usual place of residence in a crisis, rather than being admitted to hospital

- A social care crisis, such as the breakdown of unpaid carer arrangements, which causes an immediate health risk to the individual. The Care Act places duties on Local authorities to respond to people experiencing a social care crisis.

What do we need to do?

The NHS Operational Planning Guidance 2021/22 states that by March 2022 all systems in England must implement the two-hour crisis response standard. The minimum requirement is for all ICS planners, commissioners and providers to:

- Provide services at scale to achieve full geographic coverage of two-hour crisis response care across systems

- Provide services from 8am-8pm, 7 days a week at a minimum
- Accept referrals into crisis response services from all appropriate sources and make crisis response services accessible via 111
- Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard

There is also a requirement to improve the responsiveness of intermediate care/reablement services in order that citizens can access the service within two days of referral – the target for implementation is 2023/24 but is already available in Leeds.

3 Current position

Virtual Ward (Frailty) – The Virtual Frailty Ward (VFW) is a collaborative service between Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust and partner organisations to provide coordinated rapid care to people in their home who are experiencing an acute medical episode and are living with moderate or severe frailty. This rapid care involves providing responsive assessment (including medication review), monitoring, investigations, treatment, support and education for people and their carers.

Now in its third year after a protracted operationalisation, the service covers the whole of Leeds and is performing well. The team holds a caseload of around 30-35 at any one time and operates from 8am-8pm, seven days per week.

The service aims to see patients within two hours and current performance (from conception to March 2021) is 74%. There are three areas for improvement which should ensure a more consistent two hour response:

- Review of the current workforce model to ensure appropriate capacity and skillmix. This will require investment
- Maximising time to care as there has been an increase in extremely complex patients requiring increased clinical time. The service will adopt ICE (electronic pathology) and Point of Care testing by September 2021and consider equipment requirements such as ECG and pulse oximetry to improve on the spot diagnostics
- Improvement in data quality as the underperformance in response time is partly explained by poor recording

The service is listed on the Directory of Service effectively making it accessible through 111.

The system therefore is effectively meeting the Urgent Community Response standard through this service but the approach needs to be rolled out on a much larger scale. Developments over the next period will be:

- To embed the approach within each Neighbourhood Team through the Neighbourhood Model Transformation Programme
- To improve the current service pathway ensuring equity of access across the city (currently there is differential uptake between PCNs)

- To work with Yorkshire Ambulance Service to increase knowledge/awareness and improve referral rates/reduce conveyancing to hospital
- To work with the community intravenous administration service (CIVAS) to streamline transfers between services
- To work with Virtual Respiratory Ward to adopt shared processes and test a Cardiac (Heart Failure) pathway
- To work with system partners to gain a Leeds wide approach to delirium and acute onset of distressed behaviours

4 Impact:

4.1 Quality

The full implementation of the programme of work will ensure people's urgent care needs will be met in a timely way closer to home, avoiding the need for hospital admission.

4.2 Resources

Funding will be available through National Service Development Funding (SDF) for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home.

This transformation funding will be released subject to receipt of plans to accelerate the two-hour rollout in line with planning guidance and a commitment to provide complete, timely and accurate data to the Community Services Dataset (CSDS) throughout 2021/22

It is understood that the West Yorkshire and Harrogate allocation for this is £12M and it is anticipated that this will be allocated on a fair-shares basis. The proposed allocation for Leeds is c£3.9M.

4.3 Risk and assurance

At present the Virtual Ward (Frailty) is funded non-recurrently. The success of the approach is evident and the team now manages a cohort of patients similar to the size of a large ward. The full evaluation of the ward is due in quarter 3 and this should lead to the development of a robust business case for future recurrent funding.

5 Recommendations

The Board is recommended to note

- the importance of this agenda and the nationally defined expectations.
- the progress to date in establishing the Virtual Ward (Frailty) which enables the Trust to improve care and meet the national expectations
- the ambition to mainstream the approach through the Neighbourhood model transformation programme

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (12)

Title: Health equity strategy

Category of paper: For approval
History:

The following process has been followed in the development of the Health Equity strategy:

- Quality Committee (22 Feb 2021) and Business Committee (24 Feb 2021)
- Board workshop (5 March 2021)
- Quality Committee (26 Apr 2021) and Business Committee (28 Apr 2021)
- Final draft to Board for approval (28 May 2021) ***– current stage***

Responsible director:Executive Medical Director
Report author: Health Equity Lead

Executive summary (Purpose and main points)

There are currently unfair and avoidable differences in the health of different groups and communities. These have an impact at many points in people's lives and as they move between stages – through birth and childhood, as adults and older people and at the end of life. As a provider of community health services working with communities at all these stages of life, we have both the ability and responsibility to make changes that will improve the health of diverse and marginalised groups and communities.

This **Health Equity Strategy** is our response to this, in how we create equitable care and pathways. It is designed to be short and accessible, with very clear commitments for how we will work:

- ✓ We consider inequity a serious and avoidable harm to our communities. Where we identify it, we will act.
- ✓ We will not be complacent. We will go beyond our legal duties to address the needs of all our diverse communities, in new ideas and current practice.
- ✓ We will listen and act where there are differences in diverse communities' access, experience and outcomes in our services. We apologise where we have had this information and not yet acted.
- ✓ We will focus on the health needs of all our communities, tackling inequity in the health of communities not already accessing our services as well as those who already are.
- ✓ We will work with our diverse staff communities to address inequities in health as well as inequities in their experience of the workplace, supporting health and financial wellbeing.
- ✓ Collaboration with communities, third sector and other partners will be core to the way we work.
- ✓ We take our role as a large organisation seriously and will continue to find ways that we can contribute to wider improvements in health equity through employment, what we buy and how we use resources.
- ✓ We will be clear and open about our progress. This starts with understanding how we're doing now and developing new ways to measure our progress and the impact of our actions.

The **implementation plan** defines the first 3 years of what is, by necessity, a long-term approach to achieving equitable care and pathways, through greater fairness in access to our services, experience of services and in the difference our services make to people's health.

In this paper, both documents contain multiple appendices to provide assurance of the context, scope and aspirations for this work. In accordance with our wish to make this truly accessible, they will not usually be provided together, but rather as standalone documents within a developing suite of resources for staff, leaders and partners to understand and fully engage with our health equity work.

The first 3-year delivery phase (2021-2024) of our strategy focusses on:

- Improving our insight into equity in the care we deliver and pathways we are part of, through increasing staff and leadership understanding of health equity and organisational capacity and ability to analyse and use data
- Working with our communities, partners and staff (many of whom are part of our local communities) to coproduce solutions to inequities identified.

While we increase our understanding of equity in care and pathways, we will initially focus on addressing inequity in 3 contextually important areas:

- Long-Covid
- Mental health
- Frailty

LCH Board has direct oversight of the health equity strategy and associated activity and each committee has responsibility for consideration of, and impact on, health equity within their own assurance pathways. A cross-directorate working group has been meeting to develop LCH's approach and join-up strands of related work and this will be extended to include Business Unit representation to ensure a pan-organisational approach to health equity. Assurance is then proposed to come through:

- Board workshop (March)
- Board update (May)
- Quality Committee deep-dive (date tbc)
- Board update (August)
- Business Committee deep-dive (date tbc)
- Board update (December)

Recommendations

Board is recommended to:

- receive and approve the Health Equity strategy
- note the commitments to the way we will work
- approve the focus of the first 3-year delivery phase, including year 1 plans
- approve the proposed assurance route

Our health equity strategy

We are here to provide the best possible care in every community. For us, this means knowing and working with our communities (the places we live in and the groups we are part of) and providing different support depending on different needs. This helps us achieve greater fairness in access to our services, experience of services and in the difference our services make to people's health. We call this fairness **'health equity'**.[1]

There are currently unfair and avoidable differences in the health of different groups and communities. These come from differences in poverty, education, employment, living conditions, the environment and the impact of racism and discrimination. Inequity occurs at organisational and structural levels and is impacted by how communities perceive the NHS as a state body. As a large employer and buyer and in our environmental impact, we play our part[2] in contributing to improvements. This strategy focusses on our role as a provider of community health services, the care we provide and pathways we are part of. This gives us both the ability and responsibility to improve the health of diverse communities. We do this through our services, leadership and staff and the contact we have with communities in birth and childhood, as adults and older people and at the end of life.

We will work with our communities, staff (many of whom are part of our local communities), third sector and statutory partners to improve the health of culturally diverse communities, people on low incomes or living in deprived areas and people in inclusion health and vulnerable groups. This will include work to prevent ill-health and to improve care for people who already have health conditions.

Our commitments are about how we will work with all our diverse communities to understand their needs, what works now and what could be better, so we can take action to increase health equity. To do this:

- ✓ We consider inequity a serious and avoidable harm to our communities. Where we identify it, we will act.
- ✓ We will not be complacent. We will go beyond our legal duties to address the needs of all our diverse communities, in new ideas and current practice.
- ✓ We will listen and act where there are differences in diverse communities' access, experience and outcomes in our services. We apologise where we have had this information and not yet acted.
- ✓ We will focus on the health needs of all our communities, tackling inequity in the health of communities not already accessing our services as well as those who already are.
- ✓ We will work with our diverse staff communities to address inequities in health as well as inequities in their experience of the workplace, supporting health and financial wellbeing.
- ✓ Collaboration with communities, third sector and other partners will be core to the way we work.
- ✓ We take our role as a large organisation seriously and will continue to find ways that we can contribute to wider improvements in health equity through employment, what we buy and how we use resources.
- ✓ We will be clear and open about our progress. This starts with understanding how we're doing now and developing new ways to measure our progress and the impact of our actions.

We will take action to achieve health equity. We are starting on a long-term programme of work to play our part in this. The first phase, over the next 3 years, will be to look at everything we do through an equity and inclusion lens. We will bring together existing work to tackle health inequity and try different ways of working with communities to understand how our actions can be most effective. This is what it will look like:

Increasing our understanding of health equity in our services	• All services will review data and other sources of information that tell us about access, experience and service impact on diverse communities' health. We will share what we find out and work with communities and partners to make improvements. • We will continue to improve the recording of diversity and inclusion data, starting with ethnicity, postcode and communication requirements.
Partnerships	• Working with the third sector, including our third sector strategy, to improve health equity and explore new ways of working with diverse communities. • Working in Local Care Partnerships and school clusters to improve health equity, promoting partnership working.

1 Appendix 1: Health equity language and what this means for us
2 Appendix 2: Our equity and inclusion lens: the different ways we impact on health equity

	• Cross-sector work to share learning and address the wider impacts on communities' health. • Partner reviews of our progress, for example through the NHS Equality Delivery System, work with Healthwatch and exploration of other opportunities such as the Sanctuary Health Award and inclusion health assessment tools.
Tools and resources to support leaders, staff, partners and communities to work together to identify and address inequity	• Roll-out of a new combined Equity and Quality Impact Assessment process and Review Panel to ensure risks and opportunities are identified and action taken. • Co-produced learning and resources to know the diverse communities in which we work, understand how they are affected by health inequity and identify and implement actions we can take at an individual level (reasonable adjustments) and for the benefit of diverse communities.
Focus on equity in quality and safety	We will consider equity in our proactive approaches to quality, including research, evidence-based guidance and outcomes as well as by reviewing our incidents and complaints to understand inequity affecting diverse communities and act to address these.
Addressing inequity through person-centred care	Self-management and digital options provide us with tools to improve health equity, alongside shared decision-making, health literacy and personalised care and support planning. We will work with partners and communities so that knowledge of inequity in these areas can be used to embed equitable ways of working. This will allow us to use the best of these opportunities and reduce any risks they pose.
Testing different ways of working	• Some services will work with communities in specific geographic locations to work out how to best deliver care specific to that community. • Some services will work with different communities of interest[3] to focus on improving their specific health needs. • We will also work across services to understand individual and family needs and the impact we can have, for example when moving between services, or the impact of poverty on accessing multiple services.
Sharing successes and progress	We will share the actions we take to improve the access, experience and impact on people's health with communities and our partners, continuing to learn from their experience. Understanding the changes made and the impact they have will support shared learning across services, creating 'blueprints' for future work.
Understanding the difference we are making	• Exploring ways of measuring impact and progress on health equity, such as social value or social return on investment and population health. • Use this knowledge to develop an evaluation framework which helps us to understand the impact we are having and make changes or take additional action where required

'Communities of Interest'[3] are groups of people who share an identity, for example people with a learning disability, or those who share an experience, for example the homeless community. People may have multiple experiences, identify with multiple groups, or move in and out of communities. In the first 3 years of this programme, we will particularly work with communities who experience significant inequalities in their health:

- People from culturally diverse backgrounds, particularly Black, Asian and other minority ethnic communities
- Refugees, asylum seekers, vulnerable migrant communities
- Gypsy, Traveller and Roma people
- Homeless people
- People leaving prison
- Sex workers
- Unpaid carers, including young carers
- People living in deprived communities
- People with drug or alcohol issues
- People with mental health support needs
- People with a learning disability, autism or mobility issues
- People with physical or sensory impairments, or are deaf or blind
- People with long term health conditions
- LGBT+ communities

3 www.forumcentral.org.uk/communities-of-interest

We know we will not be able to achieve health equity for all in 3 years. We are committed to working with our communities and partners for as long as it takes to stop the unfair and avoidable differences in health across our diverse communities. You are part of these changes. Work with us and tell us how we are doing.

LCH Health Equity strategy implementation

There are currently unfair and avoidable differences in the health of different groups and communities. These have an impact at many points in people's lives and as they move between stages – through birth and childhood, as adults and older people and at the end of life. As a provider of community health services working with communities at all these stages of life, we have both the ability and responsibility to make changes that will improve the health of diverse communities. This programme is about taking those actions to achieve health equity (Appendix 1) for all our diverse and marginalised communities. Due to the long-term nature of both the causes of inequity and changes in population health, this is by necessity a long-term programme of work, driven by leaders throughout the organisation committed to a fundamental cultural change to truly embed this in everything we do. The first phase of this programme (2021-24) brings together existing work already underway to improve health equity, with testing additional new ways of working. This strategy and implementation plan focusses on improvements we will make through equitable care and pathways. Other ways we will contribute, for example workforce and as an Anchor Institution (Appendix 2) are implemented and reported through their own governance routes.

1. How does health equity link to 'our eleven essentials'?	
We provide the best possible care to every community we serve	To provide the best possible care we need to know and work with our communities (the places we live in and the groups we are part of) and provide different support depending on different needs. This helps us achieve greater fairness in access to our services, experience of services and in the difference our services make to people's health. This fairness is health equity.
We are open and honest and do what we say we will	Our stated vision is to provide the best possible care to every community. This health equity programme will improve care where there are currently inequalities in access, experience or outcomes in the care we provide.
We treat everyone as an individual	We will work with population and community-level data to understand broad inequalities and what we can change to address these, but this does not replace person-centred care and recognising that all individuals are different and may or may not feel part of those communities or share experiences with others on those communities. Ongoing 'better conversations' work will support this.
We are continuously listening, learning and improving	Our co-production approach with communities and staff will enable us to continue listening and learning, to make improvements in the access, experience and outcomes of diverse communities in our services. Our use of language reflects how diverse communities refer to themselves. (See separate document: our health equity language)
Caring for our patients	Our health equity programme will support changes that improve the care of patients from diverse communities.
Making the best decisions	Use of data alongside staff and community insights enables us to understand health inequalities better and make better decisions about changes to make.
Leading by example	The breadth of the programme, through our 'equity and inclusion lens' on everything we do will focus leaders' attention on health equity no matter what their role. This will be supported by work to ensure the leadership development offer considers the cultural competency of leaders and tools to enable them to consider health equity within their role.
Caring for one another	Many of our staff (66%) are also citizens of Leeds. Working with diverse staff communities, for example through our Race Equality network, will enable us to better address inequalities in health as well as inequalities in their experience of the workplace.
Adapting to change and delivering improvements	Quality Improvement ('making stuff better') has been a significant focus for LCH and this health equity programme helps us to improve access, experience and outcomes for diverse communities who may not have benefitted from other improvements, or whose care may have inadvertently been worsened or health inequalities exacerbated as a result of previous changes made.
Working together	Partnerships and co-production are essential to our programme, with communities and our staff as well as external

	organisations both in service delivery that better meets the needs of diverse communities and in place-based and ICS strategic planning.
Finding solutions	Working with the insight of staff and communities to develop solutions that improve health equity, we will share our successes and use learning from these to further develop actions. We take a positive approach, which is why we talk about health equity rather than inequalities.

In addition to health equity being central to our vision and values, there are also statutory, regulatory and strategic connections and drivers connected to this work (Appendix 3)

2. What change are we looking to achieve through our health equity strategy and why?

In the last 10 years, health improvement in England has stalled and health inequity has widened[2]. The Covid-19 pandemic has impacted on families and communities, on mental and physical health, with a disproportionate impact on those living in the most deprived neighbourhoods, Black, Asian and minority ethnic communities, older people, males, those with obesity and other long-term health conditions. In LCH, we work with people through all life stages and want to improve the health of diverse communities in birth and childhood, as adults and older people, at the end of life and as they move between these stages. There are both moral and strategic reasons to do this. It is the essence of our professions and written into our very purpose as an organisation – to provide the best possible care in every community. To do this, we need to know and work with our communities and provide different support depending on different needs.

To understand our current position (baseline), we have considered analysis of caseload and referral that has been done as part of Reset and Recovery, feedback from communities and 3rd sector partners including Healthwatch (Jan 2021), Leeds GATE work on roads, bridges and tunnels and 100% Digital (July and October 2020), and analysis of our change stories (Appendix 4).

This analysis has identified priority areas of work for the first 3-year delivery phase of our health equity strategy:

a) To improve our **understanding of health inequity in our provision of care and care pathways we are part of, through increased staff understanding of health equity and organisational capacity and ability to analyse and use data**. Segmentation data has been available to us, but we have lacked either data within our own services, or knowledge to fully utilise it to understand the impact on health outcomes and drill down to a service level. Work over the last 2 years on population health management and frailty has introduced this approach to more people within the organisation, showing the benefits of this approach, so the appetite to further this work with other groups has increased. Building on this, we will analyse data and qualitative feedback to understand and act where there are inequities. For example:
   - Are our referral, DNA rates or completion rates different between Communities of Interest[1] and other populations?
   - Do our referral rates reflect higher incidences of conditions in some populations?
   - Are there particular themes reflected in complaints from some communities or an absence of feedback?
   - Are there disparities in number or type of incidents or outcomes?

b) As we identify inequities, we will **work with our communities, partners and staff (many of whom are part of our local communities) to co-produce solutions** which will improve the health of culturally diverse communities, people on low incomes or living in deprived areas and people in inclusion health and the most vulnerable and marginalised groups, recognising that changes we make to improve the health of our most marginalised communities will have a positive impact on the health of other diverse groups. This will include work to prevent ill-health and to

improve care for people who already have health conditions. To do this, we want to achieve a fundamental improvement in the way we plan and deliver our services, so that we can improve the health of diverse groups and communities, by improving:

- access to our services, including transition between them
- experience within our services and of using multiple services at the same time
- outcomes achieved (the impact our services have)

c) While we increase our understanding of inequities in our services and pathways so we can take appropriate action, we will initially focus on addressing inequity in 3 priority areas which are relevant to our current context, where we already know there are disparities in the city and have the opportunity and responsibility to act to address this:

- Long-Covid
- Mental health
- Frailty

3. Who are our target populations?

- People from culturally diverse backgrounds, particularly Black, Asian and other minority ethnic communities
- People living in deprived communities
- Homeless people
- People with mental health support needs
- People with a learning disability, autism or mobility issues
- People with physical or sensory impairments, or are deaf or blind
- People leaving prison
- Sex workers
- People with drug or alcohol issues
- Refugees, asylum seekers, migrant communities
- Gypsy, Traveller and Roma people
- LGBT+ communities
- Unpaid carers, including young carers
- People with long term health conditions

Collectively, along with other groups, these are known as Communities of Interest[1], defined as groups of people who share an identity, for example people with a learning disability, or those who share an experience, for example the homeless community. People may have multiple experiences, identify with multiple groups, or move in and out of communities. See also separate document “Health equity language and what this means for us”.

In the first year, our initial focus will be on **Black, Asian and minority ethnic communities**, **people living in areas of high deprivation** and **inclusion health groups**, being the most vulnerable and marginalised communities and where our actions can therefore have the most significant impact.

4. What are the key objectives that are going to be delivered and how we will know the difference we're making?

The following objectives and monitoring framework covers the whole 3-year period of the strategy. For the initiatives and outcomes expected and to be reported on in the first year (June 2021 – May 2022), see Appendix 5.

Objective	Initiatives	What will happen as a result?	How will we measure progress?	Methodology for measurement
Increasing our understanding of health equity in our services	Improve the recording of diversity and inclusion data, starting with ethnicity, postcode and communication requirements Review data and other sources of information that tell us about access, experience and their impact on diverse communities' health. Sharing what we find out and work with communities and partners to make improvements.	More consistent and accurate recording and reporting of data and better use of data enabling better understanding of inequalities in access, experience and outcomes. Improved understanding of equity of access, experience and outcomes within our services Foundations for co-production of solutions (with communities and partners)	Monitoring of the proportion of patients with recorded ethnicity, postcode and communication requirements	Analysis of patient level data
			Analysis of access, experience and outcome data at service level	Identify relevant markers for access, experience and outcome then analyse as per minimum data processing standards (see below)
			Monitoring of the number of services routinely reporting health equity data	Central record of services using health equity data
Partnerships	Work through 3rd sector strategy and partnership group to address health inequalities Partnerships with THIG and WYH LCP community-led approaches to tackling health inequalities School cluster approaches Sanctuary Health award Anchor Network partnership initiatives	Third sector strategy implementation plan agreed and initiatives started LCP projects identified and started Improvements to the experience of vulnerable migrants Anchor Network initiatives started	Third sector strategy measures Citywide and ICS strategic measures Analysis of access, experience and outcome data	Potential to develop a bespoke or use existing measures of stakeholder relationships FFT, partner feedback
Tools and resources to support	Tools and resources to support staff to explore data and qualitative feedback about diverse communities' access,	Improved understanding of how to access, use and act upon health equity data	Monitoring of the number of services routinely reporting health equity data	Central record of services using health equity data

Objective	Initiatives	What will happen as a result?	How will we measure progress?	Methodology for measurement
leaders, staff, partners and communities to work together to identify inequalities and make changes	experience and outcomes in our services and transition between them. Examples include: • Principles and minimum standards for understanding and using data • CoI[1] insight documents with health data for life-course, qualitative feedback and questions to prompt action • Training for EQIA • THIG toolkit	Identification of areas for improvement to feed into co-production work	Monitoring the number of people attending relevant training sessions	
			Evaluation of staff confidence in accessing and using health equity data	Staff engagement measure to be developed
			Feedback from communities, partners and staff	Ongoing engagement work through relevant LCH leads Ongoing work with THIG (including THIG toolkit data) Staff engagement - TBC
Focus on equity in quality and safety	• Equity in proactive approaches to quality, including research, evidence-based guidance and outcomes • Reviewing incidents and patient experience to understand any inequalities affecting particular communities or communities we are not hearing from and why, and act to address these • Equity as part of Quality Challenge+	Identification of inequalities in safety and experience Co-produced work to improve this for diverse communities Increased focus on learning in patient safety	Monitoring of quality and safety data through a health equity lens including: • Research • NICE evidence-based guidance • Mortality • Pressure ulcers • Falls • Incidents • Patient experience	Identify relevant markers for quality and safety then analyse as per minimum data processing standards (see below)

Objective	Initiatives	What will happen as a result?	How will we measure progress?	Methodology for measurement
Addressing inequity through person-centred care	We will work with partners and communities to use knowledge of inequity in self-management, digital options, shared decision-making, health literacy and personalised care and support planning to embed equitable ways of working that will allow us to use the best of these opportunities and reduce any risks they pose. Self-management is a priority 3rd sector strategy focus for SBU with an emphasis on health equity.	More equitable roll out of digital options which ensures access is equitable for all our diverse communities Improved health literacy through reasonable adjustments and self-management. Impact on access, experience and outcomes	EQIA for digital strategy and individual service changes Feedback from communities, partners and staff 3rd sector strategy progress measures	Completion and review of the EQIA tool to identify risks and mitigating actions Ongoing engagement work through relevant LCH leads Ongoing work with THIG (including THIG toolkit data) Staff engagement measure
Testing different ways of working to improve health equity	Work with communities in specific geographic locations to work out how to best deliver care specific to that community Work with different Communities of Interest[1] to focus on improving their specific health needs	Prioritisation of initial areas of focus (currently underway) Co-production of new ways of working Identification of key learning from testing new ways of working Reduction in inequalities in access, experience and outcome as a result in new ways of working	Analysis of access, experience and outcome data at service level	Identify relevant markers for access, experience and outcome then analyse as per minimum data processing standards (see below)
			Feedback from communities, partners and services	Ongoing engagement work through relevant LCH leads Ongoing work with THIG (including THIG toolkit data) Staff survey

Objective	Initiatives	What will happen as a result?	How will we measure progress?	Methodology for measurement
Sharing successes and progress	Sharing the actions we take to improve the access, experience and impact on people's health with communities and our partners, continuing to learn from their experience through a range of channels including: • LCH examples included in roll-out of THIG toolkit (May) • Communication with 3rd sector and communities about feedback listened to and impact of recent changes on that • EDS2 partner review (Dec 2021) • Quality Account • Thank You event	Improved understanding of equity work across communities and partners Improved confidence in LCH from key communities	Feedback from communities, partners and staff Achievement of milestones	Ongoing engagement work through relevant LCH leads Ongoing work with THIG (including THIG toolkit data) Staff survey
Understanding the difference we're making	Monitoring (the steady flow of data to provide an overview of progress as the strategy develops) and evaluation (assessing whether the strategy has achieved its goals) of health equity work.	Monitoring and evaluation of data to identify: • Changes in inequalities in access to services • Changes in inequalities in experience of services • Changes in inequalities in clinical outcomes. Identification of learning to be taken forward in phase 2 of the strategy.	Analysis of access, experience and outcome data – outcome data will be prioritised.	Identify relevant markers for access, experience and outcome then analyse as per minimum data processing standards (see below)
			Feedback from communities, partners and staff.	Ongoing engagement work through relevant LCH leads Ongoing work with THIG (including THIG toolkit data) Staff engagement - TBC

The monitoring and evaluation process being developed as part of the strategy will help us answer the question '*What impact is LCH having on health equity for the communities of Leeds?*'. The monitoring element of the framework, described above, will provide an overview of progress as the strategy develops using easily available data reviewed at regular time points. The evaluation element of the framework will be a more formal process at a specified time point in order to identify whether the strategy has achieved its goals. In order to identify the impact the strategy has had on health equity in the communities of Leeds

the predominant focus of the evaluation will be on health outcomes. We are keen to ensure that the final evaluation focusses on people and communities, rather than services. Whilst service level data is important, the evaluation will aim to use a community focused approach.

Some of our goals/ambitions and current position cannot be specified until we have undertaken the data analysis in year 1 (Appendix 5). Understanding our impact will be linked to citywide work on social value and other strategic measurements.

5. What resources are required to deliver our health equity programme?	
Resources Required	Are they in place?
Capacity within services to work with communities and partners to co-produce solutions	Specified within some services (eg LMWS, HHIT, Sexual Health). Further work to be done to identify ways of working within all services to support the commitment that this is part of everyone's work.
3rd sector partner capacity to work with services	Of the partnerships already in place, some are commissioned / funded through contracts, other informal arrangements are maintained through partner organisations' own infrastructure and funding. Once analysis is completed and scale / complexity of issues identified, this may not be sufficient to fully co-produce solutions.
Development around diversity, inclusion and cultural competency for all staff	Equality and Diversity continues to be part of our newly-reviewed mandatory training. The specific provision is being reviewed to ensure it is up-to-date and fits current organisational as well as statutory requirements. Cultural competency is also being considered as part of a review of the leadership development offer.
Strategic and programme delivery leadership	Named Executive Lead in place and commitment of senior leadership is key to the cultural change required to make this happen through setting and promoting direction and targets. Health Equity Lead and Public Health specialist in post until Jan 2022. True cultural change requires commitment from leaders throughout the organisation, with an openness to identify and share existing inequity and the vision and tenacity to make and maintain changes.
Data availability and analysis capacity and skills (further detail of our data and intelligence approach in Appendix 6)	Limited capacity in both Business Intelligence and in services to support this work. Further work is being undertaken to identify access routes to data. Leadership knowledge and skills to analyse health equity data will be supported through training and resources delivered in year 1, with ongoing work to align this with the work of other appropriate corporate teams. Citywide opportunities may be identified through the work of the Tackling Health Inequalities Group.
Operational costs of targeted work	It is likely that solutions that support inclusion will require creativity and flexibility which themselves require time, commitment to being solution-focussed and permission to think differently. There is a strong leadership commitment to enable this to happen and the culture change work will impact on hearts and minds. The specific operational costs cannot be predicted until the analysis has been completed.

6. What is the assurance and governance route for our health equity programme?
LCH Board has direct oversight of progress in the health equity programme, with reports 3-times a year, and each committee has responsibility for consideration of and impact on health equity within their own assurance pathways. Assurance and governance of the health equity programme will therefore come through: • Board workshop (March) • Board update (May) • Quality Committee deep-dive (date tbc) • Board update (August) • Business Committee deep-dive (date tbc) • Board update (December) In addition to this, there are agreed governance routes for other strategies and programmes of work relating to health equity: • Equity and Quality Impact Assessments – EQIA Review Panel • Workforce strategy • Digital strategy including virtual consultations • Reset and Recovery, including self-management • Equality Delivery System • Quality strategy • 3rd sector strategy

7. What are the key risks which may affect delivery?	
Detail of risk	Action being taken to mitigate the risk
Overall health equity risk listed in the BAF: If the trust does not optimise its services to reduce the impact of health inequalities and allow appropriate data capture to understand and address this, the impact will be on patient outcomes, the Trust's resources and reputation.	Health equity risk added to the BAF increases awareness of the risks and possible impacts. This programme of work is the mitigation for those risks, with specific risks relating to this programme listed below.
Improved health outcomes not achieved or focus continued long-term – this is a complex and well-known problem, with various previous initiatives undertaken.	Differing approach involving emerging good practice and a system-wide partnerships and priorities with key focus on co-production and dialogue.
Politically heightened issues currently. Previous experiences and structural inequity may dissuade some communities from trusting or participating in the initiatives / processes.	By coproducing this work we will not only make sustainable changes, but also improve trust, legitimacy and reputation with our communities. Workforce strategy to increase diversity and inclusion in leadership and staffing to reflect the communities we serve, will also improve community and other stakeholder confidence in the organisation.

Potential resistance to review and redesign of service models and delivery based on traditional / well established approaches	Engagement to introduce staff to this area of work focussing on moral imperative for this work which is why many people come into caring professions / the NHS and builds on staff survey results on engagement. Actions co-produced with staff, learning from staff insights as well as data. Links also to leadership element in developing workforce strategy.
Short-termism, that a focus on actions where impact can be measured in the next few years detracts from actions that could contribute to achieving health equity for future generations	While our focus is on the first 3 years of this programme, we have a commitment to this being the first phase in a longer-term programme that. By linking with our own and citywide sustainability, climate change, prevention and social value approaches, we will be able to contribute to the wider determinants of health that will benefit the health of future generations of diverse communities as well as current patients and carers.
Progress could falter if there is insufficient focus or capacity to drive this forward, both in direct leadership of the programme or wider leadership of changes.	The focus of the strategy to embed a culture change so that health equity is everybody's business will in itself mitigate the risk. In addition to this, an exit strategy for the dedicated resource is being planned, which would include where ongoing monitoring and progress reporting would sit.
Analysis may identify unmet need – people from diverse communities not yet accessing services. Services may struggle to meet additional referrals, resulting in extended waiting lists.	Prioritising access is always assessed based on clinical need. Access should therefore not be delayed for people with the highest clinical need.

8. Which stakeholders are involved in the programme?	**9. What will be the approach to co-production?**
Communities (including people currently accessing our services as well as those we need to reach)	Direct engagement with communities and third sector organisations supporting them at all stages of identifying issues, planning and implementing changes is both essential and integral to this work. Particularly in the understanding phase, we must learn from what we have already been told by communities to ensure that we do not unnecessarily or repetitiously asks communities the same questions they have told us the answer to before. We will utilise existing sources of information and cross-check these to ensure they are current and accurate. To underpin our approach, learning from existing service models of co-production with communities we will seek to develop consistency across services in key factors of co-production (contract management, leadership and dedicated capacity).
Staff	New initiatives identified through staff insights and engagement. Learning from LMWS and other models of co-production with staff to develop approaches across all services. The process for selecting new initiatives will be staff and community driven. Many of our staff are part of the communities of Leeds and so will be both beneficiaries and coproducers of actions taken to improve health equity.
3rd sector partners	Following the principles agreed in the 3rd sector strategy
Health and care delivery partners	Establishing partnership working principles through the delivery of shared initiatives, including: • LTHT and potentially other partners in the Sanctuary Health Award • Synergi collaborative to address inequity in mental health

	• Co-delivery of services and health care eg LCPs, MDTs, partnership delivery models
Health equity improvement partners	Playing our role so that our work to improve health equity both contributes to and has a positive influence on citywide and ICS health equity work. This includes: • Membership of the Leeds Tackling Health Inequalities Group, contributing to the development and roll-out of citywide health equity resources through that group and supporting citywide health equity initiatives including the Solidarity Network and migrant health. • Membership of the WYH ICS Health Inequalities Network and associated communities of practice, contributing to the sharing of good practice and learning from it to further develop our own thinking and approaches.

References

1 Communities of Interest - Forum Central

2 Marmot Review 2020 Build Back Fairer: The COVID-19 Marmot Review | The Health Foundation

<u>Appendix 1</u>: Health equity language and what this means for us

We commit to providing the best possible care to every community. To do this we must continuously listen, learn and improve. This is reflected in the language we use and why it changes – we work with our communities to understand what matters to them and how we can communicate this in the way we talk about **health equity**.

The "unfair and avoidable differences in health across the population, and between different groups within society" are known as health inequalities (NHSE). With our focus on finding solutions, our vision is to achieve a positive outcome where there are no such differences, rather than merely reduce inequalities.

Even with this positive focus, we know that to genuinely achieve fairness in access to our services, experience of services and in the difference our services make to people's health, we will need to go beyond equal opportunity, and that different communities and groups will require different levels of support. We will therefore work to achieve equity, meaning greater fairness of outcomes, by offering varying levels of support depending upon need.

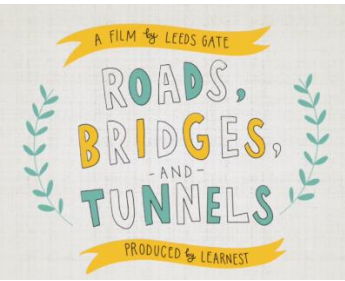
Various adaptations of a well-known illustration show the difference between equality and equity. And in this version, goes a step further to show what can be achieved if we remove the barriers creating difficulties in the first place.

This can provide a useful concept to understand equity, but the metaphor is problematic:

"These are not games but the lives of human beings. Equity is a home - a sense of belonging. Privilege is a tool that can be used to either build a home or destroy it. Experiences are materials - they can be rubble or building materials. We have to build towards equity - it takes both; people using their privilege and others using their experience. Equity, like a home, is a human right. Lifting barriers, restoring rights and protecting the most vulnerable is maintenance of that home. Equity requires ongoing work but it's a home we will pass onto future generations." (Salome Chimuku)

How we work to achieve this fairness is also sometimes called "**levelling up**".

Often, when we think about health equity, there can be a focus on **access** to services - "the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them" (WHO). All communities having good access is very important, however equity cannot be achieved in access alone. We not only need to ensure referrals and caseloads reflect the needs of our communities, we also need to ensure they have equitable **experience** and **outcomes** within our services.

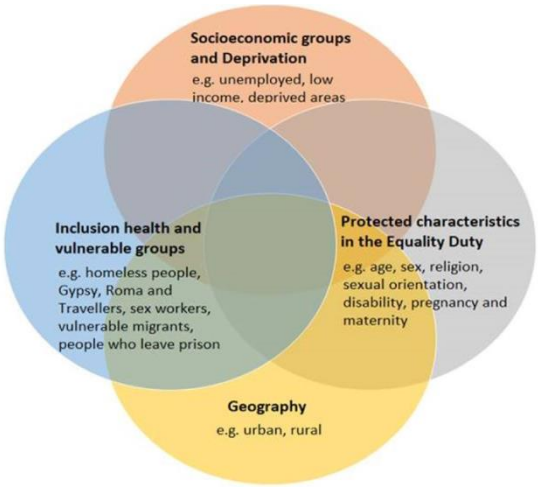


Leeds GATE, one of our third sector partners working with Gypsy and Traveller people, have developed a really helpful concept called "**Roads Bridges and Tunnels**" to help examine and understand ways in which people, especially but not only marginalised people, access public services. The Roads Bridges and Tunnels approach is an asset- or strengths-based approach which helps us to work with people and services positively. A short animation explaining these concepts is available here https://www.leedsgate.co.uk/roads-bridges-and-tunnel

Communities of Interest

'Communities of Interest' is a term used to describe groups of people who share an identity, for example people with a learning disability, or those who share an experience, for example the homeless community. People may have multiple experiences, identify with multiple groups, or move in and out of communities.

All these groups can experience health inequity, and so we will need to work to address all these groups' needs, not solely those with protected characteristics a described in the Equality Act (2010).



The definitions below are designed to share our most current understanding of how different communities describe themselves and how the language they identify is appropriate to them.

- **People from Black, Asian and minority ethnic communities**

  Diverse ethnic communities have previously been referred to by the acronym 'BAME'. The Chair of our Race Equality Network describes why this does not meet the needs of communities: *"By lumping everybody from an ethnic minority backgrounds together into one group of "other" the term didn't really acknowledge or seek to understand our individualities. The acronym BAME felt lazy and quickly became tired and a bit of a conversation 'blocker' than a 'starter'. Personally, and in discussions with colleagues, we felt being called a '**BAME person**' quickly became as grating as being called 'coloured person'*."

  You can find more advice and guidance on appropriate terms to use when discussing race/ethnicity here

- **Inclusion health groups**

  Inclusion health includes any population group that is socially excluded. This can include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery, but can also include other socially excluded groups.

  Inclusion health is a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence issues. This leads to extremely poor health outcomes, often much worse than the general population.

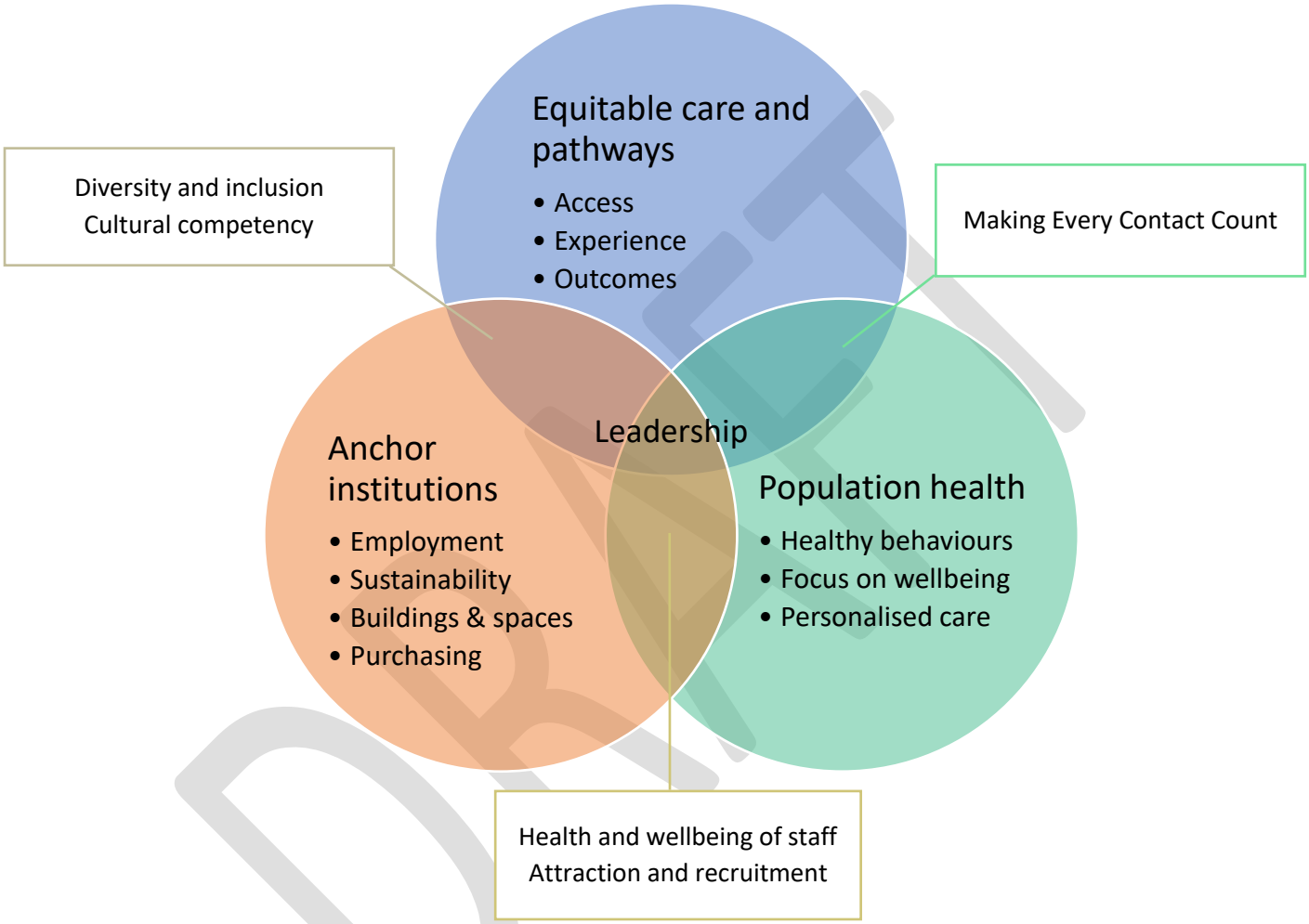
- **Vulnerable migrants**

  The term 'vulnerable migrant' includes refugees, asylum seekers and undocumented migrants, including people who have stayed after refusal for asylum, unaccompanied children and people who have been trafficked by force. Some initiatives and organisations refer specifically to refugees and asylum seekers. We recognise that undocumented migrants with no recourse to public funds are vulnerable and experience significant health inequities.

<u>Appendix 2</u>: Our equity and inclusion lens - the different ways we impact on health equity

The unfair and avoidable differences in the health of different groups and communities come from differences in poverty, education, employment, living conditions, the environment and the impact of racism and discrimination. Our aspiration is for health equity, where there are no such differences. This is a very long-term goal, but we can act now to contribute to this in a range of ways:

- As a large employer and buyer and in our environmental impact (known as being an 'Anchor Institution')
- By contributing to an increase in healthy behaviours (population health)
- As a provider of community health services, through ensuring the care we provide and pathways we are part of are equitable



Adapted from WY&H ICS Healthy Hospitals framework

Our **health equity strategy** (May 2021) focuses on equitable care and pathways. This includes work on:

- Making Every Contact Count, within our year 1 priority about mental health
- Staff learning about health equity and the health needs of diverse and marginalised groups

Our **workforce strategy** (due October 2021) will have equity as a key focus, in health, financial wellbeing and experience of the workplace. To effect the changes needed, it will focus on 4 key areas within the framework above:

- Diversity and inclusion
- Attraction, recruitment and selection
- Health and wellbeing of staff
- Leadership

Appendix 3

How does health equity link to statutory, regulatory and strategic drivers?	
Equality Act (2010)	Protects people with certain characteristics from discrimination and unfair treatment. People affected by health inequalities may have one or more protected characteristics but can also experience other factors such as deprivation and inclusion health groups, which will also be included in our health equity programme.
Health and Social Care Act (2012)	Requires due regard to reducing health inequalities between the people of England
Social Value Act (2012)	Requires consideration of economic, social and environmental wellbeing in procurement of services or contracts, which connects to our work on health equity through action on the social determinants of health, such as improving employment and housing.
DHSC White paper, Feb 2021 'Integration and Innovation: working together to improve health and social care for all' and subsequent inclusion in the Queen's speech	Sets out legislative proposals for a Health and Care Bill, including population health and collaborative working to improve the health of local areas. By addressing inequalities in the health of deprived and marginalised communities, we improve local health.
Marmot Strategic Reviews of Health Inequalities in England 'Fair Society, Healthy Lives' (2010) and 'Building Back Fairer' (2020)	Recognises the fair distribution of health, well-being and sustainability as important social goal and that tackling social inequalities in health and tackling climate change must go together. Considers inequalities in life expectancy, particularly in deprived and marginalised communities.
8 urgent actions required to tackle health inequalities in the latest phase of Covid-19 response and recovery (2020)	Identifies how the NHS should respond to COVID-19 and restore services by increasing the scale and pace of NHS action to tackle health inequalities to protect those at greatest risk.
NHS Equality and Delivery System (EDS2)	Helps local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty. See also CQC below.
Accessible Information Standards	The standards provide a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with a disability, impairment or sensory loss. Our health equity programme brings this together with a wider approach to understanding and meeting communication requirements for diverse communities.
West Yorkshire and Harrogate Health and Care Partnership '10 Big Ambitions'	Includes ambitions to reduce the gap in life expectancy for our most deprived communities and for people with mental health, learning disabilities and autism and to reduce health inequalities for children living in households with the lowest incomes.
West Yorkshire and Harrogate review report to tackle health inequalities for Black, Asian and minority ethnic communities and colleagues: Understanding impact, reducing inequalities,	• To improve access to safe work for Black, Asian and minority ethnic people in West Yorkshire and Harrogate • To ensure the Partnership's leadership is reflective of communities

supporting recovery	• To use information to plan services to meet different groups of people's needs through population planning. The review recommends that services are culturally competent and are contributing towards reducing inequalities • To reduce inequalities in mental health outcomes by ethnicity
Leeds Health and Wellbeing Strategy and ambition to improve the health of the poorest the fastest	Our approach to health equity goes beyond the protected characteristics defined within the Equality Act (2010) to include socio-economic groups, including a significant focus on people living in deprived communities. Along with the Inclusive Growth and Climate Emergency strategies, the Health and Wellbeing Strategy forms one of the emerging '3 pillars' of Leeds' strategic vision. Our contributions to citywide work around health inequalities and social value support this approach.
Leeds CCG Framework for Action and city-wide approach to tackling health inequalities	As per an excerpt from the draft health inequalities toolkit under development "i*t's no longer about the extra things we can do to tackle health inequalities, but about tackling health inequalities in everything we do"*. This is where our concept of an equity and inclusion lens on everything we do will support a more fundamental shift in our approach to achieving health equity.
Leeds CCG 5 year investment plan 'Left shift blueprint'	Focussing resources to address health inequalities to deliver better outcomes for people's health and wellbeing.
CQC consultation on their 5-year strategy	The strategy is proposed to include increased focus on reducing inequalities and accelerating improvement and will include new equality objectives. There are additional links being made between EDS2 and CQC inspections. CQC now also have a Memorandum of Understanding with the Equality and Human Rights Commission giving greater focus for CQC both on protecting the human rights of people at greatest risk of rights breaches and also on equality for staff where CQC haven't had regulatory powers but EHRC do.
NHSEI are producing a well-led approach to tackling Health Inequalities (early draft shared December 2020)	This framework will support implementation of the urgent actions to address inequalities in NHS provision and outcomes. Further detail to follow.

<u>Appendix 4</u>: **Health equity story-bank**
Edition 1: action taken prior to the strategy (our baseline)

#LCHlearns

Stories lie at the heart of change. They help us see what matters to people and inspire us to carry on when we encounter difficulties. We are using change stories to understand and take action to improve health equity among diverse communities.

Our change stories are short accounts that help us explore and better understand the range of experiences and outcomes relating to health equity. These stories provide a way for diverse voices and experiences to be heard and better understood. They can tell us what types of approaches or actions worked in what context and for whom they worked, and how and why they were important to individuals.

Here, we share some of our change stories and the insights they generate. This first edition shares stories of action already taken in services to improve health equity for diverse communities. The analysis helps give a baseline for future work, co-ordinated under our health equity strategy.

Our change stories

Our change stories are **short** (just a paragraph or so), tell us the **community they relate to** and the **area of health they have made a difference to** (access, experience or outcomes). Service stories explain the journey taken - what called our staff to accept the mission, were there doubts in taking on the challenge and how we came to answer the call of adventure and go on to achieve our mission.

A community consultation and needs assessment is the basis of our contract and service specification. This told us that Black, Asian and Minority Ethnic Communities, Refugees and Asylum Seekers, young people, older people, people with long-term conditions, LGBTQI+ Communities, perinatal women, atypical learners, Gypsy and Travellers, sex workers, care leavers, carers, and people who are digitally excluded are the groups who experience difficulties in accessing the Leeds Mental Wellbeing Service (LMWS). These groups are all highlighted in our Health Inequalities Action Plan, which is overseen by the Health Inequalities Lead and Steering Group. Our coproduction team is facilitating projects geared towards greater access, inclusion, improving outcomes and tackling health inequalities, delivered by a mixed team of members of staff, people who have used the service and other members of the Leeds community. One of our coproduction projects is the PCN 5 Project, which asks the question, 'How might LMWS better support the mental wellbeing of people living in LS9' with a specific focus on the ethnically and culturally diverse communities who live there. The project team are analysing demographic data and existing research to decide together where to focus their work. The Coproduction network are also involved in developing and then consulting on the Black, Asian and Minority Ethnic Priority Options Appraisal, looking at how LMWS can best improve access for those communities most impacted by Covid.	Changes benefitting the health of: **Black, Asian and Minority Ethnic communities** and **people in areas of high deprivation** By addressing: **access** In the: **Leeds Mental Wellbeing Service**

We identified lower numbers of referrals from Black, Asian and minority ethnic communities, although diabetes has a high prevalence in some minority ethnic communities. To address this, we developed a marketing strategy and recently our Lifestyle Practitioner, Clinical Lead Dietician and GP spoke on Fever FM. They talked about what is diabetes, the difference in Type 1 and Type 2, symptoms and what to look out for, healthy eating for diabetes, protecting your future health and who we are and how we can support.	Changes benefitting the health of: **Black, Asian and minority ethnic communities** By addressing: **access** In the: **Diabetes Service**

We know that people from a Black, Asian and minority ethnic background and people from areas of higher deprivation are more likely to have a long-term condition such as cardiac and and/or respiratory disease. To see if our cardio and pulmonary rehab reflected this, we looked at our data over a 4-month period and identified that the majority of patients were white and that although half of referrals were from areas with an LSOA deprivation score 1-2, only 10% from this group completed the course. The service has been well evaluated from people that have engaged with it, but little is known about those that didn't or couldn't engage. We are therefore planning some engagement work to learn from individuals that were not able to engage with the service to see what offer they would need.	Changes benefitting the health of: **Black and Asian communities** and **people in areas of high deprivation** By addressing: **access** and **outcomes** In the: **Cardiac and Respiratory services**

The HHIT service is commissioned from the margins – it was set up to meet the health needs of the most marginalised groups. The target populations the team engages with are; people experiencing homelessness, women who are sex working, Gypsies and Travellers. We are aware we are not offering a service for Roma people, and are currently trialling accepting referrals for Roma people to assess health needs to feedback to our commissioners.	Changes benefitting the health of: **Roma people** By addressing: **access** In the: **Homeless Health Inclusion Team**

We worked in partnership with Leeds GATE, a third sector organisation supporting Gypsies and Travellers to develop a short film to provide accurate information to the community about the Covid vaccine so they could make an informed choice whether to have it. https://www.youtube.com/watch?v=dpqM1YcmoxM	Changes benefitting the health of: **Gypsies and Travellers** By addressing: **access** To the: **Covid vaccine**

The Leeds Virtual Ward (Frailty) is a collaborative service offer between Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds Clinical Commissioning Group and other local partners including Adult Social Care and Leeds Oak Alliance. The service aims to provide coordinated rapid care utilising the skills of the multidisciplinary teams involved to people with an urgent medical need who can be safely managed in their own home to provide an appropriate alternative to a stay in hospital. Since the service went citywide in September 2020, analysing the data showed reduced referral numbers from the Beeston area, which is a highly deprived area. To target this area we arranged direct interaction and increased communication, developed a referral newsletter and information about the Virtual Ward. Over the past month referral figures have increased by around 10-15%, compared to months prior. This means more frail elderly people were assessed and accessed the Virtual Ward (Frailty) offer.	Changes benefitting the health of: **People in areas of high deprivation** By addressing: **access** In the: **Virtual Ward (Frailty)**

To address inequalities, the 18 Primary Care Mental Health Support Workers are all sited within the PCNs in the most deprived areas of Leeds and have all taken a lead role in developing links with the communities highlighted by the Health Inequalities Action Plan, developing links with organisations such as GATE, BASIS, PAFRAS and Forward Leeds to name a few. Mental Health Support Workers identified a number of clients who did not realise they were no longer on waiting lists for IAPT therapy having been sent opt in letters. Working with the coproduction team (a mixed team of members of staff, people who have used the service and other members of the Leeds community), we initiated a communications project to make the service's communication more accessible to avoid indirectly disadvantaging and excluding groups most impacted by health inequalities.	Changes benefitting the health of: **People in areas of high deprivation** By addressing: **access** In the: **Leeds Mental Wellbeing Service**

National evidence showed that people with learning disabilities had disproportionately bad outcomes from Covid-19. Thankfully there hadn't been widespread outbreaks amongst people with learning disabilities in Leeds, but we weren't sure whether this was the reason why we weren't getting referrals for people with learning disabilities to the Long-Covid service, or that people with learning disabilities were not experiencing long-Covid symptoms, these symptoms were not being recognised or that there was a gap in referrals. To address this we liaised with the Learning Disabilities team and, given the high risk to this group, decided to reduce the referral criteria from 12 to 6 weeks of ongoing symptoms. This will allow us to provide care to this vulnerable group while the evidence-base continues to develop.	Changes benefitting the health of: **People with Learning Disabilities** By addressing: **access and outcomes** In the: **Long-Covid team**

Learning from an incident in the care of a profoundly deaf man with no verbal communication and deteriorating vision, deaf awareness training for staff has been updated and is going to be provided by hearing impaired service users. As there was also learning about the recognition of domestic abuse for patients with additional communication needs, the training will include a particular focus on professional issues around domestic abuse, safeguarding, legal consent and proactive helpful hints and tips to good quality communication. To build on the standard use of first line face to face interpreting services, we are also looking to purchase the 'Sign Live' for staff to download to their laptops. This will provide an option for unexpected / emergency situations, giving instant access to a British sign language interpreter.	Changes benefitting the health of: **Deaf people** By addressing: **experience** and **outcomes** In the: **Neighbourhood Teams** (with wider learning across LCH)

Our mission statement is: *"The COVID rehabilitation team aims to provide high quality, integrated, rehabilitation to the people of Leeds, suffering from ongoing complications of Covid-19".* In order to achieve this we needed to ensure that the new service is accessible to all people in Leeds including often the underrepresented communities within health care that have also been adversely effected by the Covid pandemic. We analysed our referral data and identified low numbers of referrals for elderly people, despite evidence that elderly people who have pre-existing health conditions may take longer to recover from a COVID-19 infection, just as they would from other illnesses. We explored the reasons for low referral rates and found there was a lack of understanding about the symptoms of Long-COVID in elderly people, whose Long Covid symptoms could easily be misdiagnosed as a gradual decline or worsening frailty or dementia. To address this, we designed a poster to be distributed to all care homes and to services working with older people, to raise awareness of persistent COVID-19 symptoms in the elderly so that they can receive appropriate care.	Changes benefitting the health of: **Older people** By addressing: **access and outcomes** In the: **Long-Covid team**

Many Sex workers often have often chaotic lives, and so may struggle to access healthcare services. At Leeds Sexual Health we therefore offer a range of options for sex workers to access our service. This includes joint working with 3rd sector partners, providing outreach on the street and in saunas, home visits and drop-in clinics in their buildings where sex workers can attend and feel more comfortable. In outreach, we can offer screening, contraception, treatment, vaccinations and smear tests. This means they don't have to arrange an additional appointment which they may then be unlikely to attend. During Covid we were unable to deliver our usual outreach with partners, so we had to think about how we could do this differently. Some of the things we have done are: delivered virtual training to third sector staff; tried to encourage those most vulnerable to access the service in a different way; we have put on specific temporary clinics for sex workers close to the managed area; and had regular contact with those organisations we work closely with. In response to the pandemic, we have worked closely with 3rd sector partners, and the local homeless GP Practice to provide Covid vaccinations for sex workers within our specific clinic. We have also recently started offering TB screening in partnership with the LCH TB team. We have also been able to facilitate access to a larger variety and quantity of condoms within our specific clinic (provided by the third sector partner).	Changes benefitting the health of: **Sex Workers** By addressing: **Access and outcomes** In the: **Sexual Health Service** **TB Service**

The Role of Learning Disability Lead commenced on the 1st November 2020 to support the organisation to improve the health of people with Learning Disabilities and address inequities in their care. In the first 6 months this has been done through: • Clinical Consultancy - provided to staff in a number of different services by the LD lead including, ad hoc discussions, team consultancy, clinical supervision • NHSi Benchmarking - in 2021/22 LCH participated in all 3 areas for the first time: the organisational level data collection, a staff survey, and a patient survey. The standards are for people over the age of 18. An action plan has been drafted to meet the needs of people with a learning disability within the organisation. • LD across the wider region - the Learning Disability Lead in LCH is now a member of various LD groups in Leeds focusing on the health of people with Learning Disabilities. • Learning Disabilities Mortality Review (LeDeR) - supporting the new system for	Changes benefitting the health of: **People with Learning Disabilities** By addressing: **Access, experience and outcomes** through processes and clinical care

LeDeR and feeding learning back into the organisation. Learning about ensuring reasonable adjustments are made, availability of easy read literature, 'did not attend' appointments resulting in discharge and ensuring end of life plans are in place are feeding into other areas of work and actions being taken including our accessibility information standards work and the development of a 'not brought' approach.	**Across the organisation**

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care have been legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. LCH were working to this standard but it was not being consistently implemented across all services and for all patients. Work is underway to ensure that the Accessible Information Standards (AIS) is embedded throughout all services in LCH; this includes ensuring that the Communication template across all patient systems is mandatory and completed for all patients to identify communication needs. This has started with SystmOne and will include digital literacy with the addition of a digital ability questionnaire. There are ongoing Changes to the AIS section of the template and upon launch we will have a trust-wide report and patient alert ready to activate that acts as the flag for the need being present. Processes to review and update this information for patients will be implemented and intranet resources regularly updated to support this. To support implementation of the updated template several dedicated pages have been developed on the LCH internal intranet, these focus on patient information, interpretation and translation, creating patient literature, creating video content, creating accessible content and digital inclusion. The updated communication template will be launched in June with a plan around how to inform staff and raise awareness of AIS across Business Units. For anyone identified as having communication needs we are expected to provide information is an appropriate format- this includes all service user and service information. It is hoped compliance with AIS will sit with the Quality Challenge programme for internal monitoring.	Changes benefitting the health of: **People with access or communication needs** By addressing: **access and experience** In: **All services**

For the end of year mortality report data were analysed to identify inequalities in mortality across the neighbourhood teams. In order to take a true health equity approach, LCH data were presented with population level data to compare healthcare activity with community need. Mortality data from the neighbourhood teams were analysed and to show variation in deaths compared to expected numbers. ONS COVID mortality data were mapped to identify population need. Interpretation of the data suggested that the change in neighbourhood team activity was not well correlated with underlying population mortality rates. Comparing LCH data and population data to generate meaningful insights can be challenging. Differing geographies and the lack of obvious population sizes for the various geographical subunits make comparisons difficult. As the health inequity work progresses it will be important to work with system partners and LCH BI colleagues to explore how to improve data systems to help increase actionable data insights.	Changes benefitting the health of: **All communities of interest** By addressing: **Access and outcomes** In the: **Neighbourhood Teams**

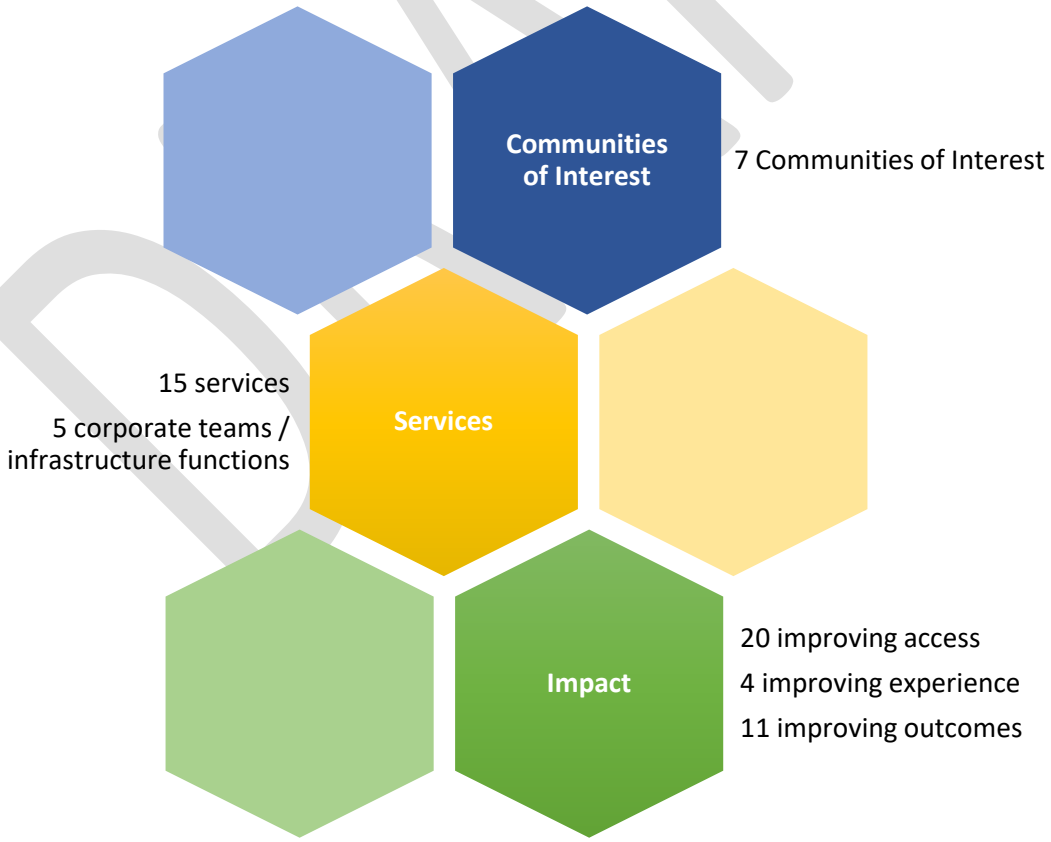
In addition to these change stories, we have also made progress in the following areas:

Community	Service	Aspect of health equity	Promising practice
• People living in areas of high deprivation • Minority ethnic communities	Frailty Partnership	Outcomes	Reviewed the frail population segmentation by age, deprivation and ethnicity. They identified the average age across the deprivation deciles increases from most to least deprived and that people from a non-white background in the most deprived areas (IMD 1) are, on average, 10.8 years younger than those people from a white background in the least deprived areas. There is now an opportunity to consider what this means for our services working with frail populations, such as virtual frailty ward
• Minority ethnic communities	Cardiac, respiratory and diabetes services	Access	Identified higher DNA/CNA (did not attend/cancelled appointments) rates in BAME communities compared with White communities as well as disproportionate numbers of appointments with Black and Asian patients compared to the Leeds demographic. This caused particular concern as there is a higher prevalence of diabetes among these communities. Further work is being undertaken to understand patient experience and act on this.
• People from Black and Asian communities	Quality and Professional Development	Experience	Bruising policy – identified by members of the Race Equality Network that a policy to support staff in identifying bruising in babies under 12 months and what action to take did not take into account the potential impact on parents of children with Mongolian Blue Spots. The policy was reviewed and additional information provided.
• Minority ethnic communities • People in areas of high deprivation	Musculo-Skeletal Service (MSK)	Access	Reset analysis considering the deprivation and ethnicity of patients who were 'paused' during Covid and then who engaged with 'mypathway' and then went on to access the service.
• People with learning disabilities	Safeguarding	Access and outcomes	Learning from incidents to develop a ‘not brought’ approach to protect vulnerable adults as well as children
• All experiencing health inequity	Clinical Outcome Improvement Network	Outcomes	Identified knowledge around health inequalities were integral to effective use of clinical outcome measures in services, so their second training session focussed on the needs and experiences of different vulnerable groups and the potential impact that has on their health needs and engagement with our services
• Black, Asian and minority ethnic communities	CAMHS	Access	Identified a decrease in referral rates so reviewed this by ethnicity, identifying patterns of change consistent with LMWS, with an increase in referrals for service users of an Indian background but decrease in those of Irish background. However as this happened in the context of a significant change in referrals overall, monitoring for emerging trends continues
• Black, Asian and minority ethnic communities	CAMHS	Experience	The new early intervention mental health team are looking at how they can address health inequalities and improve access from Black, Asian and minority ethnic communities, including how to increase cultural

			competency among staff to ensure the service is accessible for all young people
• Minority ethnic communities • People in areas of high deprivation	Podiatry	Access	Reviewing the letter-based opt-in process to understand the impact on health inequity
• People in areas of high deprivation	Community Cancer Support Service	Access and outcomes	The new Community Cancer Support Service has developed profiles for the areas they cover to help them think about and plan their work on a local level. Tha data has come from Leeds Observatory, Ward Health Profiles and some cancer specific information from the Leeds Cancer Programme. Early data for the service doesn't reflect the diversity of the populations they're working in, including some of Leeds' areas of highest deprivation. They are working with their new care navigator roles to plan specific actions to address inequity.

Analysis

Please note the breakdown below does not always equate to the total number of changes analysed (24) as some include multiple services, or may include multiple impacts or communities.



Changes have been focussed on 7 different communities of interest:

- 12 changes focussed on improvements to the health of **Black, Asian and minority ethnic communities**. They have predominantly focussed on improving access (8 changes), though there has been some consideration of experience and outcomes of diverse communities.

- 8 changes focus on improvements to the health of **people living in areas of high deprivation**, predominantly focussing on improving access.

- 2 changes focus on improvements to the health of **deaf people** and those with **additional communications needs**

- 2 changes focus on improvements to the health of **Gypsy, Traveller and Roma people**

- 2 changes focus on improvements to the health of **Older and frail people**

- 2 changes focus on improvements to the health of **People with learning disabilities**

- 1 change focus on improvements to the health of **sex workers** and other vulnerable health inclusion groups

- 3 changes focus on improvements to the health of any / all communities of interest. These tend to be at the stage of analysing data to understand what inequities exist, so that specific actions can be taken to address any inequities identified.

Most changes (20) had an element of focus on improving **access** for communities and groups experiencing health inequity. This mainly comes from analysing referrals but there was also some review of caseload, did not attend and cancelled appointments. Having identified difficulties in access for certain communities of interest, 8 services have then gone on to take specific action. This included:

- Prioritising the location of staff in areas of high deprivation (LMWS, Community Cancer Support)
- Providing information to referrers about the condition and symptoms in the specific patient group (Long-Covid)
- Partnerships with 3rd sector (LMWS, Sexual Health, HHIT)
- Changes to referral criteria (Long-Covid, HHIT)
- Sharing approaches and learning between services (Safeguarding, Learning Disability)
- Changes to communication methods (LMWS, Diabetes)

7 services have either not yet taken action or are considering further actions, although some had identified what their next steps would be, including engagement with that community to better understand the reasons for this which would help identify share solutions.

How does this inform our future actions?

- **Moving from intent to action** – exploration with services who have identified issues but not yet taken action to address them. Further discussion with those services will help identify if this is about identifying solutions or implementing them and what support may be needed to do this.

- **Raising awareness of the importance of experience and outcomes** – increase understanding that while access is very important to achieving health equity, we must also consider and act to achieve equitable experience and outcomes for communities of interest.

- **Ongoing monitoring and review** – where actions have been taken and we have promising practice in services that we think will address inequity, we need to follow up to review whether these actions have had the desired effect

- **Sharing transferable solutions** – promote actions with other services who have identified inequities in the same communities / groups or where there are similar issues

- **Promoting partnership working** – working with 3rd sector partners and services to develop mutually supportive ways of engaging to avoid duplication (being asked the same thing by multiple services) while promoting the expertise of 3rd sector partners in engaging with communities and co-producing solutions that address inequity.

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Appendix 5: Year 1 plan

Objective	Year 1 actions	Timescale
Increasing our understanding of health equity in our services	Improve the recording of diversity and inclusion data, starting with ethnicity, postcode and communication requirements	Jun 2021 onwards
	Services review data and other sources of information that tell us about access, experience and outcomes of Communities of Interest, starting with ethnicity and deprivation	Sep 2022
	Equity and inclusion lens: increase meetings and reports where health equity is considered	Mar 2022
	Review of analysis to plan year 2 priorities	Apr – May 2022
Partnerships	3rd sector strategy health equity priority	Ongoing
	Engagement with LCPs in health equity projects	Ongoing
	Engagement with THIG and WYH health equity programmes and communities of practice	Ongoing
	Support delivery of Synergi mental health projects	Ongoing
	EDS2 partner review	Dec 2021
	Achievement with provider partners of Sanctuary Health award	Mar 2022
Tools and resources to support leaders, staff, partners and communities to work together to identify and address inequity	Roll-out of Equity and Quality Impact Assessment process and Review Panel to ensure risks and opportunities are identified and action taken, including delivery of EIA information sessions	May – Sept 2021
	Launch of Health Equity MS Team channel	June 2021
	Launch of Heath Equity intranet page	June 2021
	Launch of THIG toolkit	July 2021
	Document outlining principles and minimum standards for understanding and using data	Sept 2021
	Communities of Interest insight documents with health data for life-course, qualitative feedback and questions to prompt action	Nov 2021
Focus on equity in quality and safety	Initial mortality review with demographic analysis. Learning to influence mortality reporting format to enable analysis by ethnicity and deprivation in future reports.	May 2021 (annual)
	Review of pressure ulcers and other incidents by ethnicity and deprivation	As per Quality

		strategy
	Review of complaints and concerns by ethnicity and deprivation	As per Quality Strategy
	Development of equity assessment process in the development of clinical policies and protocols	Dec 2021
Addressing inequity through person-centred care	Support 100% Digital inclusion projects and share learning within LCH service delivery	Ongoing
	Support delivery of self-management activity that improves health equity	Ongoing
	Develop awareness and identify actions to address inequity through shared decision-making, health literacy and personalised care planning and support.	Ongoing
Testing different ways of working	Identify and implement solutions to inequity in Long-Covid	Ongoing
	Identify and implement solutions to inequity in mental health - In mental health services (CAMHS and LMWS) - In physical health, through Making Every Contact Count (mental health)	Ongoing July 2021 onwards
	Identify and implement solutions to inequity in Frailty	Ongoing
	Review learning from delivery to plan broader testing in year 2	Feb - May 2022
Sharing successes and progress	1st edition of LCH changes stories shared with services and partners to prompt further engagement	Jun 2021
	Quality Account	Jun 2021
	Additional change stories shared through Midday Briefing and Health Equity intranet	Jul onwards
	Additional editions of LCH Change Stories collated, analysed and shared in Board reports	Aug, Dec, May
	Thank You event	Dec 2021
Understanding the difference we are making	Support citywide exploration of ways of measuring impact and progress on health equity, such as social value or social return on investment and population health.	May 2021
	Use this knowledge to develop an evaluation framework which helps us to understand the impact we are having and make changes or take additional action where required	Dec 2021

Priority measures that will tell us how we're doing

	Priority Measure	Current Baseline	Ambition	Comments
Data & understanding	Improve the recording of diversity and inclusion data, starting with ethnicity and communication requirements	Ethnicity 90% Communication tbc		
	Equity and inclusion lens: reports relating to care provision are analysed in relation to health equity	No requirement currently	By the end of year 1 all reports relating to care provision going through committees will include analysis by (as a minimum) ethnicity and postcode (as a proxy for deprivation)	
Tools and resources	Equity and Quality Impact Assessment roll-out: outcomes of Review Panel			Commence May 2021
	Delivery of information sessions & tools			Measure of understanding to be rolled-out
Quality and safety	Availability of analysis by ethnicity and deprivation in quality and safety reporting			As per Quality Strategy
Person-centred care	EQIAs considering digital service provision confirmed by EQIA panel			
Testing	Improvements in access, experience and outcomes in Long-Covid, Mental Health and Frailty services.			Baseline and ambition tbc
Sharing	Publication of LCH change stories and resulting feedback	New requirement	3 x yearly	
Impact	Implementation of evaluation framework	New requirement		

Appendix 6: Approach to data and intelligence

Data and intelligence are vital elements of the LCH health equity strategy and will be core to the identification and monitoring of inequities within the work of LCH. This appendix discusses the intended approach to data in more detail. As with other parts of the strategy it is expected that the approach to data will be iterative and that processes will develop over the life of the strategy.

Uses of data and intelligence

Data and intelligence will broadly have 2 functions within the LCH strategy:

- Identification of inequity within LCH
    - Initial analysis of LCH data suggests that access, experience and outcomes are not equitably distributed throughout our communities.
    - Further work is needed to identify and monitor inequity across LCH services and functions
- Identification of need within our communities
    - True health equity takes account of need in order to scale input accordingly. For LCH this means understanding need within the diverse communities we work with.
    - This is particularly important as the health equity strategy makes a commitment to include those not currently accessing our services. As per the inverse care law, those most in need of care are often those that are least able to access it, resulting in an unmet need within communities.

In order to progress towards health equity these 2 functions will need to be combined to enable a clear understanding of inequity and informed decision making to reduce identified inequity.

Data and intelligence sources

It is proposed that data and intelligence sources both internal and external to LCH will be used to aid our understanding and monitoring of health inequity. These are summarised below:

- LCH data
    - Service level
        - Access – referrals, DNAs, cancellations, contacts
        - Experience – complaints, incidents, Friends and Family Test
        - Outcome – clinical outcome measures
    - Library service
        - Bespoke evidence reviews to provide information on population need and best practice
- External data and intelligence
    - Tackling Health Inequalities Group (THIG) Toolkit
        - Currently under development
        - Links together a range of quantitative and qualitative data sources to provide a snapshot of inequalities across the city
    - Leeds City Council health needs assessments
        - Provide detailed analysis of data for a range of geographical communities and communities of interest
    - LCP profiles
        - Detailed health profiles for each LCP
    - PHE Fingertips tool
        - Health outcome data which can be viewed at city level and used to compare with regional and national areas.
        - Can also be used to identify inequalities at a national level.

Access to data

In order to maximise the use of equity data in services a key priority is to ensure that these are easily accessible. PIP is currently limited in its ability to go beyond simple reporting of demographics. Initial discussions with BI team suggest there is the potential to develop this further to offer easy access to relevant equity data. Further discussions and development work are planned.

External data and intelligence must also be easily accessible to services to guide equity work. The data sources listed above will be made available to services for reference.

Process of data analysis

The implementation plan prioritises ethnicity and deprivation as key markers of inequity in the initial phase of the health equity work. Analysis of inequality by geographical area will also provide useful insights. Services will be asked to report inequity in access, experience and outcome by ethnicity and deprivation as a minimum during year one.

As discussed above, initial discussions suggest that there may be the potential to include relevant breakdowns in PIP subject to further development work. This would ensure services had access to standardised equity analyses and would limit the demands on the Business Intelligence team.

Several services have specific data sets which may also facilitate health equity analysis and it is anticipated that analysis of these will continue to add supplementary intelligence.

Data for both ethnicity and deprivation are currently available through routinely collected data, though not yet embedded in all reporting. Deprivation is best analysed using the Index of Multiple Deprivation deciles which can be identified from postcode data and from SystmOne. Ethnicity recording is currently variable across the trust. In order to standardise comparisons across services, work will be carried out to identify potential ways to bring ethnicity recording in line with census ethnicity categories. Geographical analysis can be complex due to varying geographical subunits (e.g. electoral wards, LCPs, neighbourhood teams). Further work is needed to identify the most meaningful way to breakdown data by geography. Initial discussions with the LCP development team suggests LCPs could be a useful break down of LCH data as LCPs are understood across the system and link into important community development activities. Although LCPs are technically practice based there is the possibility to use a more pragmatic method of mapping to LCPs via postcode. Collecting postcode data also has the advantage of being able to link to other geographical subunits as necessary, although it also has challenges - full postcode is too granular and partial postcode often isn't granular enough (eg LS7 varies massively between Chapeltown and Chapel Allerton, LS8 between Harehills and Roundhay). Further discussion will help identify not just what we collect but how we use it to report.

For external data and intelligence it is proposed that rather than performing in depth analysis the existing intelligence sources are used to highlight the needs of our diverse communities.

Using data and intelligence to guide action

The health equity strategy makes a commitment to tackle health inequity where it is identified. In order to move from data to action, results of data analysis must be interpreted to identify priority areas for action, however this can be a complex process. As discussed above, true health equity should consider population need, meaning LCH data should be interpreted in the context of wider population data and intelligence. Incomplete data, differing geographies and the lack of population denominators can limit the ability to accurately link these data sets. Interpretation therefore needs a level of subjective decision making, bringing together various data sources to inform action. Key considerations include:

- What we already know about the various communities of Leeds (both geographically and by communities of interest)

- Work ongoing in the wider system (e.g. LCP development work, Leeds City Council focus on particular neighbourhoods, third sector work with communities such as Gypsies and Travellers)
- Learning captured through other health equity work within LCH.

Data and intelligence can also be used to consider possible actions that may help reduce identified inequity although the strategy makes a commitment to co-production of solutions so wider engagement at this stage is needed. Examples of how data and intelligence may identify possible solutions include:

- Considering what the data are telling us about our service model (i.e. do we need to vary delivery for a particular community of interest or do we need to vary delivery by geographical area?)
- Considering what the evidence base shows regarding effective interventions to reduce inequalities
- Considering whether universal or targeted interventions would be more appropriate
    - Universal – considering digital exclusion (likely to impact access for people across our communities)
    - Targeted – working to improve outcomes for a specific community of interest

Further developing data and intelligence systems

As the wider health and care system continues to develop, other opportunities to improve the way LCH uses health equity data are likely to be identified. One example of this is the development of the ICP which may offer opportunities for improved data sharing and population health management. Opportunities such as this sit outside the control of LCH but should be seized upon as they are identified in order to refine the way LCH uses health equity data.

Risks

Risk	Description and mitigation
Completeness of data	A key risk to the usefulness of data to guide improvement is the completeness of data. Ethnicity recording is variable across services and contains significant gaps. Other important gaps include the recording of communications preferences, serious mental illness, disability, learning disability, sexual identity and orientation, gender identity, homelessness, refugee status and carer status. The initial priority will be to improve recording of ethnicity and communication preferences with subsequent work focussed on improving collection of other characteristics.
Access to data	Access to detailed health equity data within LCH is currently limited. Initial discussions suggest there should be scope to improve access to equity data through PIP but this needs further discussion before a firm commitment can be made.
Capacity and skills for analysis	Asking all services to report health equity data in year one means a significant increase in the amount of data required. Providing analysis through PIP (if possible) would reduce the workload for the BI team however there is likely to be a requirement to supplement this at times. Capacity and skills for analysis with services is another risk. The data may be complex and incomplete meaning interpretation and translation into action may be challenging. Ongoing support from the health equity lead will be important in supporting this process.
Capacity to act on findings	Translating health equity analyses in action requires considerable capacity if the ambition of truly co-produced solutions is to be realised. Current pressures within the Reset and Recovery work may provide both opportunities and challenges to health equity work.

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (13)

Title: Third Sector Strategy Update

Category of paper: for assurance
History: none

Responsible director: Executive Director of Operations
Report author: Partnership Development Manager

Executive summary (Purpose and main points)

This paper provides a progress report on implementation of LCH's first Third Sector Strategy.

Good progress has been made across most workstreams. Reset and Recovery reporting has highlighted to Board some of the excellent partnership working with the 3rd sector, and with the wider system, which has informed service changes in response to the Covid-19 pandemic, and understanding and mitigation of adverse impact on health inequalities.

LCH supported 6 third sector partnership bids to NHS Charities Together, which address health inequalities exacerbated by the pandemic through integrated working across the 3rd sector and statutory health and care agencies.

The decision to pause non-essential work in November because of pressures resulting from the 2nd lockdown delayed establishing the Steering Group and consequently also development of the year 1 implementation plan. The implementation plan will be submitted to July Business Committee for approval. The composition of the Steering Group reflects the commitment to this being an equal partnership with the 3rd sector.

Health and care statutory partners have welcomed the strategy and are keen to connect with us on implementation.

Recommendations

The Board is recommended to:

- note progress made to date and consider whether it is assured

Third Sector Strategy Update

1 Introduction

This paper provides a progress report on implementation of LCH's first Third Sector Strategy.

2 Background

The Third Sector Strategy was launched at LCH's virtual AGM in September 2020 following approval by Board in August 2020.

The strategy was co-produced with Forum Central, the umbrella organisation for the third sector in Leeds and informed by engagement and consultation with staff and the wider third sector.

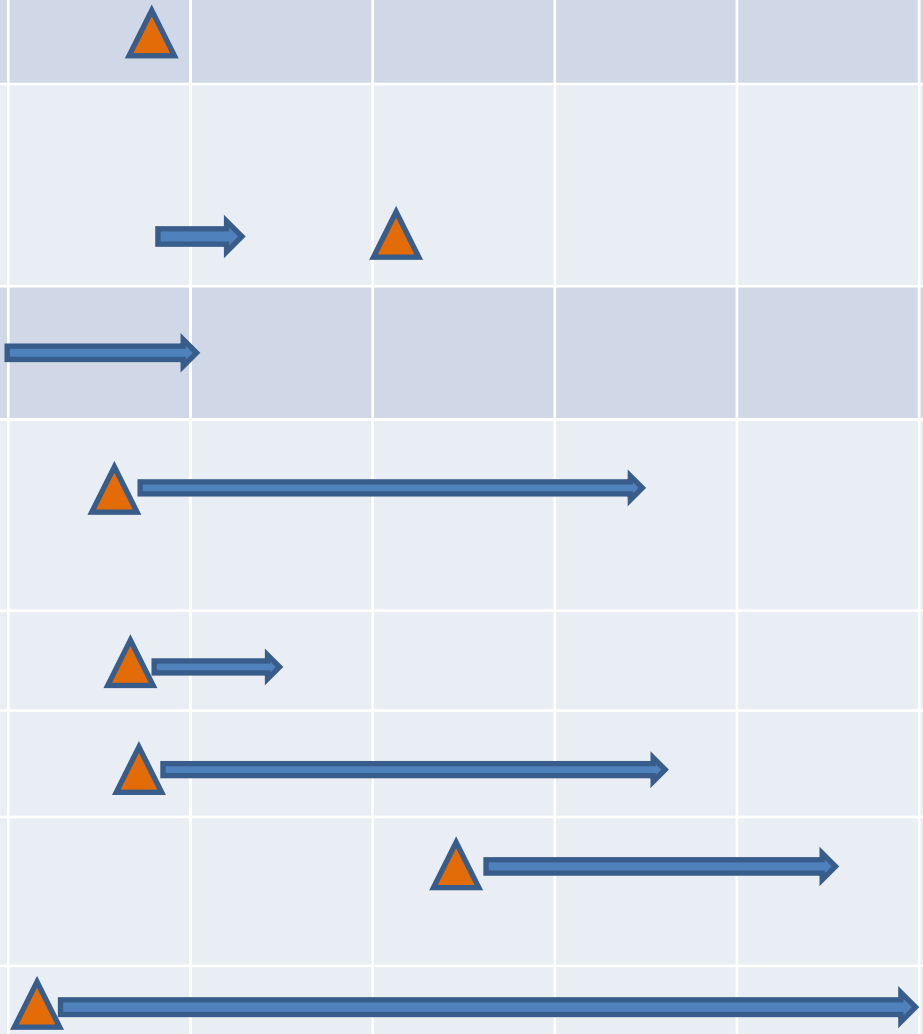
The strategy aims to deliver outstanding care to the people we serve by developing productive and effective partnerships with the third sector that maximise and value their expertise.

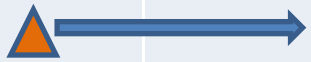
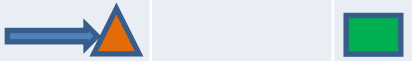
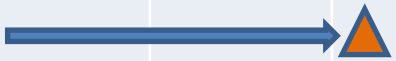
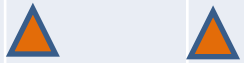
The Strategy set out seven priorities, a wide range of initiatives identified through engagement, a year 1 high level roadmap, that delivery would be directed by a Steering Group with joint LCH and third sector representation which would develop and submit to Business Committee a year 1 implementation plan for sign-off.

3 Current position/main body of the report

3rd Sector Strategy Progress Overview – see next page

	Q2 20/21	Q3	Q4	Q1 21/22	Q2	Q3	Q4
Strategy Launch							
Establish Third Sector Partnership Steering Group (bi-monthly) Identify 1st cohort of members							
Reset stakeholder engagement (including third sector) – started June '20							
Reset and recovery programme comms to encourage collaboration with third sector to support impact on health inequalities - showcase successful collaboration							
Restart priority service areas September 2020							
Digital inclusion collaboration with third sector							
Longer term embedding of innovations, including partnership working with third sector							
Implement Accessible Information Standards							



Explore with LCC, LTHT and the third sector partnership working to support recruitment from disadvantaged communities - focus on Armley locality for CAMHS T4 service	
Develop and submit partnership bids for NHS Charities Together funding - funding decisions to be announced July 2021	
Develop Year 1 Implementation Plan and submit to Business Committee for sign-off	
Develop Communications Plan (link to Health Equity Strategy comms) - strong focus on sharing good practice and learning	
6-monthly progress report to Business Committee	

Good progress has been made across most workstreams. Reset and Recovery reporting has highlighted to Board some of the excellent partnership working with the 3rd sector, and with the wider system, which has informed service changes in response to the Covid-19 pandemic, and understanding and mitigation of adverse impact on health inequalities, including:

- engagement with 3rd sector partners in Chapeltown and Harehills to understand and mitigate the increase in DNAs for the Podiatry service for service users from diverse communities as a result of changes to service delivery in response to the pandemic
- Systm1 Communication template development to support digital inclusion - informed by insight from 3rd sector and system digital inclusion forums

As a consequence of the partnership with Forum Central we were able to highlight, through Forum Central networks, to 3rd sector organisations our interest in partnering on bids to NHS Charities Together (Captain Tom Moore monies). This resulted in 6 partnership bids being submitted – see Appendix 1. The allocation for West Yorkshire and Harrogate region was considerably over-subscribed. Successful bids will be announced in July.

Steering Group

The decision to pause non-essential work in November because of pressures resulting from the 2nd lockdown delayed establishing the Steering Group and consequently also development of the year 1 implementation plan.

The steering group has now been in place since January 2020. LCH and the 3rd sector have equal representation and it is co-chaired by the Director of Operations and the Director of Forum Central.

Third sector membership will rotate annually to enable wider involvement and influence and development of relationships with a wider range of organisations. The Steering Group is committed to:

- enabling wider representation of the 3rd sector, particularly smaller organisations
- working with, strengths based approach and commitment to co-production
- adding value by ensuring connectedness to and working through existing partnership forums, workstreams where relevant
- Steering Group members representation role – LCH Business Unit (BU) members to engage with and represent the wider BU and 3rd sector members to engage with and represent their own organisation and wider organisations and service users.

<u>Development of the Implementation Plan</u>

The Steering Group has developed an outline plan with 4 workstreams:

1. Developing Accessible, Inclusive Services
2. Co-production
3. Self-management
4. Connecting better with the 3rd sector

and priority initiatives for each workstream. The plan reflects engagement by Steering Group members within LCH and the 3rd sector to identify priorities in relation to the

strategy's priorities, and taking into consideration the wide range of initiatives identified through engagement in developing the strategy.

The workstreams and priority initiatives connect with and support key LCH strategies and priority projects / workstreams e.g. Health Equity Strategy, NT Transformation, self management, digital inclusion, commitment to co-production and partnering with the 3rd sector for new service and pathway development, Anchor Network workstreams.

Working groups (Steering Group members and other 3rd sector and LCH colleagues) will develop implementation plans for each workstream. July Steering Group will agree the composite plan and submit it to July Business Committee for approval.

Connecting with statutory health and care partners

LTHT, LYPFT, LCC and Leeds CCG strongly support the strategy, its aim, focus and approach and are keen to work with us, once the implementation plan is agreed, to ensure joined up approach / cross partnership working and maximise impact.

As a result of LCH's strategy, LTHT are working with Forum Central to consider how they articulate their commitment and strategy to developing partnership working with the 3rd sector.

4 Impact:

4.1 Quality

By developing partnership working with the third sector in Leeds we will better meet peoples wider health and well-being needs and have a stronger and more effective focus on tackling health inequalities and achieving health equity.

4.2 Resources

Implementing the strategy may contribute to improving efficiency and reducing cost, whilst maintaining quality. This will be assessed when the implementation plan has been developed.

4.3 Risk and assurance

Risk	Likeli-hood	Severity	Risk score	Mitigation
Slower pace of implementation as LCH services and third sector focussed on responding to COVID	3	3	9	• Incorporate in reset and recovery programme comms, showcase good practice. • Align implementation plan with BU and 3rd sector priorities • Link work to relevant existing partnership workstreams and forums • BCDS and FC provide support to Steering Group members with engagement and implementing workstreams

Impact of COVID on third sector resilience impacts the sector's capacity to engage	3	3	9	• Discussion with third sector partners to understand the impact of COVID on resilience and explore how LCH can support
So many third sector organisations – cannot map all	3	2	6	• Advocate for system support to do this • Engage with sector more widely than just through Forum Central
Procurement/ partnership framework might still only attract the usual suspects	3	2	6	• Engage with sector through Forum Central and more widely • Offer a range of opportunities of different financial sizes to ensure diverse organisations can get involved
The implementation of the strategy would require input from corporate support functions and business teams which could be a drain on capacity	3	3	9	• To prioritise this within organisational plan • To be realistic about what to implement incrementally so that we're not trying to achieve everything at the same time – Steering Group to agree priority areas to start with • Early engagement with stakeholders • Scope additional investment for delivery
How do we make this ambition a reality and not just a paper exercise	2	2	4	• Establish implementation group with director sponsorship and delivery plan
Some of the ambition is only achievable by engaging with system partners, it can't be done in isolation	2	2	4	• Engage with system partners about delivery • Recognise what our own limitations are
Staff might be fatigued by change, may not have capacity or may not see value in working with third sector more closely	3	3	9	• Communications campaign to sell the benefits of working with the sector, including case studies to bring it to life • Regular news items on intranet/ community talk to sell the benefits • A thank you award for partnership working/ left shift

5 Next steps

July Business Committee to receive the implementation plan for sign-off. The Committee will then receive 6-monthly progress reports on delivery of the strategy.

6 Recommendations

The Board is recommended to:

- Note progress made to date

Appendix 1

Partnership bids to NHS Charities Together

1. Lead organisation: LCH
Partners: mHabitat, 100% Digital Leeds
Focus: digital inclusion. To create a co-designed accessible platform and website (similar to Mindwell) that provides a single 'go to' place for clinicians, community organisations, service users, carers and the public for information about how to access digital devices and digital inclusion support services in Leeds. Would also fund a part-time resource to be hosted in a 3rd sector organisation for 1 year to provide advice and support. Will enable identification of gaps in support. Potential for replication across the ICS.
Wider system involvement / support: ICS, Leeds CCG, LTHT and People Voices Group Digital Inclusion sub-group supportive of the bid.
Value: £100k (maximum amount)

2. Lead organisation: BASIS
Partner: LCH
Focus improving sexworkers and /or women who are sexually exploited access and experience of care. Enables extension of health influencing role, and building on achievements in increasing awareness and delivering training to improve capacity and effectiveness of staff and systems in primary care to engage with women sexworkers, working in close partnership with the Health and Inclusion team with the Leeds Community Health Care Trust, and to extend this to secondary care. To continue our work with experts by experience to develop a self-assessment framework for use bv health service providers.
Wider system involvement / support: PCNs and LCPs, LTHT
Value: £43k

3. Lead organisation: BID
Partner: LCH
Focus: supporting the emotional and physical wellbeing of adults with sensory impairment adults. BID to provide be-friending support, peer support groups and work with NHS providers and GP practices – providing sensory impairment awareness training for staff, raising awareness of support services and activities available and supporting development of accessible information and services
Wider system involvement / support: GP Confed, LTHT and LYPFT supportive
Value: £65k

4. Lead organisation: GIPSIL
Partner: LCH
Focus to build on and enable continuation of a pilot which provides community-based Wellbeing Outreach support for 17-18 year olds transitioning from CAMHS to Adult MH services - partnership working between CAMHS Transition Team and GIPSIL. To provide mental health support, practical support around housing and benefits, accessing education and employment and onward referrals around DVA and substance use plus positive activity element to reduce isolation and strengthen positive peer relationships. To also establish a pilot in Wakefield.
Wider system involvement / support: Leeds CCG very supportive as significant unmet need. Wakefield CAMHS management and CCG commissioner very supportive
Value: £99k

5. Lead organisation: Touchstone
Partner: Hamara, LCH
Focus: BAME Mental Health Outreach project. Touchstone will lead a mental health outreach team supporting BAME groups and individuals in the most deprived areas, working in partnership with Hamara and LCH. The primary aim will be to engage individuals who are not known to the system nor currently accessing mental health support with BAME Outreach workers will raise awareness, signposting or linking to MH, physical health and wider health and well-being services (formal and informal) and gateway services, tackling Covid myths, vaccine misinformation & hesitancy and promoting public health messages, reaching at least 500 people. Hamara's 9 Patient Ambassadors, based in GP practices in Burmantofts, Harehills & Richmond Hill PCN and Beeston & Middleton PCN, will refer people to the project. Learning from the project will inform the LMWS Strategic Health Inequalities action plan: to report on progress via LMWS Steering Group.
Wider system involvement / support: Touchstone will connect with community groups and networks.
Value: £100k

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (14a, b, c and d)

Title: Corporate Governance Report

Category of paper: for approval
History: Not applicable

Responsible director: Chief Executive
Report author: Head of Corporate Governance (Company Secretary)

Executive summary (Purpose and main points)

In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met. This paper covers a number of corporate governance requirements for consideration.

This paper covers a number of annual requirements, including:

- Board and Committees' effectiveness review (appendix A)
- Audit Committee annual report 2019-20 (appendix B)
- Committees' terms of reference review and Committee membership (appendix C)
- Details of use of the Trust's corporate seal (appendix D)

Recommendations

The Board is recommended to:

- note the outcome of the annual review of Board and Committees' effectiveness
- receive the Audit Committee's annual report 2020/21
- approve changes to the terms of reference of Board sub-committees
- note the content of the register of sealings

1. Introduction

This report provides a number of requirements for consideration on an annual or infrequent basis in relation to the effective corporate governance of the Trust.

2. Background

The Trust operates, at all times, within a range of statutory and mandatory regulations and national guidance that together provide a framework for the appropriate governance of the Trust.

In the main, these statutes, regulations and guidance are enacted through the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers.

Adherence to this governance framework enables the organisation to demonstrate that it is well governed and meets the requirements of corporate governance codes.

In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met. This paper deals with a range of related assurances.

3. Annual review of Board and Committees' effectiveness

At all levels in the NHS, boards are encouraged to periodically review their own performance in order to build on strengths and to identify areas where there is room for further development in order to draw out the full benefits of the NHS unitary Board model.

The report at **Appendix A** provides a summary of the outcomes from an exercise to review the effectiveness of the Board and sub-committees

4. Committees' annual reports 2020/21

The terms of reference of the Trust's Audit Committee require that the committee has oversight of Board sub-committees annual effectiveness process and reviews the adequacy of the governance of the sub-committees. This assurance is given through the provision of an annual report from Board sub-committees to the Audit Committee.

In turn, the terms of reference for each committee require that the committee's chair submits an annual report to the Audit Committee which demonstrates how the committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and committee's work plan. The reports provide an overview of the workings of the committees and demonstrate that the committees have complied with the respective terms of reference.

At the Audit Committee on 16 April 2021, the annual reports for 2020/21 for the following committees were received:

- Quality Committee

- Business Committee
- Charitable Funds Committee
- Nominations and Remuneration Committee

Each report had been reviewed by the committee's chair and executive lead and by the relevant committee. The reports provided an overview of the workings of the committees and the Audit Committee can confirm that the reports demonstrated that the committees have complied with the respective terms of reference. Sections within each annual report described:

- Duties of the committee
- Membership and attendance
- Review of committee's activities
- Review of effectiveness
- Areas for future development

In order to complete this cycle of review, the Audit Committee's annual report for 2020/21 is attached at **Appendix B** for receipt by the Board and demonstrates that the committee has operated in lines with its terms of reference and has undertaken a review of its effectiveness.

5. **Committees' terms of reference**

The Trust's Board has appointed five sub-committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically (as recorded in standing orders). Between February and April 2021, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness.

The tables in **Appendix C** summarise the changes made in order to amend and update content (the changed text being shown in red). Once approved, an electronic version of the full amended document will be made available to Board members, managers and staff. Use will be made of the Trust's intranet and website to publish the documents.

In order to reflect the best distribution of Board membership across the committees so that they are able to fully discharge their respective responsibilities, committee membership for 2021/22 is shown in the table below.

	Non-executive directors	**Executive directors**
Audit Committee	Khalil Rehman (Chair) Richard Gladman Prof Ian Lewis	(Executive Director of Finance & Resources in attendance)
Quality Committee	Helen Thomson (Chair) Prof Ian Lewis Alison Lowe Rachel Booth	Executive Medical Director Executive Director of Nursing Executive Director of Operations (Chief Executive in attendance)
Business Committee	Richard Gladman (Chair) Helen Thomson Khalil Rehman	Chief Executive Executive Director of Finance & Resources Executive Director of Operations

		(Workforce Director in attendance)
Charitable Funds Committee	Brodie Clark (Chair) Alison Lowe	Executive Director of Finance & Resources Executive Director of Nursing
Nominations and Remuneration Committee	Brodie Clark (Chair) Rachel Booth Alison Lowe	(Workforce Director in attendance)

6. Use of the corporate seal

In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal. During 2020/21 the seal has been used on a small number of occasions. The details are contained within a copy of the register attached as **Appendix D.**

In accordance with the Trust's standing orders, the seal has in each case been affixed in the presence of two senior officers duly authorised by the Chief Executive, and not also from the originating department, and has been attested by them.

From 2021/22, the Company Secretary will provide the Board with details of each use of the corporate seal at the following Board meeting rather than providing an annual summarised report.

7. Recommendations

The Board is recommended to:

- Note the outcome of the annual review of Board and committees' effectiveness
- Receive the Audit Committee's annual report 2020/21
- Approve changes to the terms of reference of Board sub-committees
- Note the content of the register of sealings and the revision to the process of reporting its use to the Board.

Appendix A

Reviewing Board and Committees' effectiveness

1.0 Purpose of the report

The purpose of the report is to provide a summary of the comments received from the review, by Board members, of the effectiveness of the non-executive and executive contribution to the Board, the Board's sub-committees and the wider Trust.

The sections below provide anonymised information gathered from a Board effectiveness diagnostic exercise.

2.0 Board effectiveness review

By way of context, the purpose of NHS Boards is to govern effectively and in doing so to build patient, public and stakeholder confidence that health and health care is in safe hands *(The Healthy NHS Board 2013).* In meeting this purpose the Board has three key roles, to:

- Formulate strategy
- Ensure accountability by holding the organisation to account for the delivery of strategy and through seeking assurance that systems of controls are robust and reliable
- Shape a strong culture for the Board and the organisation

The Trust Board reflects on an annual basis how non-executive and executive colleagues can further develop as a team to:

- Ensure strong and effective leadership at Board level and throughout the Board sub-committees
- Develop a culture of full and proper personal accountability
- Maintain a strategic perspective
- Ensure the Trust identifies the necessary operational changes to meet the quality and financial sustainability challenge
- Balance risk and opportunity
- Work in a partnership environment

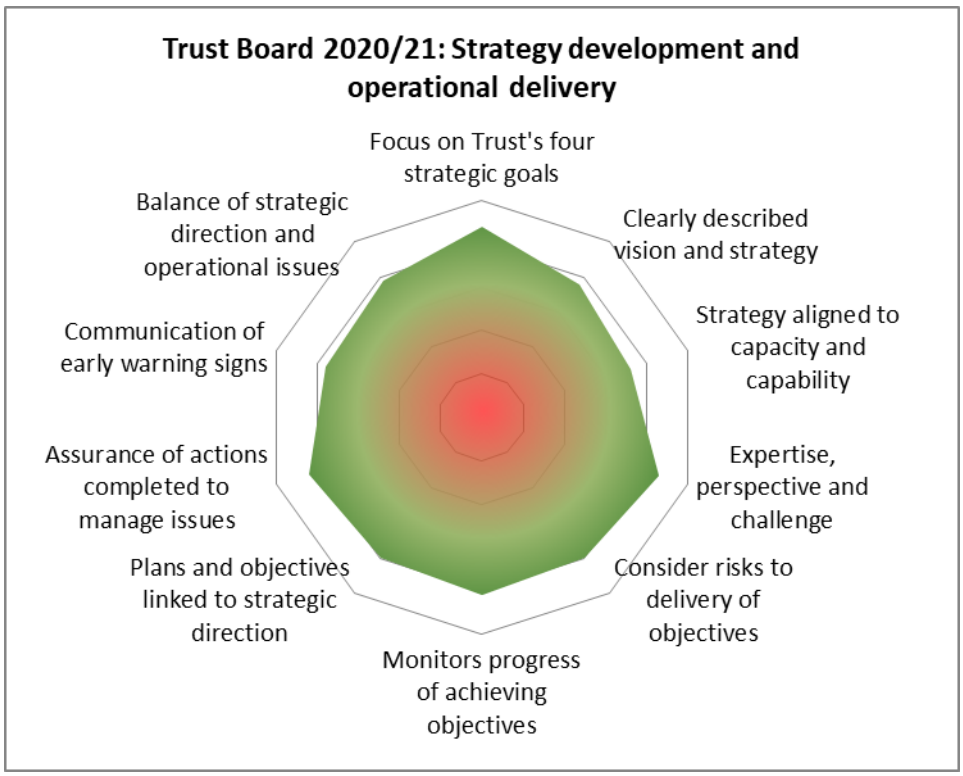
Two questionnaires were completed by Board members; one related to Board effectiveness and the second was applicable to committees' effectiveness. The questionnaires comprised 20 statements grouped under the headings of *leadership and accountability* and *strategy development and operational delivery* (Board questionnaire) and *capacity, capability and ways of working* and *conduct of business and effectiveness of decision-making* (committees' questionnaire).

The questionnaires asked for ratings on a scale of 1 (strongly disagree) to 5 (strongly agree); plus narrative comment on opportunities for change. Responses in

the questionnaires remain anonymous and have only been used to distil themes to facilitate discussion.

3.0 Board self-assessment: summary of responses

The following two diagrams indicate where the Board's strengths are, and where there are areas that could be improved upon. The green areas that stretch furthest outwards in the two decagons indicate the areas of strength, whereas the areas that are closer to the centre are the weaker areas.



The scores overall are reflective of a high quality Board, with a complimentary mix of members who demonstrate the Trust's values and behaviours. Recent appointments have enhanced this and new leadership has strengthened the Board further. The Board is regarded as 'well-led' with strong, visible leadership. There is open and constructive debate, with robust challenge and scrutiny of what is being provided, leading to clear decisions and accountability for actions. Risks are considered to the delivery of objectives.

Areas that could be improved upon are as follows:

a) Information and communication

There were two questions concerning information and communication:

- ***Adequate and appropriate information (in the form of good quality reports) to inform discussions and facilitate effective decision-making is provided to Board members***

- ***The Board receives sufficient communication and 'early warning signs' of issues and risks which have or could adversely impact on performance***

There was mixed feeling about papers, with some comments that they are generally clear and focussed towards particular decision points, with others commenting that they do not always aid effective decision making. It was also said that reports are occasionally unnecessarily wordy but less so than in the past and that the performance report and KPIs should better reflect the work of the Trust and that more notice should be taken of meaningful outcome data.

There was concern that reporting mechanisms did not always aid assurance and some issues still emerged from left field with insufficient senior sighting. It was suggested that there needed to be more leading indicators to highlight where a service or unit was showing signs of challenge.

Action:

- The Executive Director of Finance and Resources is leading a piece of work to review and revise the performance brief. A workshop took place in October 2020 which included members of the Board. Further meetings have progressed this work and changes are being made: the performance panels have been retimed so that the narrative from these meetings can inform the performance brief. It has also been agreed that the performance brief will be produced bi-monthly instead of monthly as bi-monthly reviews will be more trend sensitive, will enable a better supporting narrative and will allow a deeper analysis and consideration at the Committees. The Board will receive the performance brief at its meeting immediately following the committees review of the performance brief. In the intervening months the KPI information will still be produced and made available to the Senior Management Team in order to identify issues of concern/recovery/note. It will remain the case that any urgent issues that should be drawn to the Board's attention are advised to the Board via a Director without waiting for the formality of a report.

- Senior Management Team to brief report authors to ensure that reports are concise and support effective decision making.

b) Strategy

There were three questions concerning strategy:

- ***The Board has a credible, clearly-described and widely-owned vision and service strategy to deliver organisational purpose***

- ***The Trust's strategies are aligned to internal capacity and capability and the wider external environment***

- ***There is the right balance between consideration of strategic direction and day to day operational management at Board meetings and amongst Board members***

This topic has scored lower than in previous years. It is perhaps unsurprising, given the extraordinary circumstances of the past year, that operational matters have overtaken strategic thinking during the pandemic. 2021/22 should see a greater focus on strategic direction. It was recognised that the Board workshops were particularly useful for strategic discussions.

Action:

- New strategies being presented in draft to committees for review and to the Board for approval need to be clear and realistic about the capacity required and capability of the organisation to deliver the strategies' objectives.

c) Other comments for the Board to note and for individuals to consider further action:

Board members' participation
Members (and Executive members in particular) tend to hold to their own areas of expertise at Board and committees and should be encouraged to contribute more widely.

There are very few actions resulting from Board meetings – with a suggestion that more challenge is perhaps required.

Partnerships and wider system working
There is an appetite for Board members to more actively and appropriately champion key aspects of external work to the Trust. The Trust's vision for its role in Leeds in a post-Covid landscape needs clarity.

4.0 Audit Committee self-assessment: summary of responses

- The Committee scored highly in all areas demonstrating that the Committee is functioning well. It scored particularly well in core purpose, values and behaviours, leadership, encouraging participation and consensus, recording and completing actions, relationship between Committee and Board.

- The relationship between the Committee and its subgroup (information Governance Group) has become clearer

5.0 Quality Committee self-assessment: summary of responses

- The Committee is functioning better with all but three scores above 4.

- The reduction in the number of attendees has resulted in higher quality more focussed conversations.

- Executives tend to stick to their area of responsibility rather than seeing themselves as members who can provide challenge in other areas and who have an equal role in the Committee.

- The relationship between the Committee and its subgroups is improving following review of the sub-committee structure but this needs further work.

- The circulating of papers had improved to be a full week prior to committee, thereby allowing sufficient time for members to read them, but this has not always been sustained.

- The pandemic has affected the work of the Committee with less deep dives or exploration of wider quality issues so overall less assurance.

- Reports have improved but there are still issues with the performance report and a need for better data.

6.0 Business Committee self-assessment: summary of responses

- The Committee is functioning well; all scores were 4 or above, with some scoring 5

- As with previous years, the lowest score was for 'adequate and appropriate information' and additional comments describe the variable quality of papers and that providing verbal updates rather than written papers provide no time for the Committee to consider information in advance. It was recognised that the performance brief requires a refresh which is in hand. Papers and performance reporting do not provide for effective decision making with probably the exception of the finance report. Some duplication/overlap of papers has emerged.

- It was agreed that the committee was supported by excellent administration and the pre-meet agenda setting meeting was always helpful.

- During 2020 the duration of the meetings was cut down through necessity to respond to the Covid pandemic and it was thought that this did impact the amount of scrutiny that could be given.

- It was felt that greater attention needs to be paid to workforce strategy and issues.

- It was also noted that there have been examples where work coming back to the committee has not completed in the way it was required and set out in a previous meeting.

- The relationship with the Committee's subgroup, the Health and Safety Group is developing.

7.0 Charitable Funds Committee self-assessment: summary of responses

The Committee's strengths:

- The Committee meets the requirements for effective governance and is functioning well
- There is very healthy discussion and the Trust's values and behaviours are displayed consistently

- Members play an effective part
- There is discussion and review of role, aims and purpose.

Some improvements have been identified:

- Evaluation of performance is only done informally
- Papers are sometimes last minute

8.0 Nominations and Remuneration Committee self-assessment: summary of responses

- The Committee is functioning well
- There is effective leadership and a strong skill set amongst members
- The level of scrutiny and challenge is satisfactory
- The Committee rarely evaluates its performance

9.0 Next steps

The above information will be used to inform the Board's workplan and the Board development workshops, and each Committee's work plan and activities for the forthcoming year.

Appendix B

Audit Committee: Annual Report 2020/21

1.0 Purpose of the report

1.1 The purpose of the report is to provide a summary of the Audit Committee's activities during 2020-21.

1.2 The terms of reference for the Committee require that the Committee's Chair submits an annual report which demonstrates how the Committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and the Committee's work plan.

1.3 The sections below describe:

- Duties of the Committee
- Membership and attendance
- Review of Committee's activities
- Review of effectiveness
- Areas for future development

2.0 Background: Duties of the Committee

2.1 The Audit Committee is one of five committees established as sub-committees of the Trust's Board and operates under Board approved terms of reference.

2.2 The Committee is well established and has been conducting a portfolio of business on behalf of the Board since the establishment of the Trust.

2.3 The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

2.4 The duties of the Committee can be categorised as follows:

- **Governance, risk management and internal control:** reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- **Internal audit:** ensuring that there is an effective internal audit function that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- **Counter fraud and security management:** ensuring satisfactory arrangements in place for countering fraud, managing security and shall review the annual plan and outcomes of work.

- **Data security and information governance:** ensuring the Trust has robust information governance processes and that it complies with National Data Security Standards.
- **External audit:** reviewing the work and findings of the appointed external auditor and considering the implications of and management's responses to their work.
- **Financial reporting and annual accounts review:** including: monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance; ensuring that systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board; reviewing the annual statutory accounts before they are presented to the Board of Directors to determine their completeness, objectivity, integrity and accuracy and reviewing all accounting and reporting systems for reporting to the Board.
- **Standing orders, standing financial instructions and standards of business conduct**: reviewing the operation of and proposed changes to the standing orders, standing financial instructions and standards of business conduct, the constitution, codes of conduct and scheme of delegation.

2.5 The Information Governance (IG) Group is a subgroup of the Audit Committee. The Group meets every two months and discharges a range of duties as delegated by the Audit Committee and recorded in a Committee approved set of terms of reference. The IG Group is responsible for ensuring that the Trust has effective policies and management arrangements covering all aspects of information governance in line with the Trust's Information Governance Management Framework Policy. Approved minutes from the Group are received by the Audit Committee.

3.0 Membership and attendance

3.1 The terms of reference for the Audit Committee set out the Committee's membership, which is as follows:

- Three non-executive directors, including one non-executive director with significant, recent and relevant financial experience and who serves as the chair of the committee
    - Jane Madeley (Chair)*
    - Richard Gladman (Deputy Chair)
    - Professor Ian Lewis

    *Khalil Rehman, Associate non-executive director joined the Committee from 8 January 2021 and replaced Jane Madeley as Chair when she stepped down from her non-executive director role on 31 March 2021.

3.2 In addition to the membership, the following participants are required to attend meetings:

- Executive Director of Finance and Resources
- Company Secretary

- Internal audit representative
- External audit representative
- Counter fraud specialist

3.3 The Chief Executive attends to discuss the process for assurance that supports the annual governance statement, and the annual report and accounts.

3.4 In addition, the Chief Executive, other executive directors and senior managers may attend for discussions when the Committee is discussing areas of risk or operational management that are their responsibility.

3.5 The Committee has met formally seven times in the last 12 months and has been quorate on all occasions. In addition, there was one informal meeting. A table recording attendance is shown below.

Attendee	17 April	5 June (informal)	12 June	17 July	16 Oct	15 Jan	12 Mar	Total (7)
Jane Madeley	Y	Y	Y	Y	Y	Y	Y	7/7
Richard Gladman	Y	Y	Y	N	Y	Y	Y	6/7
Ian Lewis	Y	Y	Y	Y	Y	Y	Y	7/7
Khalil Rehman (from 15 January 2021)	N/A	N/A	N/A	N/A	N/A	Y	Y	2/2

3.6 In line with its terms of reference, the Committee has had regular private meetings with auditors prior to each formal meeting.

4.0 Review of Committee's activities

4.1 The Audit Committee has an approved annual work plan. Topics scheduled for consideration at each meeting reflect a mix of scheduled items drawn from the work plan and occasional further items that have arisen as a result of specific issues brought to the Committee's attention from internal or external sources.

4.2 *Governance, risk management and internal control*

4.2.1 The Committee reviewed the annual governance statement for 2020-21 in April 2021 prior to it being submitted for approval by the Board. In considering the statement, the Committee reviews assurances from a range of sources including the final Head of Internal Audit opinion which it expects to receive in June 2021.

4.2.2 Annual reports have been received from internal audit, counter fraud, security management, risk management and Board sub-committees during the year.

4.2.3 In 2020 the Audit Committee requested that the Company Secretary reviewed the Audit Committee's role in relation to the Board Assurance Framework

process as there was some duplication of BAF review activities between the Board, SMT and the governance committees. This duplication had led to differing views and multiple changes to the BAF. The draft revised assurance process was presented and discussed at Audit Committee in March 2020. The Audit Committee approved the revised BAF review process in which a unique role was allocated to each group – the Board, SMT, the governance committees. The role the Audit Committee agreed it would play was to evaluate the effectiveness of the BAF assurance process, which it did in October 2020 and concluded that the revised process appeared to be working well.

4.3 *Internal audit*

4.3.1 The Audit Committee has delegated authority to ensure the Trust has an effective internal audit function. The Internal Auditors provide an essential part of the Trust's system of internal control. The Trust's internal audit service is currently provided by TIAA Ltd.

4.3.2 The Committee reviewed and agreed an annual internal audit plan for 2020/21, which proposed 20 audits. Topics included a broad mix of financial, governance, operational and quality topics.

4.3.3 As the audit plan progressed, the Committee reviewed a wide-ranging portfolio of reports, considered recommendations, adopted action plans and overseen progress. The outcome of internal audits was shared with the relevant Board committee, which provided the opportunity to consider the robustness of actions to address recommendations and the associated timescales.

4.3.4 In addition to monitoring progress of the audits, the Committee also regularly monitored progress against internal audit management recommendations and associated actions. The Committee requested and received further explanation and background on the priority 1 and 2 recommendations from the audits which have been agreed to be delivered by a certain date but not completed on time. The Committee also reviewed the robustness of the proposed actions and provided feedback.

4.3.5 The Committee closely monitored progress against the internal audit plan in an effort to avoid slippage and over running toward the end of the financial year. Throughout the year, the Committee discussed the potential challenges to completing the full internal audit programme for 2020/21 in the light of COVID response focus within the Operations directorate particularly, and requested options for re-planning the audit programme for the remainder of the year, to ensure that sufficient assurance work could be successfully completed ahead of the year end and with audit scopes that would provide most value to the organisation during that period. The Committee supported a reduced internal audit plan with some planned audits to be completed in April 2021, and some to be carried over into the 2021/22 plan.

4.3.6 In March 2021, the Head of Internal Audit reported that whilst the delivery of the internal audit work for 2020/21 had been impacted by the global COVID-

19 pandemic it had not affected the auditors ability to provide an Interim Head of Internal Audit Opinion based on the work carried out that reasonable assurance could be given that there were adequate and effective management and internal control processes to manage the achievement of the Trust's objectives. A final opinion would be presented to the Committee in June 2021.

4.3.7 In March 2021, the Committee reviewed and approved the draft proposed internal audit plan for 2021/22.

4.4 *Counter fraud and security management*

4.4.1 The Committee received the local counter fraud annual report and the security management annual report in July 2020 The Committee received a mid-year update on progress against the counter fraud plan for 2020/21, which noted local counter fraud activity, and introduced lessons learnt from fraud incidence from elsewhere.

4.5 *External audit*

4.5.1 In July 2020, the External Audit Manager presented KPMG's annual audit letter for 2019/20. It stated that the auditors' had issued an unqualified opinion on the Trust's 2019/20 financial statements and concluded that there were no matters arising from KPMG's 2019/20 audit work.

4.5.2 In early 2020 the Trust undertook a tender process for external audit services and Mazars were appointed from 1 April 2020. Regular updates and progress reports have been provided by Mazars to the Committee to highlight those issues that impact on the NHS and to which the Trust should be aware. These include for example, the new approach to the Value for Money aspect to the audit and the future changes for the NHS financial regime. The Committee sought assurance that the Trust was aware and was managing such issues.

4.6 *Financial reporting and annual accounts review*

4.6.1 The Committee (with the Chief Executive in attendance) reviewed the annual report and accounts in detail in June 2020 prior to recommending the annual report and accounts to the Board for approval.

4.6.2 The Committee reviewed the charitable funds annual report and accounts in October 2020 prior to approval by the Charitable Funds Committee.

4.6.3 The Committee also discharged a number of further aspects of financial reporting, including: schedules of debtors and creditors, losses and special payments and overpayments and underpayments.

4.7 *Standards of business conduct*

4.7.1 The Committee reviewed waivers to tendering procedures, the reference costs process, and the register of gifts and hospitality.

4.8 *Data Security and Information Governance*

4.8.1 The Committee pursued evidence of compliance with data security requirements and received regular reports, which provided assurance that risks associated with data security were being adequately managed.

4.8.3 The Head of Information Governance and Data Protection Officer regularly attended the Committee to provide an update on progress against the guidance issued for the General Data Protection Regulation (GDPR) compliance, which was in force from May 2018.

4.8.5 The Committee monitored information governance/data security training compliance across the Trust and regularly received up to date information on the percentage of staff that had completed training.

4.8.6 Updates in relation to information governance and level of compliance with the Data Security & Protection Toolkit were considered by the Committee in January 2021 and it was assured that the Trust was on track to achieve necessary compliance with the standards before final submission on 30 June 2021.

5.0 Strategic Risk 2.4 (Security of IT infrastructure)

5.1 BAF strategic risk 2.4 (…maintaining the security of its IT infrastructure…) is assigned to the Audit Committee and the sources of assurance that the Committee receives for this BAF Risk were reviewed to determine if they 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 these sources provided only a limited picture of assurance and requested additional sources of assurance to be added to the BAF and to the Committee's work plan.

6.0 Assessment of the Committee's effectiveness

6.1 All members of the Committee were invited to complete a self-assessment questionnaire in February 2020, including rating elements of performance. Overall the assessment was that the Committee was functioning well.

6.2 The Committee scored highly in all areas demonstrating that the Committee is functioning well. It scored particularly well in core purpose, values and behaviours, leadership, encouraging participation and consensus, recording and completing actions, relationship between Committee and Board.

There were a number of comments:

- Jane Madeley has been a wonderful Chair

- It has not an easy year because of the shift to remote function but this was handled pretty well. Early days for new external auditors. Internal audit has been impacted by the pandemic but issues handled openly and appropriately.

- The timing and flow of the internal audit reports could be improved e.g. other committees scrutinise before Audit Committee

- External colleagues could contribute more.

- (Subgroup) Relationship with IT governance has become clearer this year

6.3 The Committee members reflected on the self-assessment scores and comments and discussed the ways in which the Audit Committee linked in with other Board Subcommittees.

Appendix C

Changes to committees' terms of reference

1. The tables below summarise the changes made in order to amend and update content

Quality Committee
Change
As greater alignment with the Board Assurance Framework (BAF) risks has taken place over 2020/21, two minor amendments to wording are proposed to the existing terms of reference: • The Committee will provide assurance to the Trust Board on all Board Assurance Framework strategic risks that have been assigned to it by reviewing the evidence (sources of assurance) and indicating to the Board whether those risks are being effectively controlled. This will be reported to the Board in the Chair's assurance report using standard classification • Committee will report in writing to the Board through the Committee's Chair's assurance report (produced after each Committee meeting). The report records key issues, actions and decisions and the level of assurance provided against each of the allocated Board Assurance Framework strategic risks to the Board by the Committee's consideration of the relevant item. As the Mental Health Act Governance Group has been disbanded as the Trust no longer has a CAMHS inpatient unit (subgroup final meeting was in April 2021), reference to this subgroup to be removed from the Quality Committee's terms of reference.

Business Committee
Change
As greater alignment with the Board Assurance Framework (BAF) risks has taken place over 2020/21, the following addition is suggested. • The Committee will provide assurance to the Trust Board on all Board Assurance Framework strategic risks that have been assigned to it by reviewing the evidence (sources of assurance) and indicating to the Board whether those risks are being effectively controlled. This will be reported to the Board in the Chair's assurance report using standard classification. Amend to include a reference to the Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters). The list of subgroups to include the Digital Strategy Implementation Group.

Audit Committee
Change
The Committee agreed that there needed to be a record of the Committee's responsibility for data security assurance. The following section is proposed to be included in the terms of reference: **Information Governance** The Committee shall: Receive escalation reports (including significant data breach incidents) as equired and minutes from the Information Governance Group. Receive notification of any significant data security risks (scoring high or extreme) and review controls and mitigating actions in order to provide assurance to the Board. Provide assurance to the Board that the Trust is compliant with relevant legislation and national guidance. Review the Data Security and Protection Toolkit prior to submission. Receive the Information Governance Group's annual report and review and approve proposed changes to the Group's terms of reference as appropriate

Charitable Funds Committee
Change
Amendment: Bids between £500 and £5000 to be signed off by the Deputy Director of Finance, rather than the Executive Director of Finance and Resources. This change allows the Charitable Funds Operational Group, of which the Deputy Director of Finance is a member, to have a degree of authority over the way that funding is spent. These are the proposed sign off levels: Less than £5000 — Deputy Director of Finance £5,000 - £25,000 — Charitable Funds Committee Over £25,000 — Board of Trustees

Nominations and Remuneration Committee
Change
No changes requested

Appendix D

Register of affixing of corporate seal 2020-21

The Board is asked to note the content of the register of sealings:

OCCASION	PARTIES INVOLVED	DOCUMENT APPROVED & SEAL ATTESTED BY	DATE
Transfer of Seacroft Clinic car park to Leeds Community Healthcare	Leeds Community Healthcare Leeds and York Partnership	Executive Medical Director Workforce Director	24.02.2021
Contract novation of CAHMS T4 building (St Mary's) to Leeds and York Partnership	Leeds Community Healthcare Leeds and York Partnership Interserve Construction Ltd	Chief Executive Executive Medical Director	08.03.2021

Leeds Community Healthcare NHS Trust

Public Board Meeting: 28 May 2021
Agenda item number: 2021-22 (15a and 15b)

Title: Chief Executive and Chair's action:
15a Telephony contract- March 2021
15b Annual leave –March 2021

Category of paper: For ratification
History: N/A

Responsible director Category: Chief Executive
Report author: Board Administrator

Executive summary (Purpose and main points)
Under Leeds Community Healthcare's Standing Orders, Board committees and other groups undertake work on behalf of the Board. At times it may be necessary for urgent matters that the Board, Board Committees and other groups would normally consider at meetings to be dealt with between meetings. These matters would then be formally reported at subsequent meetings for ratification. For the purposes of this document, the procedure relating to such actions is referred to as 'Chief Executive and Chair's action'.

Two actions have been recently taken which require ratification by the Board:

1. Decision to upgrade the Trust Telephony System by letting a contract with Virgin Media via a contract framework RM3808 (Lot 5 Telephony). The overall costs for this contract over 5 years are £962,350.

   The action was signed off by the Chair and Chief Executive in consultation with two non-executive directors: Richard Gladman and Khalil Rehman who are both members of the Business Committee.

2. Decision by the Trust Board to award an additional day of annual leave in 2020/21 to all employed staff to reflect the intense and unrelenting response to the pandemic during the year. This decision is part of a suite of actions taken during the year to respond to the health and wellbeing needs of Trust staff. The Board should note that due the late nature of this decision being taken in late March 2021 staff will effectively have the additional day carried over and be required to take the additional annual leave in 2021/22.

   The action was signed off by the Chair and Chief Executive in consultation with two non-executive directors: Alison Lowe and Rachel Booth, who are both members of the Nominations and Remuneration Committee.

Recommendations
The Board is asked to ratify the:

- decision to upgrade the Trust Telephony System
- decision to award an additional day of annual leave in 2020/21 to all employed staff.

Leeds Community Healthcare NHS Trust

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (16)

Title: Disbanding the joint CIC between GP Confederation and LCH and creating a strategic forum

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Category of paper: Approval
History: None

Responsible director: Chief Executive
Report author: Chief Executive

Executive summary (Purpose and main points)

This paper outlines the proposal to dissolve the joint Committees in Common (CiC) between Leeds Community Healthcare NHS Trust (LCH) and Leeds GP Confederation, and to replace it with a less formal structure to oversee and drive the integration agenda between Primary Care Networks (PCNs) and LCH – in particular the clinical model, joint working on underarching infrastructure and research, education and development.

In time, to consider ways in which this work can be supported and linked to the ICS which is still emergent.

Recommendations

To approve the dissolution of the joint CiC between LCH and Leeds GP Confederation and its replacement with a strategic forum to oversee the continued development of the joint work programme.

1 Introduction

The CiC between Leeds Community Healthcare NHS Trust (LCH) and Leeds GP Confederation was formed in 2018 to further drive and oversee the work between the two organisations and drive further integration of clinical services and underarching functions.

2 Current position/main body of the report

During the past year joint work has continued, generally more slowly, between the GP Confederation and LCH due to COVID and the development of a new funding model for the GP Confederation. Some work has r developed at pace however, such as, joint working in care homes and some aspects of research and education.

The Board are fully aware of the new White Paper proposing the creation of both Integrated Care Systems (ICS) (for us, at West Yorkshire level) and Integrated Care Partnerships (ICPs) at place (Leeds, in our case) level. This has also provided new context for thinking about the role and utility of the CiC.

The CIC met on 1 April 2021 and discussed whether this was the right format to take forward our joint work in the current year, with the new Confederation model and the emergent ICS being developed.

In discussion it was agreed that it would be better, and more flexible and agile at this stage, to continue to progress the joint work within the context of a strategic oversight group which could steer and discuss, in particular, the integrated clinical model and integrated training and education and research work.

Much of the underarching work that we have been discussing will be picked up by the ICP going forward, but we will continue to progress the conversations about workforce issues and about the employ/deploy model for the ARRs posts.

Where there are opportunities and it makes sense to progress joint work around underarching infrastructure, these will, of course, still be taken.

It is suggested that the new forum is executive led and joint work will continue to be reported, as it progresses, via the Chief Executive's report to the Trust Board and to the Quality Committee.

3 Next steps

To develop the new forum and its work programme and to continue to work with the ICP in highlighting the importance of joint working between primary care and community services, and the importance of integrated provision.

4 Recommendations

The Board is recommended to agree the dissolution of the Committees in Common and the creation of the strategic forum

Leeds Community Healthcare NHS Trust

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (17)

Title: Compliance with NHS Provider Licence (self-certification)

Category of paper: for approval
History: Not applicable

Responsible director: Executive Director of Finance and Resources
Report author: Head of Corporate Governance (Company Secretary)

Executive summary (Purpose and main points)

The Health and Social Care Act 2012 introduced the requirement for organisations which provide an NHS service to hold a provider licence unless, as is the case for NHS Trusts, they are exempt. However, NHS England/Improvement (referred to as NHS Improvement throughout this document) bases its single oversight framework on the conditions of the provider licence and requires NHS trusts to self-certify under these licence provisions.

This report sets out the self-certification framework and describes how the Trust has met the requirements of the provider licence.

Providers need to publish a statement that they are compliant with the following two conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (condition **G6**)
- The provider has complied with the required governance arrangements (condition **FT4**)

The Trust must publish a statement on its external website declaring compliance with condition G6 and must also confirm that it complies with condition FT4. This is the statement that will appear on the Trust's website, within a month, if the Board agrees:

'NHS Trusts are required to self-certify against the NHS provider licence and are specifically required to publish the declaration for general condition 6.

The Board considered the evidence to support compliance against this condition at its meeting held on 11 June 2021 and confirmed that it was compliant. More detail on the process and evidence considered by the Board when declaring compliance can be found in the Board papers for the 11June 2021 meeting (link to papers).

General Condition 6

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

The licensee also confirms that it has complied with the requirements for governance arrangements set out in condition FT4'

The document attached at **Appendix A** is a tabulation showing an assessment of compliance with the provider licence's conditions; including the two conditions (G6 and FT4) against which the Trust is required to self-certify. It should be noted that a limited number of conditions are not applicable as they apply to foundation trusts only.

When reviewing the document, the Board will note that the Trust is recording compliance against all applicable conditions.

Recommendations

The Board is recommended to:

Agree that the self-certification against required NHS provider licence conditions is accurate (noting particularly sections G6 and FT4) and that a statement of compliance with condition G6 and FT4 as described above may be published on the Trust's website.

Leeds Community Healthcare NHS Trust
NHS Provider Licence: compliance assessment

Section 1: general conditions

Condition	**Compliance**
G1: Provision of information *The Licensee shall furnish such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports as NHS Improvement may require.*	Compliant. The Trust has systems and processes in place to ensure compliance with all information requests whether routine, regular or ad-hoc in such form as requested and in a timely manner.
G2: Publication of information *The Licensee shall comply with any direction from NHS Improvement to publish information about health care services, in a manner that is accessible to the public.*	Compliant. A wide variety of routine information published on website and in hard copy documents, including: Board and associated papers; annual reports and information and advice to the public and referrers about services. The Trust is committed to openness and making information available in accessible formats. The Trust has published an Accessibility Statement on its public facing website.
G3: Payment of fees to NHS Improvement *The Act gives NHS Improvement the ability to charge fees, the Licensee shall pay all fees to NHS Improvement in each financial year of such an amount as NHS Improvement may determine.*	Not applicable. Fee requirement did not transfer from Monitor to NHS Improvement. The Trust pays all other fees as due (eg to the Care Quality Commission and to NHS Resolution).
G4: Fit and proper persons *The Licensee shall ensure that no person who is unfit may become or continue as a governor (FTs only) or as a director.* *The Licensee shall not appoint as a director any person who is an unfit person.*	Compliance with requirements reported to Board on 26 March 2021. On appointment and annually thereafter, all directors are subject to a fit and proper persons' declaration process. Information is validated externally where possible. All directors complete an annual declaration of interests' statement.
G5: NHS Improvement guidance *The Licensee shall at all times have regard to guidance issued by NHS Improvement.*	Compliant. The Trust has full regard to guidance issued. Guidance notified to the Trust is reviewed on receipt by the relevant director and a lead is assigned in accordance with subject matter to enact as appropriate.

Condition	Compliance
G6: Systems for compliance with licence conditions and related obligations *The Licensee shall take all reasonable precautions against the risk of failure to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution, including: processes and systems to identify risk and guard against occurrence and regular review of the effectiveness of these processes and systems* ***The Licensee must self-certify that:*** *'Following a review, the directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.'*	Compliant. The Trust is compliant with requirements to take all necessary steps to manage the risk of failure to comply with conditions; there are robust processes are in place to identify and manage risks to compliance. The Trust utilises the Datix® risk management system to create and populate its risk registers. Strategic and operational risks are scrutinised at each meeting of the Trust Board and at Board sub-committees, as well as regular review at executive director and service level. The Audit Committee scrutinises the risk management process and provides assurance to the Trust Board. Risk management training is provided to all staff at induction, and ongoing training and support is provided by a qualified and experienced risk manager. Additional risk management resources are available for staff on the Trust intranet. The Trust reviews and revises its board assurance framework strategic risks annually to ensure continued alignment with the operational plan and strategic goals. The board assurance framework includes: identification of strategic risks that would otherwise impede delivery of Trust's objectives, the level of risk in terms of likelihood and consequence, controls to mitigate the risks and the sources of assurance available for committee oversight and assessment. The Trust Board receives board assurance reports at each meeting which provides details of the current assurance level for each strategic risk. The Trust has an up to date risk management policy and procedure which is accessible to all staff via the policy library on the Trust's intranet. The Trust's risk appetite statement is appended to the risk management policy and procedure and describes parameters within which risk is managed. The risk appetite statement is reviewed annually by the executive team and changes are notified to the Audit Committee.

G7: Registration with the Care Quality Commission *The Licensee shall at all times be registered with the Care Quality Commission.*	Compliant. The Trust is registered without conditions. The Trust was rated Good in its 2019 inspection by the Care Quality Commission (CQC. The Trust has a quality governance approach including quality assessment visits which is fully aligned to the Care Quality Commission's domains.
G8:Patient eligibility and selection criteria *Licence holders are required to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.*	Compliant. Service information is published on the Trust's website and in patient information material. Service eligibility and selection information is detailed in service specifications and is available readily to 'Choose and Book' referrers. Published material is comparable to that available from other trusts. All patients meeting eligibility criteria are accepted for initial assessment and treatment if required.
G9: Application of Section 5 (continuity of services) *The condition applies where the Licensee is subject to a contractual obligation to provide a commissioner requested service and relates to maintenance of continuity of services.*	Compliant. The Trust is aware of services which the commissioners deem to be commissioner requested services; also known as essential services. The Trust achieves a good level of compliance with commissioned contractual requirements. Contract management arrangements between the Trust and its commissioners provide oversight of service delivery in line with contractual requirements.

Section 2: Pricing

Condition	Compliance
P1: Recording of information *The Licensee shall obtain, record and maintain sufficient information about costs of providing services.*	Compliant. Finance systems and processes are set up to meet all internal and external reporting requirements. Board approved annual budgets and financial plan in place. Reference costs are reported annually, when requested.
P2: Provision of information *The Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require.*	Compliant. Trust complies with all requests to supply information as requested. The information collected and recorded in relation to condition P1 is made available as requested.
P3: Assurance report on submissions to NHS Improvement *If required by NHS Improvement, the Licensee shall, as soon as reasonably practicable, obtain and submit to NHS Improvement an assurance report in relation to the accuracy of costing and pricing.*	Compliant. The Trust will fully comply with any such request as and when the requirement arises.
P4: Compliance with national tariff *The Licensee shall only provide health care services for the NHS at prices which comply with, or are determined in accordance with, the national tariff.*	Compliant where applicable. This condition is not generally applicable to community trusts. The Trust only provides one service which is part of the national tariff with which it is fully compliant.
P5: Constructive engagement concerning local tariff modifications *The Act allows for local modifications to prices. The Licensee shall engage constructively with commissioners to reach agreement locally.*	Compliant where applicable. The Trust operates under mainly under block contracts or where it has tendered w. Only one service is subject to national tariff and is supplied at national tariff.

Section 3: Choice and competition	
Condition	**Compliance**
C1: The right of patients to make choices *The Licensee shall ensure that at every point where a person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by commissioners, he or she is notified of that choice and told where information can be found.*	Compliant. The Trust offers choice where applicable. Choice and 'choose and book' approaches in place in relation to applicable services, namely those described as 18 week reportable services.
C2: Competition oversight *The Licensee shall not enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting completion in the provision of health care.*	Compliant. The Trust would pursue service opportunities within statutory and accepted procurement, bidding and contracting practices; this ensures that competition is not prevented, restricted or distorted by the Trust. Procurement and contract bid processes have been the subject of internal audits. No compliance issues identified.

Section 4: Integrated care	
Condition	**Compliance**
IC1: Provision of integrated care *The Licensee shall not do anything that would reasonably be regarded as against the interests of people who use health care services for the purposes of the NHS to be integrated with the provision of such services.*	Compliant. The Trust is a significant leader in the development of integrated care approaches as reflected by the role played in the West Yorkshire Integrated Care System, emerging provider partnership arrangements in Leeds, the Leeds Health and Care Plan and the development of new models of care and initiatives to effect closer integration. .

Section 5: Continuity of services

Condition	Compliance
COS1: Continuing provision of commissioner requested services *The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any commissioner requested service except where permitted to do so in the contract.*	Compliant. Contract management arrangements in place between the Trust and its commissioners; any material changes agreed through a contract management board. Trust achieves good level of compliance with commissioned contractual requirements including those services deemed to be commissioner requested services. Contracts and service specifications are in place and as agreed with commissioners.
COS2: Restriction on the disposal of assets *The Licensee shall establish, maintain and keep up to date, an asset register of assets relevant to commissioner requested services and have due regard to consent before disposal.*	Compliant. No issues identified in the disposal of assets related to commissioner requested services without consent of NHS Improvement. Asset register processes have been the subject of scrutiny by internal and external audit.
COS3: Standards of corporate governance and financial management *The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:* *(a) suitable for a provider of the commissioner requested service provided by the Licensee, and* *(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.*	Compliant. The Trust has robust systems for corporate and financial management including standing orders, standing financial instructions, and schemes of reservation and delegation of powers**.** Compliance is monitored through Audit Committee, recorded in the annual governance statement and 'going concern statement' and has been subject to internal and external audit. The Trust was rated "good" in the most recent assessment by the CQC
COS4: Undertaking from the ultimate controller *The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee.*	Not applicable.

COS5: Risk pool levy *The Licensee shall pay any sums required to be paid in consequence of any requirement imposed on providers by way of a levy.*	Not applicable. No NHS Improvement risk pool levy system in place. The Trust would comply with this condition when any requirement arose. The Trust participates in NHS Resolution's clinical negligence scheme for trusts.
COS6: Co-operation in the event of financial stress *The Licensee shall provide such information as NHS Improvement may direct and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.*	Not applicable. The Trust would comply with this condition as and when any requirement arises.
COS7: Availability of resources *The Licensee shall at all times act in a manner calculated to secure that it has, or has access to the required resources.*	Compliant. Evidenced through annual contract negotiations, approval of operational plan and associated financial plan and annual budgets, approval of going concern statement and regular monthly monitoring of performance against plan.

Section 6: NHS foundation trust conditions

Condition	Compliance
FT1: Information to update the register of NHS foundation trusts *The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents:* *(a) the current version of the Licensee's constitution;* *(b) the Licensee's most recently published annual accounts and any report of the auditor on them, and* *(c) the Licensee's most recently published annual report*	Compliant where applicable. All information as required to be supplied to NHS Improvement from NHS trusts supplied in accordance with requirements. Constitution applies to foundation trusts only.
FT2: Payment to NHS Improvement in respect of registration and related costs *The Licensee must pay NHS Improvement a fee in respect of NHS Improvement's exercise of its functions.*	Applicable to foundation trusts only.
FT3: Provision of information to advisory panel *The Licensee shall comply with any request for information or advice made of it.*	Applicable to foundation trusts only.

Condition	Compliance
FT4: NHS foundation trust governance arrangements 1. *The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health services to the NHS.*	Compliant. The Trust develops an annual governance statement which is scrutinised by a Board sub-committee prior to Board approval (11 June 2021). The annual governance statement is reviewed by auditors as part of the process for finalising the Trust's report and accounts. The Trust has satisfactory opinion reports from the Head of Internal Audit (TIAA Limited) and from the Trust's external auditors (Mazars) The Trust operates at all times within a framework of standing orders, standing financial instructions, and schemes of reservation and delegation of powers and approved policies and procedures.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to	Compliant. The Trust's governance arrangements are developed with due regard of all guidance as issued by NHS Improvement from time to time. The

time.	Trust also regularly reflects on guidance information provided by the Good Governance Institute. Governance arrangements are reviewed annually, including a review of the standing orders, reservation and delegation of powers, and standing financial instructions.
3. The Board is satisfied that the Licensee has established and implements: *(a) Effective Board and Committee structures* *(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees* *(c) Clear reporting lines and accountabilities throughout its organisation.*	Compliant. The Trust has a fully constituted Board and five sub-committees. The terms of reference for all committees have been reviewed in early 2021; ensuring appropriate membership, lines of accountability and clear areas of delegated responsibility. The Board and committees operate to annual cycles of business. Board and committee effectiveness is reviewed annually (and reported to Audit Committee and the Board). Each committee produces an annual report. There is a robust process for recording assurances provided by committees to the Board against matters contained in the board assurance framework. Details of the Trust's governance arrangements are displayed on the intranet, accessible to all staff. A number of sub-groups have been aligned with an appropriate committee. Each sub-group escalates issues to committees as necessary.
4.The Board is satisfied that the Licensee has established and effectively implemented systems and/or processes: *(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively* *(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations* *(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions* *(d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern* *(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making* *(f) To identify and manage (including but not restricted to*	Compliant. The Board gains assurance that the Trust operates efficiently, economically and effectively through its standing orders and financial instructions, schemes of reservation, delegation of reporting to Board and its sub committees and the following established organisational processes: The review and approval of The Trust's operational plan involved consideration of key areas of risk in respect of quality of services, financial performance (as recorded in board assurance framework), national and local standards and requirements and delivery of key strategies. Areas of risk have been reported to Board through risk assurance reports and monitoring of delivery of the operational plan and strategic priorities; the latter having been considered in detail by the Trust's Quality and Business Committees. Assurances are provided by committees to the Board against matters contained in the board assurance framework. Performance management framework allows the timely monitoring of main operational, quality, workforce, contractual and financial indicators. Performance reporting is fully aligned to the Care Quality Commission's five domains. Performance data (quality, activity, contractual and financial) is

manage through forward plans) material risks to compliance with the Conditions of its Licence *(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery* *(h) To ensure compliance with all applicable legal requirements.*	reported to the sub-committees and Board for scrutiny. There are also regular reports on key issues (eg patient safety, clinical effectiveness, patient experience, demand and capacity, recruitment and retention etc). Quarterly finance reports track actual performance against plan. The Board sets an annual budget to meet the Trust's financial obligations and through detailed monthly monitoring at the Business Committee and bi-monthly at the Board ensures that the plan is adhered to. An annual 'going concern' review is undertaken by Audit Committee and approved by Board. Quality priorities are recorded in the Trust's Quality Strategy. Annual Quality priorities are agreed as part of the annual planning process aligned to the operational plan. Actions to enhance quality are contained in improvement plans; performance against which is monitored by Quality Committee and Board. The Trust is registered with the CQC without conditions. The Care Quality Commission last inspected the Trust in 2019 and concluded an overall rating of 'Good'. To ensure compliance with standards set by regulators of health care professionals the Trust has the following arrangements: • On appointment of new staff, status checks are completed with professional bodies. • Periodic checks are made to ensure registrations are renewed appropriately • There is ongoing monitoring of clinical supervision to ensure staff access this. • The Trust has a system of medical revalidation. • Annual appraisals are monitored and cover the professional standards set by the relevant governing body. • The Trust supports continual professional development. Performance and finance reports are scrutinised by Business Committee and Trust Board. The Audit Committee provides oversight of systems of internal control including efficacy of financial reporting.

	The risk appetite statement is reviewed annually. The board assurance framework is updated annually to align with the Trust's operational plan. Timely and robust risk reporting processes are in place with scheduled reports to committees and Board. A programme of internal and external audit is in place aligned to strategic risks. An annual business planning cycle produces operational plans aligned with the Trust's key strategies, system plans (West Yorkshire and Harrogate Health and Care Partnership Plan and the Leeds Health and Care Plan) and commissioner plans. Business Committee and Board receive progress reports on delivery of plans. The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.
5. The Board is satisfied that the systems and/ or processes referred to in paragraph 4 (above) should include but not be restricted to systems and /or processes to ensure: *(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided* *(b) That the Board's planning and decision making processes take timely and appropriate account of care considerations* *(c) The collection of accurate , comprehensive, timely and up to date information on quality of care* *(d) That the Board receives and takes into account accurate , comprehensive, timely and up to date information of the quality of care* *(e) That the Licensee, including its Board, actively engages on quality of care with patient, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources* **(f)** *That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board*	Compliant. The Board has strong complementary skill sets amongst non-executive and executive Board members. There is a clear distinction of 'portfolios' whilst remaining fully operational as a unitary board. Essential leadership of the quality agenda is provided by medical and nursing directors. Board approved quality strategy sets out strategic action areas enacted through action plans and monitored through quality and safety reports to Quality Committee and Board. Annual Quality priorities are agreed as part of the annual planning process. Quality Committee receives a comprehensive Clinical Governance Report. Quality account, quality challenge+ and the clinical audit programme all require measurement, evaluation and reporting of essential quality data. These are scrutinised by the Quality Committee, which communicates the level of assurance these provide to the Trust Board. Internal audit reviews of data quality have indicated reasonable assurance in all instances.

where appropriate	There is an active programme of Board members engagement with patients and staff through visits and leadership initiatives. All Board meetings include a 'patient story', which involves a patient and or a carer either attending or recording their story on video to provide the Board meeting with their account of the quality of care they have experienced. The Trust has multiple means to raise concerns related to quality of care including communicating issues to the patient experience team, stakeholder meetings, staff forums and 'freedom to speak up' activities. The Trust engages with Healthwatch and other key stakeholders in developing and agreeing Quality priorities and the Quality Account. A Quality Impact Assessment process is completed for all service changes that have potential to impact on patient care, including service and pathway improvement, service development and transformation and service offers developed in response to tenders.
6. *The Board is satisfied that there are systems in place to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the NHS provider licence.*	Compliant. Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The Trust has a fully constituted Board and committees each with full and active membership. Ongoing Board development **i**ncludes workshops, networking events and training opportunities. Full line management structure linked to each executive director's portfolio. The Chief Executive is subject to formal review by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executives are subject to annual appraisals by the Chair, these will inform individual development plans for all Board members. The Chair has an annual multi-sourced appraisal, coordinated by the Senior Independent Director in accordance with NHS England/Improvement's Chair appraisal process. All appointments to senior management positions are subject to rigorous and transparent recruitment processes.

	The Trust develops its leadership capability through its coaching strategy which supports the development of staff. Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. Trust Board is fully apprised at each meeting of key quality, workforce and financial indicators. Workforce indicators include compliance with safe staffing ratios, vacancy rates, staff turnover, retention, agency staff deployment, sickness absence, appraisal rates, professional revalidation and training compliance. Business Committee has oversight of workforce issues; extensive consideration of areas of challenge (eg recruitment and retention in clinical services, health and safety issues) through a suite of reports including the performance brief and the risk register report, which are received at each meeting. Business Committee communicates the level of assurance these provide directly to the Board.

Leeds Community Healthcare NHS Trust

Board Meeting held in public : 28 May 2021

Agenda item number: 2021-22 (18a)

Title: Audit Committee minutes: 12 March 2021

Category of paper: for noting
History: Audit Committee 16 April 2021

Attendance

Present:	Jane Madeley	Chair of the Committee, Non-Executive Director
	Richard Gladman	Non-Executive Director
	Ian Lewis	Non-Executive Director
	Khalil Rehman	Associate Non-Executive Director
In Attendance:	Bryan Machin	Executive Director of Finance and Resources (for Item 49 only)
	Cherrine Hawkins	Deputy Director of Finance and Resources
	Diane Allison	Company Secretary
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	David Robinson	Internal Audit Manager (TIAA Limited)
	Mark Dalton	Director for the Public Sector (Mazars)
	Louise Stables	Assistant Manager (Mazars)
Apologies:	Bryan Machin	Executive Director of Finance and Resources
Minutes:	Liz Thornton	Minutes

Item: 2020-21 (49)

Discussion points:
Welcome, introductions, apologies and preliminary business

The Chair of the Committee, Non-Executive Director (JM) welcomed everyone to the meeting.
This would be the last meeting of the Committee before her term of office as a non-executive director at the Trust ended. The Executive Director of Finance and Resources joined the start of the meeting to place on record his personal thanks to her as the longstanding Chair of the Audit Committee, for providing such effective support and constructive challenge on governance and financial management within the Trust.

a) Apologies
Executive Director of Finance and Resources.

b) Declarations of interest
Associate Non-Executive Director (KR) reminded the Committee that Mazars were the external auditor for East Lancashire Hospitals NHS Trust where he was also a Non-Executive Director.

c) Minutes of the meeting held on 15 January 2021
The minutes of the meeting were agreed as a correct record.

d) Matters arising and review of the action log
Item 2020-21 (38di) – Internal Audit Annual Plan-progress on 2020-21 plan: covered by minute 2020-21(50a).

Item 2020-21 (50)

Discussion points:
Internal Audit

a) Summary internal controls assurance report

The Internal Audit Manager introduced the report. The Committee reviewed the progress against the annual audit plan for 2020/21 as at 1 March 2021, noting that the internal audit work had been significantly impacted by the Covid-19 pandemic.

Completed audits
The Committee discussed the executive summary and strategic findings for the three completed audits.

Appraisals
This audit had been determined as **reasonable assurance** with one important, two routine and one operational recommendations relating to the application of appraisal policy.

The Chair of the Committee asked if the Business Committee had reviewed the Audit. The Company Secretary confirmed that the Business Committee had reviewed the audit at its meeting in January 2021.

The Committee was content with the recommendations, the management response and agreed that the timescales were reasonable and realistic.

Health and Safety
This audit had been determined **limited assurance** with two urgent, nine important and two routine recommendations. The recommendations in the main related to manager's awareness of their responsibilities within the Health and Safety Policy and its delivery, and that serious incident and accident outcomes do not consistently identify root causes or translate into learning.

The Company Secretary said that she had been involved in setting the scope for the audit and she welcomed the in depth audit report which she believed was an accurate reflection of the position within the Trust.

The Committee agreed that the audit had produced some helpful recommendations and discussed the urgent recommendation made in relation to health and safety training needs particularly for managers to ensure that they were competent to fulfil their responsibilities.

The Company Secretary said that a significant amount of training was available to managers and they were encouraged to attend, however it was not a mandatory requirement for supervisory roles.. In addition a senior health and safety advisor had been recruited to a permanent post within the Trust and would be available to provide specialist support to managers and staff. A Training Needs Analysis (TNA) was required to scope the requirements across the organisation and responsibility for this would sit within the Workforce Directorate where a member of staff had been identified to take this forward.

The Committee was advised that some of the timescales provided for managers' actions were reflective of the need for a cultural change to ensure that health and safety responsibilities, systems and processes were embedded throughout the organisation.

Cyber security

This audit had been determined **reasonable assurance** with two important recommendations relating to the implementation of proactive security plans and the Bring You Own Device Policy and one routine recommendation related to the Trust developing procedures for security checks.

The Chair of the Committee sought assurance that the audit had been undertaken by an expert in the field of cyber security.

The Internal Audit Manager confirmed that this was the case.

The Deputy Director of Finance and Resources said that an Information Security Manager had recently been appointed to provide additional capacity in the area of cyber security and undertake a review of the measures in place across the Trust.

The Chair of the Committee asked that the Information Security Manager provide an update on their findings and progress with the audit recommendations to the Committee in six months time.

Action: Information Security Manager provides an update on their findings and progress to the Committee in six months time.

Responsible Officer: Executive Director of Finance and Resources

Internal audit plan 2020-21

The Chair of the Committee asked for confirmation that all the outstanding audits would be presented to the Committee on 16 April 2021.

The Internal Audit Manager said that it would not be possible to finalise all the audits by the 16 April 2021 but they were committed to having all the outstanding audits completed and presented to the Committee by 7 June 2021.

The Committee agreed that, due to the year end, the aim should be to present as many completed audits as possible to the Committee on 16 April 2021 even if they had not been considered by other committees in advance of that meeting.

Outcome: The Committee:

- noted the contents of the summary internal controls assurance report, including the completion and outcome of three audits, and progress against the 2020-21 plan.

b) Internal audit recommendations update

The Committee reviewed the recommendations update paper and noted that three actions were

overdue all related to Statutory and Mandatory training.

The Committee had received a detail progress report from the Director of Workforce at its last meeting on 15 January 2021 on this audit and actions and was pleased to note the progress made. It was agreed that the new deadlines were realistic in the current circumstances

Outcome: The Committee:

- noted the update report.

c) Interim Head of Internal Audit opinion

The Head of Internal Audit introduced the draft year-end report and reminded the Committee that the delivery of the internal audit work for 2020/21 has been impacted by the global COVID-19 pandemic. As a consequence TIAA were not able to complete or partially complete the reviews of Specialist Business Unit Review, Adult Business Unit Review, Quality Challenge and Governance of the Mental Health Act. A review of Covid Financial Governance was substituted into the programme.

This had not, however, affected TIAA'S ability to provide a full Head of Internal Audit Opinion based on the work carried out.

The draft opinion was that:

"…. a reasonable assurance could be given and that there was a generally sound system of internal control, designed to meet the organisation's objectives and that controls were generally being applied consistently. However, some weaknesses in the design and/or the inconsistent application of controls put the achievement of particular objectives at risk.

Action: Final internal audit year-end report to be presented at the next Committee meeting on 16 April 2021 including the final opinion.

Responsible Officer: Head of Internal Audit

On behalf of the Committee the Chair placed on record her thanks to TIAA and the Trust's directors for their efforts to ensure that sufficient internal audit work had been undertaken to gain reasonable assurance during 2020/21.

Non-Executive Director (RG) asked whether TIAA would consider undertaking some audits remotely in 2021/22.

The Internal Audit Manager expected the approach to be a combination of both remote and on site audits. TIAA intended to include a question in their annual stakeholder survey to seek views on feasibility for undertaking audits remotely.

Outcome: The Committee:

- noted the Head of Internal Audit draft opinion.

d) Draft Internal Audit Strategy and Annual Plan 2021/22

The draft internal audit annual plan for 2021/22 was presented by the Internal Audit Manager. He advised that no significant changes had been made to the plan since it was last presented to the Audit Committee in January but he confirmed that it had been reviewed by both the Quality and Business Committees who were content with the breadth of coverage within the plan.

Non-Executive Director (IL) observed that the scope of all audits appeared to be process and business driven and he was concerned that quality, clinical risk and governance were not addressed when audits were undertaken and that there was insufficient read across of findings from audits to the rest of the plan.

The Committee agreed, quoting an example in the findings from the Health and Safety Audit where

there were themes identified that could be explored in other internal audits and suggested that these should be considered when scoping other audits.

The Chair of the Committee said that as part of the process for agreeing the scope of each audit the Senior Management Team (SMT) should ensure it was rich enough to address areas of concern or known risk where appropriate. She suggested that to ensure this was the case it should be re-emphasised to members of SMT.

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Action: SMT to be reminded that in setting and agreeing the scope for audit the clinical aspects, learning from incidents and risk are fully addressed.

Responsible officer: Executive Director of Finance and Resources to raise with the SMT.

The Chair of the Committee expressed surprise that in light of the findings from recent audits the follow up audits for Health and Safety, Statutory and Mandatory Training and Managing Clinical Risks were scheduled for 2023/24 and suggested that this should be reviewed when the plan was agreed next year.

Outcome: The Committee:

- approved the draft Internal Audit Plan for 2021/22.

Item 2020-21 (51)

Discussion points:
External audit

a) External audit progress report

The Director for the Public Sector provided a verbal update and confirmed that overall audit progress was on track for the end of year reporting with no significant issues arising which required reporting to the Committee.

b) External audit strategy memorandum (annual plan and fees year ending March 2021)

The Assistant External Audit Manager referred the strategy for the year ending 31 March 2021 which had been prepared following initial planning discussions with management. The document summarised Mazars audit scope, approach and timeline. It highlighted significant audit risks and areas of key judgements and provided the details of the audit team. From the work that had already begun, the external auditors confirmed that there were no matters that it wished to bring to the Committee's attention.

The Assistant External Audit Manager reminded the Committee that regarding the Value for Money "VfM" element of the audit, a new approach was 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.

Non-Executive Director (IL) said that he would prefer the VfM aspect of the audit to extend beyond financial considerations and include quality assurance on the delivery of healthcare services.

The Chair of the Committee asked if a draft of the VfM audit outcome would be presented to the Committee and this was confirmed.

Outcome: The Committee:

- noted the external audit progress report and the external audit strategy memorandum (annual plan and fees year ending March 2021)

Item 2020-21 (52)

Discussion points:
Annual report and accounts

a) Annual report and accounts planning and progress report

The Deputy Director of Finance and Resources presented the report which had been prepared to provide assurance that the Trust was sighted on the requirements for the 2020-21 annual report and accounts process including a detailed timetable. The Deputy Director of Finance and Resources said that all aspects were being completed to timescale.

Outcome: The Committee:

- received the timetable for the production of the Trust's annual report and accounts and noted the assurance that all aspects were being completed to timescale.

b) Revaluation of non-current assets

The Deputy Director of Finance and Resources presented the paper and explained that one of the main areas of audit focus when reviewing the Trust's accounts is the valuation of property plant and equipment. The paper provided the Committee with details of the information considered by management, as advised by the Executive Director of Finance and Resources in reaching the decision not to revalue the Trust's Property Fixed Assets.

The Chair of the Committee sought and received assurance that the External Auditors were content with the proposal.

Outcome: The Committee:

- noted the decision not to undertake a revaluation exercise for the 2020/21 accounts, and
- approved the approach that a formal revaluation will be undertaken at least every five years or when triggered by a movement of 5% or more in the BCIS index.

c) Going concern consideration

The Deputy Director of Finance and Resources presented the going concern paper for consideration by the Committee.

The Committee considered the matters in the paper and with an awareness of all relevant information it concluded that there were no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern.

Some amendments were suggested to the wording in the conclusion around the signing of contracts with commissioners. It was agreed that the final wording would be agreed with the Chair of the Committee before presentation to the Board on 26 March 2021.

Outcome: The Committee:

- recommended to the Board that when approving the annual accounts it does so in agreement that the Trust is a going concern subject to some minor revisions to the wording in the conclusion to the paper before presentation to the Board.

d) Changes to accounting policy 2020/21 accounts

The Deputy Director of Finance and Resources presented the paper which informed the Committee of changes to accounting policies which will be used to present the Trust's annual report and accounts for 2020-21.

She said that there were no new accounting standards for the 2020/21 accounts but there had been some amendments to the International Financial Reporting Standards (IRFS) in how they are applied to NHS accounts and these were detailed in the report.

Outcome: The Committee:

- noted there were no new accounting standards for the 2020/21 accounts and noted the

annual reporting requirements adopted by the Trust, in order to comply with the Department of Health Group Accounting Manual 2020/21.

Item 2020-21 (53)

Discussion points:
Data security

a) **Information governance –annual effectiveness review**

The Deputy Director of Finance and Resources presented the report which provided a summary of the key activities of the Information Governance Group in 2020/21.

The Chair of the Committee referred to the table of attendance at Information Governance meetings and noted that the Clinical Advisor/Clinical Safety Officer had not attended any meetings during the year. She asked that the Director of Finance and Resources check why the individual had not attended meetings and report back outside the meeting.

Action: Executive Director of Finance and Resources to report back on the non-attendance of the Clinical Advisor/Clinical Safety Officer at Information Governance Group meetings.

Responsible Officer: Executive Director of Finance and Resources.

Outcome: The Committee:

- noted the effectiveness report and the annual review of the terms of reference.

Item 2020-21 (54)

Discussion points:
Financial controls

a) Tender quotations and waiver report

The Deputy Director of Finance and Resources presented the report which provided the Committee with details on the procurement of goods and services where the procedures on seeking tenders and quotations for items of material expenditure had been waived, including an extract from the 2020/21 register of wavers completed since the last audit committee meeting.

Associate Non-Executive Director (KR) queried the cost of the two higher specification servers at £59,244 Plus VAT.

The Deputy Director of Finance and Resources provided assurance that the servers had been purchased through the NHS Framework arrangement.

Non-Executive (RG) said that he believed that the cost for two servers was reasonable but agreed to discuss this further with the Assistant Director of Business Intelligence, Clinical Systems and IT outside the meeting.

Outcome: The Committee:

- received and noted the report and the extract from the 2020/21 register.

b) Losses and special payments report

The Deputy Director of Finance and Resources confirmed that there was no report for this meeting.

c) Over and under payments and off payroll payments

The Deputy Director of Finance and Resources presented the report which detailed the over and under payments of salary for the financial year up to February 2021.

The Chair of the Committee noted that in relation to underpayments a significant number were attributed to errors by Trust staff and queried if these had been investigated further.

The Deputy Director of Finance and Resources confirmed that a significant number of the errors

had occurred through the e-rostering system.

Outcome: The Committee:

- received and noted the report.

d) **Receivables and payables: over 6 months old and over 5K**

The Deputy Director of Finance and Resources presented the report to provide assurance of the Trust's routine operational processes and identify any potential risks to the financial position ahead of the closure of the accounts for 2020/21. The report provided details of trade receivables and payables individually over £5,000 in value and over six months old as at 28 February 2021, subsequent transactions, and actions taken to clear balances.

The Committee received assurance that all outstanding matters were being addressed and where current actions had not had the desired results matters had been escalated.

Outcome: The Committee:

- received and noted the report.

Item 2020-21 (55)

Discussion points:

a) **Audit Committee effectiveness evaluation summary**

The Chair of the Committee drew member's attention to the effectiveness evaluation summary which had been circulated and the positive results from the survey.

The Chair of the Committee suggested that in future years all regular attendees of the Committee could be invited to input to the evaluation summary.

Outcome: The Committee received and noted the results from the annual effectiveness review.

Item 2020-21 (56)

Discussion points:
Committee's work plan

There were no items removed or changes made to the workplan.

Item 2020-21 (57)

Discussion points:
Minutes for noting

Information Governance Group
None for this meeting.

Item 2020-21 (58)

Discussion points:
Matters for the Board and other committees and review of the meeting

The Chair noted the following items to be referred to Board colleagues:

- Internal Audits completed and Head of Internal Audit (interim) opinion
- Internal Audit draft plan 2021/22
- External audit strategy memorandum
- Annual report and accounts 2020/21

Item 2020-21 (59)
Discussion points:
Any other business

Individual members of the Committee placed on record their thanks to the Chair of the Committee for leading the Audit Committee so effectively during her tenure of office.

The Deputy Director of Finance and Resources placed on record her personal thanks to the Chair

for her support to the Finance Team.

The Chair said that she had been proud to work with the Trust and to support financial management and governance as Chair of the Audit Committee. She thanked all those in attendance for their contribution as members of the Committee and also those who attended from across the Trust at various times during the year to update the Committee on their particular work streams.

Date and time of next meeting

Friday 16 April 2021 9.00-11.30am
Wednesday 12 May 2021 8.45-10.00am (Page turner –annual report)
Monday 7 June 2021 9.00am-11.30am
Friday 23 July 2021 10.00-12.30pm
Friday 15 October 2021 10.00-12.30pm
Friday 10 December 2021 10.00-12.30pm

Leeds Community Healthcare NHS Trust

Board Meeting held in public: 28 May 2021

Agenda item number: 2021-22 (18b)

Title: Quality Committee minutes 22 March 2021

Category of paper: for noting

Attendance

Present:	Helen Thomson (HT)	Chair, Non-Executive Director
	Rachel Booth	Non-Executive Director
	Alison Lowe (AL)	Non-Executive Director
	Steph Lawrence	Executive Director of Nursing and AHPs
	Sam Prince	Executive Director of Operations
In Attendance	Diane Allison	Company Secretary
	Thea Stein	Chief Executive
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Stuart Murdoch	Deputy Medical Director (Deputising for Executive Medical Director)
	Brodie Clarke	Trust Chair
Apologies:	Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Non-Executive Director
Minutes:	Lisa Rollitt	PA to Executive Medical Director

Item: 2020-21 (83)

Discussion points:

(a) Welcome and introductions

The Chair welcomed members and attendees.

Apologies were noted from a Non-Executive Director (IL) and the Executive Medical Director.

(b) Declarations of interest

In advance of 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.

(c) Minutes of the previous meeting 22 February 2021

The minutes of the meeting held on 22 February 2021 were reviewed and agreed as an accurate record.

(d) Matters arising and review of action log

Item 2020-21(67c) Quality Improvement plan (CQC)

The item was on the agenda and it was agreed that the action was complete.

Item 2020-21(77a) Schedule of Key Performance Indicators (KPI)

The action was agreed as complete.

Item 2020-21 (78c) Internal audit annual plan 2021/22

The Executive Director of Nursing and AHPs confirmed that the Safeguarding Adults audit had been completed in the previous year. A review of Safeguarding Children would take place, focussing on the front door and statutory requirement to be involved in certain meetings. The action was agreed as complete.

Item 2020-21 (79a) Work plan

The Assistant Director of Nursing and Clinical Governance confirmed that the work plan had been reviewed and aligned with the BAF risks. It was noted that there was robust assurance on risks 1.1 and 1.3, with variable assurance on risks 1.2 and 1.4. There was an expectation that the robustness would improve.

The action was agreed as complete.

2020-21(84)

Key issues

a) Covid-19 update

The Executive Director of Nursing and Allied Health Professionals highlighted that the number of Covid-19 outbreaks in Care Homes had significantly lowered since last

month. The Committee noted the infection preventions and vaccination work which had contributed to the data.

In response to a query from the Deputy Medical Director, the Executive Director of Operations confirmed that 90% of Care Home residents and 78% of Care Home staff had received the vaccination. Work was ongoing to encourage the uptake of the vaccination in the remaining residents and staff.

With regards to the Care Home complaint, it was noted that a response had been sent. There had been no further correspondence. No further issues were expected from the Care Home community.

Ongoing conversations were taking place in the Care Homes Silver Group regarding protocols on visiting. The Committee heard that the Leeds Care Association's suggested protocols had been unworkable and this had been made clear to the Group. An alternative protocol had been developed by the Trust which had been accepted by the Care Homes Silver Group. A meeting was due to take place with the Leeds Care Association Operational Manager to discuss the protocol to hopefully agree a conclusion.

Testing was noted as ongoing and it was now mandatory for all frontline staff to test themselves. Where staff don't think they should be tested, individual conversations would be taking place to understand the concerns.

The Executive Director of Operations spoke about DNAs in the vaccination centre at Elland Road following the national news around the safety of the AstraZeneca vaccine. Overall, the vaccine supply is the same as it has always been. However due to the target for second doses, the Trust has been asked to close all untaken slots in the national bookings service and local systems from 1 – 30 April 2021. Work was underway to consider how to actively invite people to Elland Road and to ask staff to start to go back into local areas to vaccinate people and spend time talking through why they might be hesitant to receive the vaccine.

The Executive Director of Operations spoke about the positive work taking place at a centre in Harehills which will continue to run for the next six weeks.

b) Reset and recovery update from previous month

The Executive Director of Operations stated that work continued to address waiting lists. It was noted that progress was being made in the Dental Service, with all C1 and C2 clients being contacted. Good progress continued with C3 clients. It was noted however that other issues e.g. team culture, still required more work.

The Committee heard that a presentation would be made to the Business Committee, focussing on themes. This would include virtual consultations, backlogs and waiting lists and self-management.

It was noted that the administration review continued and during the past year the telephone system has been upgraded to enable more flexible working, giving staff a choice to work from home or the office, in line with balancing staff lives and business continuity.

The Chief Executive asked about the programme looking at health inequalities and requested that this was included in the presentation as a theme.

Action: Presentation for Business Committee focussing on themes to be shared with Quality Committee members and attendees.

Actionee: Executive Director of Operations

The Committee Chair expressed concern about the waiting list in the Podiatry Service. The Executive Director of Operations shared these concerns. It was noted that there were a number of patients who had been waiting over 52 weeks, classed as a never event. The CCG had suggested decommissioning this group of patients however this had not been confirmed. Clarity was required to enable planning as the clinical risk lies with the Trust and extra resourcing may be required. It was agreed that assurance was needed that all processes were thorough.

Action: Formal letter to be sent to CCG requesting clarity regarding the group of patients who have been on the Podiatry waiting list for over 52 weeks.

Actionee: Executive Director of Operations

c) Never event: verbal update

The Executive Director of Nursing and AHPs gave an update on the previously reported never event, stating that this had been concluded and the investigation was complete. The report has been submitted to the Commissioner.

It was noted that a number of learning actions had been identified.

The Executive Director of Nursing and AHPs brought the Committee's attention to an issue in 2015 where a National Patient Safety Alert (NPSA) around national and local safeguards relating to safe surgery practice was issued. It had been identified that this alert was received by the Trust. Some work had been done to address this, but was not concluded, and therefore assurance of safety standards for local safe surgery processes were not put in place. Work was now underway to look at which services should be undertaking the safety checks and ensuring that these would be put in place, if not already, and assurance can be provided.

A Non-Executive Director (RBo) asked about learning and if this was filtered into individual staff supervision? The Executive Director of Nursing and AHPs confirmed that it would depend on the learning identified and this would be fed into individual supervision and recorded if needed, should there be future incidents.

It was noted that an update on the Never Event would be given to the Board at its meeting on 26 March via the Director of Workforce.

d) Private item

Please refer to the private minutes.

2020-21 (85)

For discussion: Quality governance and safety

a) Performance Brief and Domain reports

The Executive Director of Nursing and AHPs presented the report and highlighted the significant drop in safe staffing fill rates. It was noted that the lower percentage for the safe staffing fill rates was due to lower numbers of patients and staffing being adjusted accordingly rather than there being a staffing issue. The reporting of safe staffing will be reviewed for future reports.

The Executive Director of Nursing and AHPs referred to the Patient Safety incidents and informed the Committee that two incidents at HMYOI Wetherby and Adel Beck Secure Children's home had been reported as separate serious incidents (SI), however there would be one overarching investigation completed.

The Committee Chair asked about the report of suspected sexual abuse by the Kippax Neighbourhood Team. The Assistant Director of Nursing and Clinical Governance confirmed that this incident was an incident that occurred outside of the Trust and should not have been included in the report. The incident related to unexplained bruising on a care home resident and was appropriately referred to Safeguarding. It was noted that the data would be corrected within Datix.

A Non-Executive Director (AL) referred to Datix reports and asked whether protected characteristics were recorded to identify issues such as racism or homophobia etc. it was agreed that the Executive Director of Nursing and AHPs and the Assistant Director of Nursing and Clinical Governance would review how this could be addressed and would report this back to a future meeting. The Assistant Director of Nursing and Clinical Governance also stated that changes were restricted by stipulations linked to national reporting.

Action: Datix reporting to be reviewed to consider recording protected characteristics.

Actionee(s): Executive Director of Nursing and AHPs and Assistant Director of Nursing and Clinical Governance

A Non-Executive Director (RBo) stated that it would be helpful to see data broken down between business units. It was noted that the bi-yearly SI reports to Board were broken down by business unit, and it could prove difficult to do this on a monthly basis due to the timescales and smaller numbers. It was agreed that the Executive Director of Nursing and AHPs would consider this.

Action: Consideration to be given to providing data in the monthly Performance Brief and Domain reports by business unit

Actionee: Executive Director of Nursing and AHPs

b) Clinical Governance report inc. PE & Sis flash reports and Clinical Leads' reports

The Executive Director of Nursing and AHPs presented the report and drew the

Committee's attention to the Moderate harm incidents in Podiatry resulting in Serious Incident. It was noted that five of the eleven incidents had occurred in Quarter 4. Six had progressed to Serious Incidents and were deemed avoidable by the Trust. A deep dive would take place to investigate these and a report would be provided to the Quality Committee.

There was a discussion about the Leeds Mental Health and Wellbeing Service (LMWS) deaths. It was noted that the Trust was part of an integrated system plan across the city which has a commitment to zero suicides and agreed that there was a need to understand why these patients were referred to the service and why they weren't picked up. It was agreed that a standalone report with a deep dive, including which other partners were involved in the care of the patients, and commitment to zero suicide would be brought back to the Quality Committee.

Action: Standalone report with deep dive into deaths in the LMWS service to be presented to Quality Committee

Actionee: Executive Director of Nursing and AHPs

The Trust Chair asked for a copy of the Patient Safety Strategy update which had been presented to QAIG.

Action: Patient Safety Strategy update to be shared with the Trust Chair

Actionee: Executive Director of Nursing and AHPs

The Trust Chair referred to the Virtual ward for Frailty and asked for clarity around the number of referrals compared to the maximum capacity of 40 patients. The Executive Director of Nursing and AHPs gave assurance that the all referrals were accepted and at the point of further investigation, the appropriateness of the referral was considered with the oversight of a geriatrician. Where it is agreed that the virtual ward is not appropriate for the patient, this would be discussed with their GP.

The Chief Executive referred to school closures and asked about the backlog of immunisations. The Executive Director of Operations confirmed that the Immunisations Team had gone back into schools from 8 March 2021 and they were working towards completing the programme before the end of the school term. It was noted that consent opt out rather than opt in options were being considered. The use of a separate venue during school holidays was also being considered to address the backlog and meet the target date of 31 August 2021 for completion.

It was agreed that a progress report would be presented to the Quality Committee at the meeting in April 2021.

Action: Progress report on school immunisations to be presented to Quality Committee at the meeting in April 2021

Actionee: Executive Director of Nursing and AHPs

c) Neighbourhood Team Triangulation report

The Executive Director of Operations presented the report, commenting that given the data presented, it was difficult to understand why the felt experience in the teams was so bad. As a result, the Senior Management Team (SMT) had agreed to a thorough review of the Neighbourhood Teams (NT) and a paper, outlining the extent of the review would be presented to the private Board meeting in the coming week.

The Deputy Medical Director asked about patient complexity. The Executive Director of Operations stated that the issue was more around patient dependency rather than complexity. There has been an increase in End of Life care, with predominantly non-registered staff providing care. The Executive Director of Nursing and AHPs stated that a piece of work on patient acuity was underway to understand patient complexity; however nothing was obvious at the moment.

The Trust Chair asked if the current positive staffing position would be permanent and if post the Covid-19 pandemic there was an expectation that there would be staff who would take early retirement. The Executive Director of Operations stated that she was hopeful that the current staffing position would be permanent. With regards to retirement, it was noted that there had been higher attendance at the Trust retirement readiness courses and a paper would be presented to the Business Committee on this subject. The Executive Director of Nursing and AHPs commented that there was some excitement around transformation of the NT model.

The Committee Chair commented that it would be helpful to look at some of the positive areas at some point going forward.

d) Schedule of Key Performance Indicators (KPI)

The Executive Director of Nursing and AHPs presented the paper which comprised of the propose amendments to the 2020/21 Key Performance Indicators for 2021/22.

The suggested new KPIs were proposed to be developed and put into the Performance Brief for April 2022.

The Committee recommended that the Board should approve the 2021/22 KPIs.

e) Quality Account first draft

The Executive Director of Nursing and AHPs presented the first draft of the Quality Account and it was noted that confirmation of publication timescales was awaited, given the significant delay in publishing the 2019-20 account as a result of Covid-19.

In response to a query from the Committee Chair, it was confirmed that comments from partners had been incorporated from the previous year's Quality Account.

A Non-Executive Director (AL) asked if there had been the opportunity for co-production on the report e.g. Patient and Staff Voice and Youth Board. The Executive Director of Nursing and AHPs confirmed that this was being considered.

It was agreed that the Covid-19 pandemic needed to be predominant in the report.

It was also agreed that the report would need to include a summary at the beginning covering areas we are proud of, what went exceptionally well and what didn't go so

well.
It was agreed that an updated draft would be presented to the Committee in May 2021, with further iterations to be made in between this time.

Action: Updated draft to be presented to the Committee in May 2021 with further iterations to be made in between this time.

Actionee: Executive Director of Nursing and AHPs

f) Operational plan: draft 21-22 priorities
The Executive Director of Nursing and AHPs presented the report.

It was agreed that the language in the report would be amended to include information about patients and citizens.

g) Quality Improvement Plan
The Executive Director of Nursing and AHPs presented the plan and highlighted the completion of the must do actions with one outstanding, relating to the work required around compliance and audits on the ligature risk assessment policy. It was expected that this would be completed by May 2021. It was also noted that the should do action would be completed by the end of March 2021.

h) Risk Register
The Chief Executive presented the report.

The Executive Director for Nursing and AHPs advised that two further risks were currently being assessed and would be added to the risk register in due course:

- Capacity within the 0-19 Public Health Integrated Nursing Service
- Capacity and demand within Children's Community Feeding Team

The Company Secretary referred to Risk 1002: Coronavirus (COVID 19) Increased spread of infection, and asked the Committee to note that following circulation of this report, the risk score had been reduced from 15 to 12 and was no longer classed as an extreme risk.

The Committee Chair asked about Risk 1028: Overdue actions from patient safety incidents. The Executive Director of Nursing and AHPs stated that this risk had been identified by the Head of Clinical Governance. The backlog was being worked through and was expected to be cleared imminently.

The Trust Chair expressed concern about the number of additional risks in the report and asked if there was a broader issue in the Trust. He also commented that there were some completion dates and risk owner details missing. The Company Secretary replied that target dates were included on the seven new risks. It was noted that the Risk Team was working with services around risk management.

2020-21 (86)

For approval: Clinical Effectiveness

a) **Patient Group Directions**
The Committee received and ratified the Patient Group Directions.

b) **Clinical audit**
The Executive Director of Nursing and AHPs presented the report and stated that there had been some difficulty pulling information from frontline services. It was agreed that the updates would be presented to the Committee meeting in April 2021.

Action: Updates to Clinical audit report to be presented at the Quality Committee meeting on 26 April 2021

Actionee: Executive Director of Nursing and AHPs

c) **Internal audit reports**
The Executive Director of Nursing and AHPs presented the internal audit report on the Patient Experience Team and it was noted that the report gave substantial assurance.

2020-21 (87)

For approval: Patient Experience

a) **Engagement Strategy update report**
The Executive Director of Nursing and AHPs presented the six monthly update from the Patient Experience Team, highlighting that progress had been maintained on implementing the Engagement Strategy operation plan despite difficulties presented throughout the Covid-19 pandemic. It was noted that the team had worked well with partners in the city e.g. Patient voices and Healthwatch.

It was also noted that work around leadership continued with an increase in the number of engagement champions, support and resources offered.

There was a discussion about outcomes and agreement that these should be included in the strategy, including the link to WDES and WRES feedback from staff.

It was also agreed that it would be helpful for the objectives to be linked to the business units or services so that the work could then be reported into the main strategy. There was a suggestion that the information should be reported on a regular basis rather than having a biannual update.

2020-21 (88)

For approval: Committee Governance

a) Committee's annual report including review of terms of reference
The Assistant Director of Nursing and Clinical Governance presented the report and asked for approval of the two changes to the terms of reference. These were approved.

The following additions were also agreed:

- Acknowledgement of the Non-Executive Director's (IL) role as Committee Chair
- Acknowledgement that the Mental Health Act Governance Group (MHAGG) would be closed down in April 2021 due to the handover of the CAMHS inpatient service to Leeds and York Partnership Foundation NHS Trust (LYPFT).
- Inclusion of Health Inequalities in the terms of reference

b) Committee's BAF assurance activity
The report was presented following work from the previous meeting to describe how the Committee had provided levels of assurance against the Board Assurance Framework (BAF) risks assigned.

The Committee heard that a new BAF risk would be presented at the Board meeting in March 2021 around Health Inequalities and the Trust's role in inclusion.

2020-21 (89)

For noting and any questions: Clinical Effectiveness

a) Internal audit annual plan 2021/22
The Company Secretary presented the plan and it was noted that this had been approved by the Audit Committee on 12 March 2021.

2020-21(90)

Sub group minutes

a) Quality Assurance and Improvement Group: minutes 21.01.2021
The Committee received the minutes.

b) Safeguarding Children's and Adult's Group: minutes 18.02.2021
The Committee received the minutes.

c) Mental Health Act Governance Group: minutes 22.01.2021
The Committee received the minutes.

2020-21 (91)

Quality Committee work plan

a) Work plan
The Committee received the up to date work plan.

b) Items from the work plan not on agenda:

i. Board members' service visits – no visits to report
ii. PLACE report – not undertaken 2020/21
iii. Committee's annual report inc. Committee members' declaration – deferred to April 2021

2020-21 (92)

Matters for the Board

Committee's assurance levels and additional comments

The strategic risks identified as relevant to the Committee were discussed, with an overall level of assurance being reasonable, excluding Risk 1.2, with comments to be made against the following items:

- 0-19 Service: Immunisation programme
- CQC Improvement plan: ligature issue
- Podiatry: waiting list
- LMWS: death

2020-21 (93)

Reflections on Committee meeting

The Committee Chair acknowledged the amount of items to be addressed in the time allocated and thanked everyone for their contributions.

2020-21 (94)

Any other business

There was no further business discussed.

Date and time of next meeting

Monday 26 April 2021 9.30am – 11.30am (Via MS Teams)
Boardroom Stockdale House
Stockdale House
Leeds LS6 1PF

Leeds Community Healthcare NHS Trust

Board Meeting held in public : 28 May 2021

Agenda item number: 2021-22 (18C)

Title: Business Committee minutes 24 March 2021

Category of paper: for noting

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 24 March 2021 (9.00 am to 11.00 am)

Present:	Richard Gladman (Chair)	Non-Executive Director (RG)
	Helen Thomson	Non-Executive Director (HT)
	Khalil Rehman	Non-Executive Director (KR)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Laura Smith	Director of Workforce
	Diane Allison	Company Secretary
	Emma Bolton	Associate Director of Estates
Observer:	Harry Doodson	Information Manager (BI Team)
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to the Exec Director of Finance & Resources

Item 2020/21 (76): Welcome and introductions

Discussion points:

a) Apology: Please see above

b) Declarations of interest
Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda to ensure there was no known conflict of interest prior to papers being distributed to Committee members. No additional potential conflicts of interest regarding the meeting's agenda were raised.

c) Minutes of meeting dated 24 February 2021
The minutes of meeting dated 24 February 2021 were noted for accuracy and approved by the Committee.

d) Matters arising and review of action log
The Committee reviewed the action log and noted updates.

Item 63b – Trust risk register: impact of pension enquiries
The Director of Workforce (LS) reported that the number of pension enquiries had been reasonably stable and there were no concerns at present based on the information reviewed but this would be continued to be monitored. An email had also been circulated to the members of the Committee providing additional information.

Item 2020/21 (77): e-Rostering

Discussion point:
The Committee received a presentation on the current position of the project. The e-Rostering project, which commenced in April 2018, had been a well-managed and successful project to date; meeting its target with its robust rollout until the beginning of the pandemic in March 2020. The project team experienced some disruption to its implementation phase as a consequence of this and the associated business continuity plans within the Trust.

During the period of disruption the e-Rostering project team continued to work on e-Rostering benefits realisation and in support of the Covid-19 response, focusing for example on delivering workforce capacity and availability data for command decision making, and on supporting the rostering approach for the Leeds Covid-19 vaccination programme.

The March 2021 nationally set deadline for all Trusts to attain level 1 had not been met. The Covid-19 disruption had led to a revised expected attainment date of September 2021, a six months delay for implementation and rollout across all of clinical services for achieving key project milestone, which was a similar position for many other NHS organisations.

The Director of Workforce (LS) said that the valuable e-Rostering tool enabled a better oversight of a whole range of workforce information including the actual e-Rostering of staff, sickness, annual leave, capacity and demand, etc.

The Director of Workforce (LS) said she was conscious and concerned about possible further surges of Covid-19 infection impacting on services in a similar way but she was confident that when members of the project team returned from their redeployed roles in April 2021 they would continue working with those remaining services and the Trust should be able to reach attainment level 1 by September 2021.

The Committee was keen to find out about the next steps after attainment of level 1. The Director of Workforce (LS) said that the work being completed in attainment 1 about better use of data for capacity and demand was also included in attainment level 2. She was happy to provide the Committee details about the future attainment levels and opportunities including a business case to secure resources beyond end of September 2021.

The Executive Director of Operations said that she had begun to see the benefits of the project and it was proving useful for staff during the pandemic and that it continued to build on the benefits of further rollout.

The Executive Director of Operations reflected on several other work streams. These included: virtual consultations, backlogs and waiting lists, self-management, internal integration, reset of admin review, adapting call centres and offices, safe working environments and staff wellbeing. She said there was notable progress made in the first three months of the pandemic which otherwise may have taken up to two years.

The Committee Chair thanked the Director of Workforce (LS) for the update and appreciated the work of the project team supporting the vaccination centres and using e-Rostering techniques. He was looking forward to seeing the achievement of the revised target of September 2021 for attainment level 1 and seeing a business case for subsequent phases.

Outcome:
The Business Committee noted the good progress made by the e-Rostering programme overall, the revised attainment date of the project milestone, and the continued focus on delivering e-Rostering benefits throughout the period.

Item 2020/21 (78): Covid and Reset and Recovery

Discussion points:

a) Covid update

The Committee received an update on the infection rate in the city, currently at 4.2%. The rate was just under 100 per one hundred thousand and the over 60's rate had significantly reduced. The Committee was advised that there were fifty people in hospital and six people in critical care. In terms of the vaccination programme, 325k people had been vaccinated in Leeds which equated to 44% of the population.

Outcome:

The Committee received an update on the local situation including current infection rates, the number of patients in hospital with this disease, and the latest information on the vaccination programme. A similar update was to be provided to the Board at its next meeting.

b) Reset and Recovery cross-cutting work streams

The Executive Director of Operations provided the Committee with a high level view of the cross-cutting work streams within the Reset and Recovery Programme.

The Executive Director of Operations said that she was still concerned about the Dental service, although some progress had been made. She was confident that those patients needing to be seen had been seen and other routine work was continuing.

Detailed discussions had taken place at the Quality Committee on 22 March 2021 regarding the Podiatry Service. There were still large numbers of people on the waiting list generally at low risk. There were some concerns on the paediatric waiting lists as reported in the Performance Brief. The Executive Director of Operations said that there were still some families who were very cautious about bringing their child to an out-patient setting.

The Committee was advised that a significant number of cases in the Child and Adolescent Mental Health Service (CAMHS) had been outsourced at the end of last year. The Executive Director of Operations said that double the numbers of referrals were now coming through for people requiring a paediatric neuro-disability assessment as new referrals.

The Committee discussed the commissioning issues around increased demand in the CAMHS Service and requested information about any known hotspot areas to be provided at the April 2021 meeting.

The Committee Chair referred to the dashboard which had been helpful in some services in terms of the backlog and he asked whether that was being maintained. It was noted that this was reviewed on a regular basis in the organisation to manage the waiting lists. The Executive Director of Operations said that the dashboard was less relevance to this service but she was happy to circulate the mechanism that was being used to address the backlog and waiting list and where the pressure points were.

A Non-Executive Director (KR) stated it was important to see a demonstration of relationship between capacity and demand for services and to assure the Board that the Trust was serving its population. He said it would be helpful to continue to have transparency of areas of concern and to facilitate the necessary conversations and decisions.

The Executive Director of Operations said that the next stage was to agree new income streams with the Commissioners to reflect the significant referral increases for some services, however if that was unsuccessful, there would need to be a discussion at the Board about how the service was provided. She said that there had been significant and successful efforts this year to reduce backlogs and achieve a stable position.

The Committee agreed that the approach being taken to bring the various cross-cutting work streams together was a sensible one in terms of overall management and stability and asked whether this was part of the reset and recovery work. The Executive Director of Operations said that during the pandemic the business unit support managers and corporate teams came together to work as one and that had worked well. This was one of the recommendations to continue as a business change development service led by the Programme Lead for Reset and Recovery after the pandemic.

The Committee discussed the overall transformation post-Covid and relationship with the other strategy work e.g. Workforce, Digital, Estates. The Chief Executive said that all the work streams interacted and connected with all those different strategies. There was learning during the pandemic of better ways of organising and doing things, embedding it and facilitating it better. The Executive Director of Operations added that the different strategies were directing and influencing ways of resetting and recovering all the services and making sure it worked in sync across the organisation.

The Committee Chair thanked the Executive Director of Operations for the significant efforts of staff and leaders in reducing backlogs and handling large increases in referrals for some services, particularly around children. He noted the cross-cutting work streams and highlighted the challenges and opportunities around significant transformational work across all services. Further consideration was needed of the best way to deliver and report on this significant cross service transformation programme. He said he would like to continue with further discussions at the next meeting in April 2021 on some of those highlighted issues and concerns with waiting lists, particularly services who were experiencing large increases in demand or operational constraints.

Action:
Executive Director of Operations to circulate the mechanism that is being used to address the CAMHS backlog and waiting list and where the pressure points were.

c) Electronic Patient Record: Leeds Sexual Health system replacement
The Committee received an options appraisal to replace the existing IT system. The current contract for the current system which did not meet service requirements was due to expire in July 2021 and no longer fit for purpose. The Executive Director of Operations said that SystmOne met all the functionality requirements and was asking Committee's approval to move to the next stage of the process.

It was noted that the Business Committee gave its approval in November 2019 for the service to explore the possibility of migrating to SystmOne. After consulting with the service and visits so clinicians seeing SystmOne in action it was agreed that SystmOne was the preferred option.

The other work going on behind the scenes was reconfiguration of SystmOne to support standardised processes; looking at 'Did Not Attends' and cancellations from a productivity point of view, patient contacts and addressing the backlog so not disadvantaging anyone in the community.

Outcome:
The Committee approved the recommendation to implement SystmOne as the preferred

electronic patient record (EPR) system within that service.

Item 2020/21 (79): Finance

Discussion points:

a. Revenue and Capital Budgets 2021/22
The Committee reviewed the revenue expenditure budget and the capital budget. It recognised the considerable uncertainties currently surrounding the NHS financial regime for the revenue budget, particularly around contract income values and explored the risks to the Trust and to the wider Integrated Care System. The Executive Director of Finance and Resources said that the capital budget proposal for estates was based on the assessment of backlog maintenance.

Revenue budgets
The Executive Director of Finance and Resources said that normally at this time of the year the Committee would be in a position to recommend to the Trust Board the approval of revenue budgets; knowing the financial regime for the year, the forecast income, the expenditure plans and a cost improvement programme plan. The paper to the next Trust Board meeting on 26 March 2021 was to approve the expenditure budgets only.

The Executive Director of Finance and Resources said that the principal risk arises from the uncertainty of funding for developments commissioned by NHS Leeds Clinical Commissioning Group.

The Committee reviewed and discussed the revenue budget calculations outlined in the paper. The report described the national, integrated care systems and Trust approach to the allocation distribution and setting of Leeds Community Healthcare's revenue and capital budgets for 2021/22.

The Executive Director of Finance and Resources said that given the considerable uncertainty of the NHS financial regime for 2021/22 the budgets recommended for approval in the report would require adjustment as the year progresses.

b. Backlog maintenance and estates capital programme
The Committee Chair welcomed the Associated Director of Estates to the meeting to present this item.

The key point to note was that the 2019 NHS ERIC return reported £3m worth of backlog maintenance, which included £740k critical infrastructure risk. The Executive Director of Finance and Resources said that the high and significant level of backlog maintenance in the current financial year had been addressed through the capital programme. There were now no items which were considered high risk in the estate which required immediate rectification.

In line with good estate management practice, the six facet surveys had recently been renewed across the estate. The surveys have reported that there was no current critical backlog maintenance requirement but identified £1.18m for a five year maintenance plan for the Trust. The Associate Director of Estates said that subject to capital availability all items of backlog within 2021/22 that had been identified through the survey would be addressed.

The Associated Director of Estates said that in addition to the 6 facet surveys commission, fire surveys across the estate were being undertaken to establish compartmentation and identification of hazard rooms. These were now being reviewed by a specialist company against existing compartmentation to produce costed plans.

Capital budgets
Following the spending review, the NHS provider capital allocation for 2021/22 had been set and allocated across the NHS on basis of an indicative allocation to Leeds Community Healthcare NHS Trust of £4.4m. The Executive Director of Finance and Resources said that a realistic assessment of need for the Trust in 2021/22 was £3.7m. He proposed an allocation of that resource across estates, IT and clinical equipment.

Outcome:
The Committee discussed and analysed the budget proposals in detail and agreed to recommend a revenue expenditure budget of £179.8m and a capital budget of £3.7m allocated across the areas proposed by the Executive Director of Finance and Resources for Board's approval.

Item 2020/21 (80): Strategy update

Discussion point:

Workforce strategy update
The Committee received an update on the current workforce strategy and the plans for its replacement. The Director of Workforce (LS) said that this was being presented to the Committee prior to being received at Trust Board to offer an additional opportunity for scrutiny and discussion.

The workforce strategy provided narrative update in the body of the paper on its six priorities during 2019 to 2021 with additional detailed objectives in the appendix. The paper also asked for the Trust Board to consider and approve the plan for designing and developing the replacement workforce strategy and approval for an extension until autumn for final approval by the Trust Board in October 2021.

The Committee confirmed that it was content with the proposal to delay the introduction of the new strategy by six months, although it expressed its concern that this may not be enough time to thoroughly engage with the workforce and to produce a strategy that was sufficiently ambitious.

A Non-Executive Director (KR) said that it was key to integrate all different narratives that were being presented, for example, inequalities, Integrated Care System, various funding, etc. The Chief Executive responded to say that the vision of the Trust which was to provide the best possible care to every community it serves and to provide outstanding place for workforce to work, recognised the importance of the workforce in the delivery of care.

The Director of Workforce (LS) thanked the Committee for its feedback and said the workforce strategy was ambitious, focussed, having a line of sight around capacity and demand model that fits as well as resource planning.

Action:
An update on the refreshed workforce strategy is to be given to the Committee for further discussion on progress in June 2021.

Outcome:
The Committee received an update on the current workforce strategy and the plans for its replacement.

Item 2020/21 (81): Approval

Discussion point:

Telephony upgrade – contract approval
The Committee received a verbal account of the Trust's desire to upgrade its telephony system, and an outline of the benefits that could be realised. Similar information was also being provided to the Trust Board.

The Executive Director of Finance and Resources said the contract with Virgin Media was to replace Trust's telephony infrastructure. The value of the contract was circa £802k excluding VAT over a five year period.

The Executive Director of Finance and Resources outlined the benefits of the proposed contract in terms of communication technology for the 'call centre' teams to operate far better, with more flexibility and the ability for staff to work from wherever they wished with the same extension number and he said that this would justify an increase in cost.

Outcome:
A business case was being drafted and the Committee agreed that approval should be sought via the Chief Executive and Chair's action procedure.

Item 2020/21 (82): Performance management

Discussion points:

a) Performance brief and domain reports
The Executive Director of Finance and Resources introduced the Performance Brief and Domain reports for month eleven. He said there were no issues or concerns to highlight as most of the updates were part of earlier discussion in the meeting.

The key highlight to note was sickness levels and turnover remained low. Statutory and mandatory training rates were becoming a concern and there was a commitment to focus attention on this in the coming months.

FINANCE
In terms of finance, the Committee was comfortable that at month eleven, the Trust was meeting its financial obligations. The Committee noted that some of the key performance indicators for services with financial sanctions indicated a poor position however there was assurance that penalties had been suspended in most areas.

b) Quality, staffing and finance triangulation report
The report provided an update in quarter three period covering ongoing impact in the neighbourhood teams as a result of COVID-19 pandemic.

There had been positive increases in contracted and utilised capacity during this quarter. The referrals had now returned to normal levels and also seen a continuation in the increased level of demand for End of Life care against the previous year and community based support to avoid hospital admission with the embedding of the citywide model for the Virtual Ward (Frailty) as part of the Neighbourhood Team offer.

The Executive Director of Operations said that during the latter part of the quarter, the Adult Business Unit was in an escalated position with a range of citywide actions to address areas of concern and maintained safe care and system flow.

It was noted that a paper on a comprehensive review of the service and processes and the experience of the team during the pandemic was being considered in the private section of the Trust Board meeting on 26 March 2021.

Outcome: The Committee received the report and noted the issues outlined.

c) Strategy framework (priorities 2021/22)

The Committee reviewed the proposed draft 2021/22 strategic framework priorities and agreed that they were appropriate.

The 2021/22 priorities were also presented to the Quality Committee meeting on 22 March 2021 and would be presented to the Trust Board. The Executive Director of Finance and Resources said that this was a good reflection of the organisation and may need to be refined against the national guidance that was being issued on 25 March 2021.

d) Operational and non-clinical risks register

The Committee received the summary report for consideration showing changes to note to non-clinical risks on the Trust risk register.

It was noted that the risk relating to COVID 19 increased spread of infection in the community had been deescalated from an extreme risk, reduced to 12 from 15.

Outcome:
The Committee noted the new risks, controls and proposed mitigation.

Item 2020/21 (83): Governance

Discussion points:

a) Business Committee annual report

The Company Secretary introduced the Business Committee's annual report. The report would be presented for approval at the Audit Committee meeting on 16 April 2021 and described how the Business Committee was carrying out its activities in line with its terms of reference.

The Committee considered and agreed the proposed changes to the terms of reference prior to submission to the Audit Committee approval.

The Committee noted the following proposed changes to the terms of reference.

- The Committee will provide assurance to the Trust Board on all Board Assurance Framework strategic risks that have been assigned to it and reported to the Board in the Chair's assurance report using standard classification.
- Amended to include a reference to the Procedure for emergency powers and urgent decisions.
- List of subgroups to include the Digital Strategy Implementation Group.

The Committee Chair felt that more time should be allocated to discussions in future meetings on areas of the Committee's duties that needed more focus. He proposed to do this from next month in April 2021.

Outcome:
The Committee reviewed and agreed its annual effectiveness report and agreed some minor changes in its terms of reference.

b) Health and Safety Group minutes to note, dated 18 February 2021

The Committee received the minutes for noting. The Executive Director of Finance and Resources said that the Health and Safety Group continued to move in the right direction and in the new financial year the group planned to have more frequent meetings, which would allow it to focus on some areas of its remit in more depth.

Item: 2020/21 (84): Matters for the Board and other Committees

Discussion point:

The Committee reviewed and discussed the levels of assurance for the strategic risks related to the agenda items.

The following agenda items would be included in the Chair's assurance report to the Board:

- E-Rostering
- Covid update and reset and recovery
- Telephony contract
- Leeds Sexual Health system replacement
- Capital and Revenue Budgets and backlog maintenance
- Finance position
- Workforce Strategy
- Performance brief and domain report
- Strategic framework (priorities 2021/22)
- Business Committee's annual report and review of terms of reference

Item 2020/21 (85): Business Committee work plan

Discussion point:

Future work plan

The Committee reviewed the work plan and noted the items deferred.

Item 2020/21 (86): Any other business

None discussed.

Minutes of the

West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)

held Thursday 22 April 2021, 10.00 – 12.30pm

Virtually by Microsoft Teams

Present:

Cathy Elliott (Chair) (CE) – Chair, Bradford District Care NHS Foundation Trust
Chris Jones (CJ)- Deputy Chair & Senior Independent Director, South West Yorkshire Partnership NHS Foundation Trust
Keir Shillaker (KS)- Programme Director, West Yorkshire and Harrogate Health and Care Partnership
Sara Munro (SM) – Chief Executive Officer, Leeds & York Partnership NHS Foundation Trust
Sean Rayner (SR)- Director of Provider Development, South West Yorkshire Partnership NHS Foundation Trust
Sue Proctor (SP) - Chair, Leeds & York Partnership NHS Foundation Trust
Thea Stein (TS) – Chief Executive Officer, Leeds Community Healthcare NHS Trust
Therese Patten (TP) - Chief Executive Officer, Bradford District Care NHS Foundation Trust

In attendance:

Andy Weir (AW) – Deputy Chief Operating Officer, Leeds & York Partnership NHS Foundation Trust and Senior Reporting Officer, West Yorkshire and Harrogate Health and Care Partnership
Anita Brewin (AB)-Consultant Clinical Psychologist, Bradford District Care NHS Foundation Trust and Clinical Lead, West Yorkshire and Harrogate Health and Care Partnership
Jo Butterfield (JB)- Programme Manager, West Yorkshire and Harrogate Health and Care Partnership
Lucy Rushworth (minutes) (LR) – Project Support Officer, West Yorkshire and Harrogate Health and Care Partnership
Patrick Scott (PS)-Chief Operating Officer and Deputy Chief Executive, Bradford District Care NHS Foundation Trust and Senior Reporting Officer, West Yorkshire and Harrogate Health and Care Partnership
Tom Jackson (TJ)- Senior Reporting Officer, West Yorkshire and Harrogate Health and Care Partnership

Apologies:

Angela Monaghan (AM) – Chair, South West Yorkshire Partnership NHS Foundation Trust
Rob Webster (RW) – Chief Executive Officer, South West Yorkshire Partnership NHS Foundation Trust

Glossary of acronyms in this document can be found on page 5.

Item	Discussion / Actions	By whom
1	**Introductions:** Cathy Elliott (CE) welcomed the group, the apologies and deputies are noted as; Apologies: Angela Monaghan- Chris Jones (CJ) deputised Rob Webster – Sean Rayner (SR) deputised CE Shared that the provider collaborative will be possibly featured as a case study in the NHS Providers national report to profile best practice in provider collaboratives, and a final draft version of the report will be circulated to the Committees in Common (CinC) when available. CE highlighted that Sara Munro (SM) has been appointed a Trustee and Non-Executive Director for the Workforce Development Trust and attendees congratulated her on the appointment. **ACTION** Lucy Rushworth (LR) to circulate the final draft version of the provider collaborative case study or report when shared by NHS Providers, ideally with the post CinC meeting papers. **ACTION 1/04**	**LR**
2	**Declaration of Interests Matrix / Conflict of Interest:** There were no conflicts of interest, or changes to the declaration of interest matrix.	
3a	**Review of Previous Minutes:**	

Item	Discussion / Actions	By whom
	The minutes from the 21st January 2021 were reviewed by the meeting group and were accepted as an accurate record.	
3b	**Actions log and matters arising:** There were no matters arising. The action log was updated with the below: **1/01, Reviewing the Memorandum of Understanding (MoU)** – the meeting between Keir Shillaker (KS) and Paul Hogg has taken place completing this action. **2/01, Reviewing the Memorandum of Understanding (MoU)** – There has been limited capacity to support website presence for stakeholder updates due to current focus on wellbeing hub and suicide prevention micro-sites, however this is in future communication plans. **9/01, ATU** – This action is now complete as covered in today's agenda. **10/01, PMVA**-The Prevention and Management of Violence and Aggression (PMVA) workshop is due to take place 22/04/2021, the meeting group were made aware that the Academic Health Science Network (AHSN) have been asked nationally to prioritise reducing restricted practice, KS has held discussions already held regarding how they can support identification and flow of metrics. and an update on progress with the PMVA project will be provided at the July 2021 CinC meeting. Alert/Advice/Assure (AAA) board reporting was confirmed to be working well for the CinC members and their respective trust Boards.	
4	**Chair's update: ICS Reference Group** A document was circulated in advance outlining the Terms of Reference for the Integrated Care Service (ICS) Reference Group which is made up of some NHS Chairs and leaders of councils on the ICS Partnership Board. The Group will act as an advisory group to the ICS team on the set up of the ICS Statutory Board in line with the Government's White Paper on integrated care. CE and Brodie Clark (BC) are part of this Group and will be linking work between the CinC and into the Reference Group, with CE particularly reflecting the role of the provider collaborative, having been nominated by the NHS Chairs on the CinC. It was suggested for the Strategic meeting session in May this year that there could be a check in on the developments of the ICS to reduce repeated information as well as informal updates to NHS Chairs on CinC. **AGREED** The CinC agreed that CE will check in with CinC NHS Chair members each month for any items to raise at the ICS Reference Group monthly meetings, with updates to be received back in turn at quarterly CinC meetings, as relevant.	
	Governance	
5	**Memorandum of Understanding (MoU)** The MoU was revised collaboratively by Trusts and was reviewed at the January 2021 CinC meeting before going to the respective Trust Boards for approval. NHS Trust Chairs confirmed that their respective Boards have approved the MoU.	

Item	Discussion / Actions	By whom
	AGREED The CinC have formally agreed to use the MoU going forward. *Thea Stein (TS) entered the meeting at this point.*	
	Problem Solving	
6	**Learning Disability (LD) Challenge – speaking as one voice** The LD Health inequalities challenge has been agreed by System Leadership Executive (SLE), including a workplan which links funding to awareness training for staff, improved data and metrics, raising the profile of people with LD on waiting lists to help Acute Trusts intelligence and working with Local Authorities (LA) to improve employment status & housing availability. Two Non-Executive Directors are helping to raise the profile with this needing to be high on everyone's agenda. There was a discussion between CinC members, including the following points: • the requirement of change to be more significant at the local level with a focus on small things to make the biggest impact. • potentially the ICS being the monitor of the work and helping to share learning for places doing well on this challenge. • a common approach and minimum standards for Health Checks across providers in the ICS. • Need to start in our own trusts and service provision to improve our offers and demonstrate good practice to other providers and ICS partners to in turn influence their practice. • Use of compelling cases when reporting and informing at all levels in the ICS could be a way of maintaining the level of engagement into this work. Going forward, in relation to the metrics required for this work, there are measures available that could be reported at an ICS level, including physical health checks and COVID19 vaccination rates. Over the next 12 months there will be added measures to grow the suite of metrics to potentially have a well sourced ICS level dashboard. It is acknowledged that the LD workforce is under subscribed, particularly for nurses, and this item has been set as a priority strategy within the programme. The LD steering group will continue and be a source of best practice and learning. **ACTIONS** Mairead O'Donnell and K Shillaker to develop a communication plan to support the compelling case for change regarding the Learning Disability Challenge. **ACTION 2/04** Mairead O'Donnell to ensure an exchange of practice and metrics as local providers to benchmark service provision. **ACTION 3/04**	**MO & KS** **MO**
	Assurance	
7	**Focus on: Assessment and Treatment Unit (ATU) transformation plan** The following people joined the meeting for this item: Jo Butterfield (JB), Tom Jackson (TJ), Patrick Scott (PS) and Andy Weir (AW). AW gave an overview of the ATU transformation plan to date.	

Item	Discussion / Actions	By whom
	It was relayed to the CinC that work on the ATU transformation plan had spanned over 3 years, challenged by the pandemic and due to a need to bring all commissioners and providers together, as a first attempt at collective, collaborative, commissioning. The lead provider collaborative framework has proven useful to support this work. There are some areas to develop such as workforce skills mix, consistency in delivery as we begin to work as one unit and year 2 financial flows, but these will not impact on our ability to start the implementation. The ATU working group is committed to move forward and will continue to measure and monitor to ensure working together. It was noted that BDCFT is the lead provider. To summarise the work to date: • Year 1 funding has been agreed, and due to the changes in commissioning year will be worked on and agreed between now and quarter 2 which has the support from Directors of Finance. • Support gained by the Joint Health Overview and Scrutiny Committee • Formal sign off from the Joint Committee of CCGs has been agreed There were questions and comments raised which included occupancy numbers post COVID19, with confidence that the model works within the beds set, and the additional contingency, and this will continue to be monitored. Standardising inpatient areas and working towards a shared culture will highlight inequity in community services which may need further support from the CinC. The working group confirmed they are keeping sight of the aim which is for the ATU system to be the centre of excellence. The CinC thanked all members of the ATU workstream for their work and persistence. **AGREED** The CinC approved the implementation of the ATU reconfiguration. **ACTION** K Shillaker and P Scott to meet and discuss future reporting arrangements into the CinC. **ACTION 4/04**	**KS & PS**
8	**Focus on: Mental Health (MH) & Wellbeing Hub** The following people joined the meeting for this item: Jo Butterfield (JB) and Anita Brewin (AB) to give a presentation of the MH & Wellbeing Hub. They stated that West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) received funding from NHSE in December 2020 with the expectation to mobilise a wellbeing hub immediately, and further funding will be received throughout 21/22. There is an expectation of quick access for mental health assessment & appropriate support to any staff member, along with creating a wellbeing offer for staff disproportionately impacted by Covid19. The service model was relayed back to the CinC and aims to support all organisations, including Health, social care and Voluntary, Community and Social Enterprise (VCSE) across West Yorkshire and Harrogate (WY&H). The hub was launched on the 6th April 2021 which sees training, coaching, therapy offers and upcoming peer support networks being delivered as part of the delivery plan, along with in house provisions, a website 'microsite' which is available across the partnership and also the utilisation of Schwartz Rounds. The Hub evaluation plan and next steps were also shared. There was a question regarding gaining the maximum exposure for the service and the team	

Item	Discussion / Actions	By whom
	confirmed there are clear plans in place to communicate with people and promote the service, this will include face to face, resource packs, sharing information with managers and building competency on workforce to look out for one and other. Embedding the service for the long term effect was also raised; the funding is currently non recurrent, however the Hub's main aim is to help those impacted by the pandemic – a more robust local psychological offer is required to help with the population and staff need. Peer support was also raised as a key support line for staff and to not underestimate the power of this form of contact, The CinC thanked the team for the quick mobilisation and level of engagement.	
9	**Programme Update** <u>Autism</u> There is systemwide work happening on autism. The pandemic has not allowed full focus, however work has still continued with better understanding using barriers to access, good practice, health and employment. TP shared that BDCFT have a focus week for autism which produced some good learning that can be shared. <u>Children and Young People</u> There are significant pressures existing nationally and regionally particularly for tier 4 inpatient services, with regular meetings to try to manage risks. <u>Governance and Future working</u> The future 'mechanics' of how the programme works is being discussed in line with the Government's White Paper. The work seeks to balance place-based discussions about infrastructure with what is needed across the system and includes VCSE partners as well as statutory services. It was shared that doing this work is challenging given the uncertainty around the ICS, however the aim is to continue to add value at both system and Place. The CinC thanked the thoroughness of the paper which is well balanced. TP added that a Transforming Care Pathway (TCP) funding bid was not sighted in Bradford until very late on, and KS will raise this information back to the TCP Programme. SR shared that a SWYFT Perinatal Mental Health Service (PMHS) peer support worker shared her story at their Trust Board which helped bring the service to life, and the PMHS is also featured in the Programme as a focus point. **ACTION** K Shillaker to raise the TCP late funding information to Bradford with the Transforming Care Programme. **ACTION 5/04**	**KS**
	Horizon Scanning	
10	**Strategic meeting on 17th May 2021** • Future demand modelling • Capital The meeting is an opportunity to discuss demand modelling at each place and comparing capital strategy, and the Directors of Finance (DoF's) will be invited to present at the strategic meeting.	

Item	Discussion / Actions	By whom
	SM would like to share the future provider collaboratives and national guidance at this meeting also.	
	Agreement of Outputs	
11	**The following will be reported at the Boards:** May: • Advise: The LD Health inequalities challenge. • Advise: MHLDA Core Team Structure – Private Board. • Assure: ATU Reconfiguration. • Assure: CE to continue as the Chair of the CinC – as referenced below • Assure: MH Wellbeing Hub mobilised • Assure: Wider programme progress update	
12	**Any Other Business** The rotation of the Chair for the CinC is usually every 12 months, though due to the White Paper implementation and the future of the ICS structure the CinC have agreed for CE to continue as Chair of the CinC until January 2022, linking also with the ICS Reference Group. **AGREED** The CinC Chairs have confirmed for CE to continue as Chair of the CinC until January 2022	
	Date and Time of Next Meeting: 22nd October 2021 10am-12.30pm	

Item	Discussion / Actions	By whom

Glossary

ATU	Assessment and Treatment Unit
BDCFT	Bradford District Care Foundation Trust
CQC	Care Quality Commission
CAMHS	Child and Adolescent Mental Health Services
C-In-C	Committees in Common
CCG	Clinical Commissioning Group
DTOC	Delayed Transfers of Care
ICS	Integrated Care System
LD	Learning Disabilities
LCH	Leeds Community Healthcare NHS Trust
LYPFT	Leeds and York Partnership NHS Foundation Trust
MHLDA	Mental Health, Learning Disabilities and Autism
MoU	Memorandum of Understanding
NCM	New Care Model
NED	Non-Executive Director
NHSE/I	National Health Service England / Improvement
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
TCP	Transforming Care Programme
VCH	Voluntary and Community Sector
WY&H	West Yorkshire & Harrogate
WY&H HCP	West Yorkshire & Harrogate Health and Care Partnership
WY&H ICS	West Yorkshire & Harrogate Integrated Care System (internal reference to WY&H HCP)
WYMHSC C-In-C	West Yorkshire Mental Health Services Collaborative Committees in Common

West Yorkshire and Harrogate
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

Escalation and Assurance Report

Report from: West Yorkshire & Harrogate (WY&H) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common
Date of the meeting: 22/04/2021

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert/Action:

- No items to alert/for action

Advise:

- The Learning Disability Health Inequalities challenge has been agreed by WY&H ICS Leadership Executive, highlighting collective ambition and a workplan to:
    - Raise awareness in frontline staff of learning disability and spotting signs of deterioration in health
    - Improve understanding of housing options, support discharge and increase employment
    - Use people with a learning disability to 'quality check' the services provided in each place
    - Report consistent, clear metrics at a WY&H ICS level
    - Support acute trusts to understand where people with a learning disability are on waiting lists and to prioritise by individual need where possible

Agreement to work in future as a provider collaborative and CinC partners on benchmarking, developing metrics and influencing other providers on the improvement of learning disability services.

- Discussions are on ongoing between the CinC provider collaborative and the ICS' leadership on future financial funding flows and how these will support a stable MHLDA programme team structure.

Assure:

- The transformation work around Assessment & Treatment Units (ATUs) was approved to move to implementation phase, following support from the Joint Health Overview & Scrutiny Committee regarding the engagement undertaken, the Joint Committee of CCGs regarding the commissioning model and CinC support for the clinical and operational models.
- Support of CinC for Cathy Elliott to remain as chair of the CinC during the ICS' transition period (serving during July 2020 to January 2022), resulting from the Government White Paper regarding the future of Integrated Care systems. (CinC Chair role usually rotates on a 12 – 15 month basis).
- CinC noted that the WY&H Mental Wellbeing Hub has mobilised and is now receiving referrals for staff across the system who have need specialist psychological support. The hub also supports the wider wellbeing agenda, curation of good practice, training for managers and provision of self-help material via a website.
- The MHLDA programme continues to progress all workstreams with particular updates provided on:
    - Autism – better understanding barriers to access and good practice.

- Children & Young People – the work of the CYPMH partnership board and developments regarding the new inpatient unit at Red Kite View.
- Future ‘mechanics’ of the programme to ensure service user, staff and public voice is at the heart of a formal ICS infrastructure for MHLDA in WY&H.

Report completed by: WY&H MHLDA Programme Director **Date:** 27/04/21

Distribution: Chairs and Company Secretaries of Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds & York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust.

Leeds Community Healthcare NHS Trust

Agenda item 2021-22 (19)

Version 1: 20 05 2021

Topic	Frequency	Lead officer	2 October 2020	4 December 2020	5 February 2021	26 March 2021	28 May 2021	11 June 2021 end of year	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-Covid rehab	X	X		X	X	X
Quality and delivery											
Chief Executive's report	every meeting	CE	X	X Inc COVID19	X Inc COVID19	X Inc COVID19	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 defer June	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 Defer June	X			
Health equity strategy	3 x year (December,March, (May 2021) August)	EMD		X First report		X taken at Board workshop 5 March 2021	X				X
Mortality report	4 x Year	EMD		X	X		X plus annual report 2020-21		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									
Serious incidents report	2 x year (Feb and August)	EDN&AHPS		X	X				X		
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						
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 Quarterly report x Annual report 2020-21 (Deferred June 2021)	X Quarterly report and annual report 2020-21	X Quarterly report		X
Strategy and planning											
Organisational priorities position paper	3 x year	EDFR	X			X 2021-22	x End of year report Defer June	X End of year		X	
Third Sector Strategy	2x year		X First report		X Deferred		X			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 Defer August			X		
Workforce Strategy	2x year	DW	X	X part of CE report	X part of CE report	X				X New strategy for approval	
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 Defer June	X			
Annual accounts	annual	EDFR					X Defer June	X			
Letter of representation (ISA 260)	annual	EDFR					X Defer June	X			
Audit opinion	annual	EDFR					X Defer June	X			
Audit Committee annual report (part of corporate governance report)	annual	CS					X				
Standing orders/standing financial instructions review (part of corporate governance report)	annual	CS							X		
Annual governance statement (part of corporate governance report)	annual	CS					X Defer June	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