Bundle Public Board Meeting 6 August 2021

Agenda

Final Agenda Public_Board_Meeting_6_August_2021- blue box.docx

33 09:00 - Welcome, introductions and apologies: (Brodie Clark)

34 Declarations of interest: (Brodie Clark)

35 09:10 - Questions from members of the public: (Brodie Clark)

****Minutes adoption for approval****

36 Minutes of previous meeting and matters arising: ((Brodie Clark)

For approval

36.a Minutes of the meetings held on 28 May 2021

Item 36a Draft Public Board minutes 28 May 2021.docx

36.b Minutes of the meeting held on 11 June 2021

Item 36b Draft Public Board minutes 11 June 2021.docx

36.c Actions' log: 28 May 2021 and 11 June 2021

Item 36c Public Board 6 August 2021 actions' log.doc

37 09:15 - Patient's story: CAMHS: (Steph Lawrence)

38 09:30 - Chief Executive's report: including Covid-19 update: (Thea Stein)

Item 38 CEO Report - August 2021 V2.docx

39 09:45 - Committee Chairs' Assurance Reports:

39.a Charitable Funds Committee: 25 June 2021

Item 39a Charitable funds Committee Chair Assurance Report June 2021.docx

39.b Audit Committee: 23 July 2021: (Khalil Rehman)

Item 39b Audit Committee Chairs assurance report 23 07 2021.docx

39.c Quality Committee: 21 June 2021 26 July 2021: (Helen Thomson)

Item 39ci Quality Committee Chairs assurance report June 2021.docx

Item 39cii Quality Committee Chairs assurance report July 2021 V2.docx

39.d Business Committee: 23 June 2021 and 28 July 2021: (Richard Gladman)

Item 39di Business Committee Chairs assurance report June 2021.docx

Item 39dii Business Committee Chairs assurance report July 2021.docx

39.e Nominations and Remuneration Committee: 2 July 2021

Item 39e Nom and Rem Committee July 2021 - Chairs assurance report.docx

40 10:00 - Performance Brief: June 2021: (Bryan Machin)

Item 40i Performance Brief Cover Paper (Board) bm August 2021.docx

Item 40ii Performance Brief (Jun 2021) TrustBoard.docx

41 10:10 - Significant Risks and Board Assurance Framework (BAF) Summary Report: (Thea Stein)

Item 41 Significant risks and risk assurance report Aug 2021 v2.docx

42 10:15 - Freedom to Speak Up Guardian Annual Report 2020-21: (John Walsh presenting)

Item 42 FTSUG annual report 2020-21.docx

43 10:25 - Guardian of Safe Working Hours Quarter 1 2021-22: (Dr Nagashree Nallapeta presenting)

Item 43 GoSWH Quaterly report August 2021.docx

44 10:35 - Nursing and Allied Health Professionals re-validation and registration: (Steph Lawrence)

Item 44 Professional registration Trust Board August 2021 (2).docx

45 10:40 - Workforce Strategy (Jenny Allen/Laura Smith)

Item 45i Workforce strategy cover paper.docx

Item 45ii 20210728_Draft Workforce Strategy 2021 25 V0.4.docx

46 10:55 - Health Equity Strategy (Update) (Ruth Burnett)

Item 46 Health Equity Strategy update July 2021.docx

47 11:05 - Research and Development Strategy (Ruth Burnett)

Item 47i R&D Strategy Update Jul 21.docx

Item 47ii R&D Strategy Milestones Jul21 update.pdf

48 11:10 - Medical Director's Annual Report (for approval of compliance statement):Dr Ruth Burnett

Item 48i Annual Medical Directors report - Board.docx

Item 48ii Annual Board Report and Statement of Compliance July 2021 - FINAL.docx

49 11:20 - Safeguarding Annual Report: (Steph Lawrence)

Item 49i Safeguarding Annual Report July 2021 cover paper.docx

Item 49ii Safeguarding Combined Annual Report D4 2021.docx

50 11:30 - Review of Standing Orders and Standing Financial Instructions: (Bryan Machin)

Item 50 Review of SOs and SFIs August 2021 Board.doc

51 11:40 - Quality Strategy: (Steph Lawrence)

Item 51 Quality Strategy 21 24 Draft for Board Aug 21.docx

52 11:50 - Board workplan: (Thea Stein)

Item 52 Public Board workplan 2021-22 v2 29 07 2021.xlsx

53 11:55 - Close of the public section of the Board; (Brodie Clark)

54 BLUE BOX ITEM: Patient experience: 6 monthly /Annual Report – seen by Quality Committee July 2021 (Steph Lawrence)

Item 54 Patient Experience report.docx

55 BLUE BOX ITEM: Patient Safety Report - seen by Quality Committee July 2021 (Steph Lawrence)

Item 55 Patient safety report.docx

56 BLUE BOX ITEM: Serious Incidents Report (this is the twice yearly thematic/learning report) – seen by Quality Committee July 2021 (Steph Lawrence)

Item 56 Serious Incident Report.docx

57 BLUE BOX ITEM: Mortality Report Mortality Report – Quarter 1 2021-22 – seen by Quality Committee July 2021 (Ruth Burnett)

Item 57i Mortality Report Q1 2021.docx

Item 57ii Mortality Q1 Adults Mortality Flash report for QAIG 2021.pdf

Item 57iii Mortality Q1 Child Mortality 2021-22.pdf

Item 57iv Mortality Report Addendum 2021 Annual report.docx

58 BLUE BOX ITEM: Health and Safety Compliance Report – seen by Business Committee July 2021 (Bryan Machin) –

Item 58 Health and Safety Compliance Report.docx

59 BLUE BOX ITEM: Safe Staffing Report – seen by Business and Quality committees July 2021 (Steph Lawrence)

Item 59 Safe staffing July 2021.docx

60 BLUE BOX ITEM: Trust Priorities – Quarter 1 – seen by Quality and Business committees July 2021

Item 60 Board Meeting_Trust Priorities Update Q1 2021_22.docx

61 BLUE BOX ITEM: Approved minutes and briefing notes for noting – all approved by the respective committees : (Brodie Clark)

61.a Audit Committee: 16 April 2021 and 7 June 2021

Item 61ai AC approved minutes 16 April.docx

Item 61aii AC approved minutes 7 June.docx

61.b Quality Committee: 24 May 2021 and 21 June 2021

Item 61bi QC approved minutes 24 May 2021.docx

Item 61bii QC approved minutes 21 June 2021.docx

61.c Business Committee: 26 May 2021 and 23 June 2021

Item 61ci BC approved minutes May 2021.docx

Item 61cii BC approved minutes June 2021.docx

Leeds Community Healthcare NHS Trust

Agenda Trust Board Meeting Held In Public

Virtual meeting and live streamed

Date 6 August 2021

Time 9:00 – 12.00noon

All items listed (Blue Box) in blue text, are to be received for information/assurance and no discussion time has been allocated within the agenda

AGENDA		
2021-22 33	9.00am	**Welcome, introductions and apologies** *(Brodie Clark)*
2021-22 34		**Declarations of interest** *(Brodie Clark)*
2021-22 35		**Questions from members of the public**
2021-22 36	9.10am	**Minutes of previous meetings and matters arising** *(Brodie Clark)* *For approval*
36.a		Minutes of the meetings held on 28 May 2021
36.b		Minutes of the meeting held on 11 June 2021
36.c		Actions' log: 28 May and 11 June 2021
2021-22 37	9.15am	**Patient's story: CAMHS** *(Steph Lawrence)*
QUALITY AND DELIVERY		
2021-22 38	9.30am	**Chief Executive's report: including Covid-19 update** *(Thea Stein)*
2021-22 39	9.45am	**Committee Chairs' Assurance Reports:**
39.a		Charitable Funds Committee: • 25 June 2021 *(Brodie Clark)* • Charity development update *(Kirsty Drakes)*
39.b		Audit Committee: 23 July 2021 *(Khalil Rehman)*
39.c		Quality Committee: 21 June 2021 26 July 2021 *(Helen Thomson)*
39.d		Business Committee: 23 June 2021 and 28 July 2021 *(Richard Gladman)*
39.e		Nominations and Remuneration Committee 2 July 2021 *(Brodie Clark)*
2021-22 40	10.00am	**Performance Brief: June 2021** *(Bryan Machin)*
2021-22 41	10.10am	**Significant Risks and Board Assurance Framework (BAF) Summary Report** *(Thea Stein)*
2021-22 42	10.15am	**Freedom to Speak Up Guardian Annual Report 2020-21** *(John Walsh presenting)*
2021-22 43	10.25am	**Guardian of Safe Working Hours Quarter 1 2021-22** *(Dr Nagashree Nallapeta presenting)*

2021-22 44	10.35am	**Nursing and Allied Health Professionals re-validation and registration** *(Steph Lawrence)*
STRATEGY		
2021-22 45	10.40am	**Workforce Strategy – 2021-25** *(Jenny Allen/Laura Smith)*
2021-22 46	10.55am	**Health Equity Strategy (Update)** *(Ruth Burnett) – Em Campbell presenting*
2021-22 47	11.05am	**Research and Development Strategy (update on progress)** *(Ruth Burnett)*
FOR APPROVAL		
2021-22 48	11.10am	**Medical Director's Annual Report** (reviewed by Quality Committee July 2021 – for approval of compliance statement for submission) *(Ruth Burnett) – Leanne Wilson presenting*
2021-22 49	11.20am	**Safeguarding Annual Repor**t (reviewed by Quality Committee July 2021 - to approve publication) *(Steph Lawrence)*
2021-22 50	11.30am	**Review of Standing Orders and Standing Financial Instructions** (to approve amendments) – reviewed by Audit Committee July 2021 *(Bryan Machin)*
2021-22 51	11.40am	**Quality Strategy** (Reviewed by Quality Commitee – July 2021) *(Steph Lawrence)*
INFORMATION FOR NOTING		
2021-22 52	11.50am	**Board workplan** *(Thea Stein)*
CLOSE		
2021-22 53	11.55am	**Close of the public section of the Board** *(Brodie Clark)*

Additional items (Blue Box)	
2021-22 54	**Patient Experience: 6 monthly /Annual Report – seen by Quality Committee July 2021** *(Steph Lawrence)*
2021-22 55	**Patient Safety Report:- seen by Quality Committee July 2021** *(Steph Lawrence)*
2021-22 56	**Serious Incidents Report (this is the twice yearly thematic/learning report) – seen by Quality Committee July 2021** *(Steph Lawrence)*
2021-22 57	**Mortality Report – Quarter 1 2021-22 – seen by Quality Committee July 2021** *(Ruth Burnett)*
2021-22 58	**Health and Safety Compliance Report – seen by Business Committee July 2021** *(Bryan Machin) –*
2021-22 59	**Safe Staffing Report – seen by Business and Quality committees July 2021** *(Steph Lawrence)*
2021-22 60	**Trust Priorities – Quarter 1 – seen by Quality and Business committees July 2021**
2021-22 61	**Approved minutes and briefing notes for noting – all approved by the respective committees :** *(Brodie Clark)*
61a	Audit Committee: 16 April 2021 and 7 June 2021
61b	Quality Committee: 24 May 2021 and 21 June 2021
61.c	Business Committee: 26 May 2021 and 23 June 2021

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (36a)

Title: Draft Trust Board meeting minutes 28 May 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
	Richard Gladman (RG)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Helen Thomson (HT)	Non-Executive Director
	Alison Lowe (AL)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director (from 14)
	Diane Allison	Company Secretary
	Sophie Lennon	Senior CAMHS Practitioner, Leeds Community Healthcare NHS Trust (for Item 5)
	Em Campbell	Health Equity Lead, Leeds Community Healthcare NHS Trust(for Item 12)
Minutes:	Liz Thornton	Board Administrator
Observers:	Andy Irvine	Public Health Registrar, Leeds Community Healthcare NHS Trust
Members of the public:	None present	

Item 2021-22 (1)

Discussion points

Welcome introduction, apologies and preliminary business

The Chair of Leeds Community Healthcare opened the Trust Board meeting held in public 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, and Sophie Lennon, Senior CAMHS Practitioner who were both attending to support items on the agenda. He also welcomed Andy Irvine, Public Health Registrar at the Trust who was supporting an item on the agenda and attending as an observer.

Apologies

Apologies were received and accepted from Laura Smith, 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 operationally, the Trust continued to deliver its services within a pressured and challenging environment and had successfully risen to the further work required in tackling backlogs, the consequences of Covid, including Long-Covid and mental health pressures and leading the outstandingly successful vaccination programme across the city. The operational demand would remain considerable and would not reduce for some time to come as a key challenge, focus and strand of the business.

Alongside that operational demand, the Trust continued to drive forward with its strategic priorities including health equity; the aging well programme and the important third sector partnership. The Trust was making significant contribution to a 'new build' NHS structure by inputting to the city and the Integrated Care System governance mechanisms.

All of which would be discussed at this meeting.

He said that the balance between day to day operational demands and strategic ambitions felt well managed, the focus and emphasis felt right and the Board agenda reflected that balance.

The Trust's staff were champions and they continued to deliver, support and commit to the business in ways that everyone could be proud of. Two recent examples were the 'outstanding' Care Quality Commission review of Adel Beck and the outcome of the Health and Safety Executive spot check on the Trust's arrangements for a Covid secure environment, an area where very positive progress had been made over the past 12 Months. He placed on record congratulations to those directly involved in both these area of work

Item 2021-22 (2)

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.

Non-Executive Director (AL) declared an interest in Item 13 in relation to her position as the Chief Executive Officer at Touchstone and their involvement in leading one of the partnership bids to NHS Charities together. She added that she had not been personally involved in the work on the bid.

Item 2021-22 (3)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2021-22 (4)

Discussion points:

a) Minutes of the previous meeting held on 28 May 2021

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

b) Items from the actions' log

There were no items on the actions' log.

Item 2021-22 (5)

Discussion points:

Patient's story

The Executive Director of Nursing and Allied Health Professionals advised that members of the family were unable to attend the meeting today to present the story. It was agreed that this item would be deferred.

Item 2020-21 (6)

Discussion points:

Chief Executive's report –including Covid-19 update

The Chief Executive presented her report particularly highlighting:

- Covid response
- Health and Safety Executive spot-check
- Funding for research in the community
- Returning to work – developing a hybrid model
- Appointment of the Executive Director of Nursing and Allied Health Professionals as National Professional Advisor for Adult Community Services at the Care Quality Commission (CQC)

Non-Executive Director (RG) said that it was pleasing to see the progress being made to formulate the Trust's approach to staff working beyond the pandemic and it was important that the Trust's Digital, Workforce and Estates strategies developed in a way which could support a blended model incorporating both remote working and in-base working.

The Director of Workforce, Organisational Development and System Development (JA) said that the aim was to build and strengthen the successful implementation of remote working and virtual practices which had worked so effectively in the Trust over the past 15 months. She added that the results from a recent staff survey had demonstrated how important the option for flexible and remote working was to many staff in the Trust.

Non-Executive Director (IL) noted the completion of the scoping project to determine the feasibility of an integrated research governance, management and delivery system and said that this was a positive step in terms of strengthening collaborative research with other organisations in the city and supporting research in the community.

Outcome: the Board

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

Item 2021-22 (7)

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 (KR) who highlighted the key issues discussed, namely:

- **Internal Audit**: the committee received an update on the current status of the remaining audits for 2020-21 and an update from the Internal Auditors that they anticipated being able to provide an overall option of reasonable assurance once two final audits had been concluded. All the outstanding audit reports would be completed and presented to the Committee on 7 June 2021.
- **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. The external auditors confirmed that they had completed some interim audit work and there were no concerns to raise.

b) – Quality Committee – 26 April 2021 (written report) and 24 May 2021 (verbal report)

The reports were presented jointly by the Chair of the Committee, Non-Executive Director (IL) and the Deputy Chair of the Committee, Non-Executive Director (HT). A verbal report was provided from the meeting on 24 May 2021 and the key issues discussed were highlighted, namely:

- **0-19 Service update and service spotlight presentation:** including the approach to recovery of gaps in the current vaccination regime due to school closures related to Covid-19. The work underway to address Health Visitor vacancies and expedite the recruitment process.
- **Wetherby Young Offenders Institute and Adel Beck:** plans are now in place for either transfers of care or more comprehensive packages of wrap round care for the young people involved. It was also reported that Adel Beck had an unannounced CQC/Ofsted inspection and have been rated as Outstanding. This has been recognised directly to the team by the Chief Executive and the Trust Chair.

c) – Business Committee – 28 April 2021 and 26 May 2021 (verbal report)

The reports were presented by the Chair of the Committee, Non-Executive Director (RG). A verbal report was provided from the meeting on 26 May 2021 and the key issues discussed were highlighted, namely:

- **Reset and recovery:** 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 and Recovery Programme Team and an introduction to the Improving Patient Flow and Prioritisation Programme.
- **Virtual Ward (Frailty):** the Committee received a progress report, the service's development plan and a summary of its performance to date.
- **Health and Safety Compliance report:** the Committee received an update on progress in relation to the action plan noting that significant progress had been made.
- **Assurance against the strategic risks:** the Committee agreed a substantial level of assurance against the Trust delivering on its agreed income and expenditure position. Reasonable assurance was agreed against the Trust having suitable and sufficient staff capacity and capability and maintaining a low level of sickness absence whilst acknowledging that there were some hotspots.

Outcome: the Board

- noted the update reports from the committee chairs and the matters highlighted.

Item 2021-22 (8)

Discussion points:

Performance Brief and Domains Report: April 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 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 (KPIs) 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
Non-Executive Director (KR) asked if the high number of incidents related to foot ulcers was a long standing trend and what was being done to reduce the number of incidents.
The Executive Director of Nursing and Allied Health Professionals said that this was a new issue and an Improvement Plan was being developed to provide more assurance along with an action plan to ensure learning was embedded across the Service.

Non-Executive Director (IL) said that the Quality Committee had discussed the issue in depth and the city wide work to reduce the historically high level of diabetic foot ulcer amputations. A further report on the city wide work and progress against the Improvement Plan would be considered by the Quality Committee in July 2021.

Caring
Non-Executive Director (KR) asked about tracking the themes related to complaints and how the Trust could ensure that learning from the responses to the Friends and Family Test and formal complaints were embedded across all services.

The Executive Director of Nursing and Allied Health Professionals said that the level of complaints in the Trust was very low. She acknowledge that poor communication was at the heart of almost every complaint the Trust received and that this was important area of focus for improvement. She added that the Board received a thematic report on complaints twice each year.

Effective
Not included in this report as issues are reported quarterly.

Responsive
Non-Executive Director (RG) suggested that more data from the Trust's internal Performance Information Portal (PIP) system should be included in this section in future reports.

The Executive Director of Finance and Resources said that the format and content of the Performance Brief was under review and would change over the coming year. He said that he would welcome any suggestions from Board members about how the report could be improved.

It was suggested that the Board might benefit from a training session on understanding healthcare data and it was agreed that this would be considered within the Board's development programme.
Well-Led
No questions raised.

Finance
No formal summary financial report has been produced for April 2021. 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 2021. Accordingly, the finance team had 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 six months and this would be shared with the Board. There is no cause for concern about the Trust's financial position in the first 6 months.

No questions were raised.

Outcome: the Board:

- noted the levels of performance against the Key Performance Indicators (KPIs) in April 2021.

Item 2021-22 (9)

Discussion points:

Significant risks and Board Assurance Framework (BAF)

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

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

The Board noted changes to the risk register as follows:

- One extreme risk scoring 16 (extreme) had been added to the register
  - Delayed transfer of children and young people from Wetherby Young Offenders; Institute (WYOI) who require medium secure CAMHS hospital beds.
- 12 risks scoring 12 (very high). One of these had recently been added:
  - Connection issues to the wifi at Stockdale House.
- Two newly identified risks were currently being assessed:
  - Patient Case Management Information System (PCMIS) used by Leeds Mental Wellbeing Service does not have functionality to run a system capture of all safeguarding cases.
  - As a result of both Leeds Community Equipment Service (LCES) budget limitations and a current supply delay there is a risk that patients being cared for in the community may not receive prescribed equipment in a timely manner.

The Board noted that the extreme risk for WYOI and the controls in place had been reviewed by both Quality and Business committee and would continue to be monitored closely.

The Trust Chair referred to the section of the report which provided information on risks by theme and asked Executive Directors to provide their perspective on the strongest themes across the register.

The Director of Workforce, Organisational Development and System Development (JA) said that resourcing was a top priority in the workforce plans for each of the Trust's business units. The overall 'fill rate' last year was 92% and the aspiration was to achieve this percentage again this year. It was noted that five of the seven risks related to staff capacity were as a result of services being paused in response to Covid-19 which had resulted in an increase in workload and waiting times.

The Executive Director of Finance and Resources explained that the Business Committee would be scrutinising and monitoring digital provision and related risks over the coming months. He said that the wifi problems at Stockdale House were related to complex connectivity issues and this was causing intermittent problems. In relation to Helpdesk Support Capacity he provided assurance that plans were in place to build resilience in the team.

The Executive Director of Operations spoke about the risks related to patient safety and the work underway to quantify what needs to be done over the next six months to:

- manage the increase in demand and ongoing referrals to enable the Trust to return to a 'business as usual' position.
- improve patient flow and plan for a more demanding complex case load.

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 2021-22 (10)

Discussion points:

Mortality reports

- **Quarter 4 2020-21**

The Executive Medical Director presented the report which provided assurance on the mortality figures and processes within the Trust in Quarter 4 2021.

Outcome: the Board

- received assurance regarding the Trust's mortality processes during Quarter 4 2020-21
- noted the ongoing contribution to improving data quality within the Trust and city, and the continuous work to ensure surveillance and learning is optimal.

- **Mortality Annual report 2020-21**

The Executive Medical Director presented the report for 2020-21. She highlighted the following key points:

- despite the increased workload there had been no significant lapses in care related to end of life care during the past year
- the increasing trend of patients choosing to die out of hospital continued and had been amplified by the increased number of deaths during 2020-21
- 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.

She added that since the report had been written the Trust had received some more detailed mortality data relating to ethnicity and this would be included in future reports.

Non-Executive Director (HT) asked if deaths in nursing and care homes was captured in the data.

The Executive Medical Director advised that if the patient was on the Trust's caseload it was. Overall data for deaths in nursing and care homes was collected as part of the Public Health data for the city.

The Director of Workforce, Organisational Development and System Development (JA) that a significant amount of support had been put in place to help staff who were delivering end of life care to patients including counselling and one to one support from a clinical psychologist.

The Trust Chair asked for the Board to receive a short briefing note on the support available and the uptake from staff.

Action: A short briefing note to be circulated on the health and wellbeing support on offer to staff who were delivering end of life care – covering details on the Trust offer to staff and evidence of the staff uptake.

Responsible officer: The Director of Workforce, Organisational Development and System Development (JA).

Non-Executive Director (IL) said that he was pleased that future reports would include data on ethnicity. Noting the section on learning and improvements he said that key learning themes were of fundamental interest to regulators and he suggested that consideration should be given to including more information in the report including how learning was disseminated across the Trust.

Outcome: the Board

- received the assurance provided regarding the Trust mortality process during 2020-21
- noted the high quality of care provided during 2020-21 despite the significantly increased workload for the neighbourhood teams and the additional pressures the pandemic created for the workforce and the Trust
- noted 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.

Item 2021-22 (11)

Discussion points:

Ageing well

The Executive Director of Operations presented the report and provided some background and context to the community response as part of the Ageing Well Programme.

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

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

Non-Executive Director (RG) asked how the third sector would be involved in the programme of work.

The Executive Director of Operations said that in that a number of partners were involved including Age UK to support the home and comfort element, Carers Leeds to ensure carers needs were addressed and Care and Repair to provide equipment.

Non-Executive Director (KR) asked how the Trust intended to evidence the impact and social value of the programme to support confidence and the release of further recurrent funding.

The Executive Director of Operations said that a full evaluation of the Virtual Ward (Frailty) was planned for Quarter 3 and this should lead to the development of a robust business case for future recurrent funding.

The Board welcomed the positive progress made so far in establishing the Virtual Ward (Frailty) and looked forward to receiving further updates when a more defined plan had been developed.

Outcome: the Board noted

- 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

Item 2021-22 (12)

Discussion points:

Health Equity Strategy

The Executive Medical Director presented the strategy which included information about the focus of the first 3-year delivery phase, including year 1 plans and the proposed assurance route.

The Health Equity Lead led Board members through the detail of the implementation plan and the assurance governance routes for the programme pointing out that as part of the development process, previous versions of the strategy had been reviewed at a Board workshop and considered by both the Quality and Business committee.

Non-Executive Director (AL) that she was pleased to see how the strategy had developed since it was first presented to the committees in February 2021 and she welcomed the addition of references to the impact of racism and discrimination on health equity.

She observed that the Trust still needed to do more to ensure that its workforce was more representative of the diverse community it served to ensure good progress. More emphasis should

be placed on strong leadership at all levels across the Trust to raise expectations and increase the understanding of health equity in its services.

The Director of Workforce, Organisational Development and System Development (JA) provided assurance that strengthening leadership in this area would be an integral part of the new workforce strategy. She said that working in partnership with the Trust's Race Equality Network Group a range of initiatives were being developed to increase representation of Black and Minority Ethnic staff at all levels of the organisation.

Non-Executive Director (KR) suggested that the assurance mechanisms should include more explicit references to resistance and barriers, include benchmarking against national and internal work and a clear assessment of the financial resources and the other associated costs that would be required to support successful implementation.

Non-Executive Director (IL) pointed out that the timeline for assurance mechanisms and oversight of progress finished in December 2021 and needed to be extended until the end of the year.

He observed that successful implementation of the strategy was extremely important for the Trust but the delivery would pose significant risks in terms of capacity and resources over the next three years and beyond.

The Chief Executive said that the strategy was well balanced in terms of ambition and achievability and compared favourably with others nationally however, she acknowledged that there were risks around the Trust's capacity to deliver such a significant agenda and the availability of resources to support it.

The Trust Chair said that next steps should include the Trust promoting and publicising the strategy across the city and the co-operation of other organisations should be welcomed. He added that further assurance on organisational capacity and resources should be provided to the Board as soon as possible and the interconnection between the heath equity strategy and the new workforce strategy needed to be made clearer.

Outcome: the Board

- received and approved the Health Equity strategy
- noted the commitments to the way we will work
- approved the focus of the first 3-year delivery phase, including year 1 plans
- approved the proposed assurance route.

Item 2021-22 (13)

Discussion points:

Third Sector Strategy – update

The Executive Director of Operations presented the progress report on the implementation of the Trust's strategy. She highlighted the good progress made across most of the workstreams. Reset and Recovery reporting had highlighted some of the excellent partnership working with the third 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.

The Trust had supported six third sector partnership bids to NHS Charities Together, which addressed health inequalities exacerbated by the pandemic through integrated working across the third sector and statutory health and care agencies.

The decision to pause non-essential work in November 2020 because of pressures resulting from the second lockdown had delayed establishing the Steering Group and consequently also development of the year 1 implementation plan. The implementation plan would be submitted to the Business Committee for approval in July 2021. The composition of the Steering Group reflects the commitment to this being an equal partnership with the third sector.

Non-Executive Director (AL) suggested that where bids were unsuccessful the ideas and focus of the bids should be blended into existing programmes of work in the Trust if possible.

Outcome: the Board

- received assurance and noted the progress made to date on the implementation of the Trust' Third Sector Strategy.

Non-Executive Director (RB) joined the meeting

Item 2021-22 (14)

Discussion points:

Corporate governance report

The Company Secretary presented the report which covered a number of corporate governance reports for consideration:

- ***Annual review of Board and committees' effectiveness –*** the report provided information gathered from a Board and committees' effectiveness review.
- ***Audit Committee and committees' annual reports 2020-21 –*** the terms of reference for the Trust's Audit Committee required that the committee had oversight of Board sub-committees. The report demonstrated that the Audit Committee had operated in line with its terms of reference and had undertaken a review of its effectiveness and received annual reports from the Board sub-committees.
- ***Committees' terms of reference –*** 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 Board noted the summary of the changes made in order to update the content.
- ***Details of the use of the Trust's 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 report contained a copy of the register of sealings.

Referring to the Audit Committee's annual report a Non-Executive Director (KR) confirmed that the final Head of Internal Audit Opinion and the ISA 260 external audit opinion would be received by the Audit Committee on 7 June 2021.

The Board discussed the value of an external assessment of its effectiveness next year. The Trust Chair said that he would reflect on this and discuss it further with the Company Secretary before the next review was due.

Outcome: the Board:

- noted the outcome of the annual review of Board and committees' effectiveness.
- received the Audit Committee's annual report for 2020-21.
- approved the amendments made to the terms of reference of Board sub-committees.
- noted the use of the corporate seal and noted the content of the sealings register.

Item 2021-22 (15a and b)

Discussion points:

Chair's actions

The Trust Chair presented the paper which set out information about two actions which had been taken under the special procedures in the Trust's Standing Orders which required ratification by the Board.

a) 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 five 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.

b) 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.

Outcome: the Board ratified

- decision to upgrade the Trust Telephony System
- decision to award an additional day of annual leave in 2020/21 to all employed staff.

Item 2021-22 (16)

Discussion points:

Leeds Primary Healthcare Collaborative – disbanding the joint Committees–in-Common between the GP Confederation and Leeds Community Healthcare NHS Trust

The Chief Executive presented the paper which outlined the proposal to dissolve the joint Committees-in-Common (CiC) between Leeds Community Healthcare (LCH) NHS Trust 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. She said that this needed to be done in time, to consider ways in which this work can be supported and linked to the Integrated Care System (ICS) which is still emergent.

Next steps would be to develop the new forum and its work programme and to continue to work with the Integrated Care Partnerships (ICPs) in highlighting the importance of joint working between primary care and community services, and the importance of integrated provision.

A number of Non-Executive Directors expressed concerns about entering into a less formal arrangement in terms of the posts which were shared across LCH and the GP Confederation, the lack of clarity on governance and accountability and losing the strategic focus on integration with Primary Care.

The Chief Executive acknowledged the concerns raised and agreed to discuss these with the CEO of Leeds GP Confederation in order to provide more clarity and assurance on the future arrangements to the Board.

Action: The Chief Executive to speak with the CEO of the Leeds GP Confederation and report back to Board members.

Responsible officer: Chief Executive

Outcome: the Board

- The Board is to receive a further briefing to address the concerns raised by Board members prior to making a decision about the future of the Committees in Common.

Item 2021-22 (17)

Discussion points:

NHS Provider licence compliance

The Company Secretary introduced the report and explained that organisations which provide an NHS service are required to hold a provider licence, unless, as is the case for NHS trusts, they are exempt. However, NHS England/Improvement bases its single oversight framework on the conditions of the provider licence and requires NHS trusts to self-certify under these licence

provisions. The report set out the self-certification framework and described how the Trust has met the requirements of the provider licence.

The Board reviewed the document, and noted that the Trust is recording compliance against all applicable conditions.

Outcome: The Board

- agreed 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 may be published on the Trust's website.

Item 2021-22 (18)

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: 12 March 2021
b. Quality Committee: 22 March 2021
c. Business Committee: 24 March 2021
d. West Yorkshire and Harrogate Health and Care Partnership – Committees in Common (CiC) - Minutes 21 January 2021
e. West Yorkshire and Harrogate Integrated Care System Mental Health, Learning Disability and Autism Committee-in-Common – Minutes 22 April 2021

Outcome: the Board

- noted the minutes.

Item 2021-22 (19)

Discussion points:

Board workplan

The Chief Executive presented the Board work plan (public business) for information.

Outcome: the Board

- noted the work plan.

Item 2021-22 (20)

Discussion points:

Any other business

No matters of any other business were raised.

Item 2021-22 (21)

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 12.00 noon

Date and time of next meeting
Friday 11 June 2021, 1.30pm – 3.00pm (end of year business only)
Friday 6 August 2021 9.00am-12.00 noon
Both virtual meetings and live streamed

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (36b)

Title: Trust Board meeting held in pubic – draft minutes 11 June 2021 (Extraordinary meeting – end of year business)

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
	Richard Gladman (RG)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Helen Thomson (HT)	Non-Executive Director
	Alison Lowe (AL)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	Diane Allison	Company Secretary
	Cherrine Hawkins	Deputy Director of Finance and Resources
Minutes:	Liz Thornton	Board Administrator
Observers:		
Members of the public:	None present	

Item 2021-22 (22)

Discussion points

Welcome introduction, apologies and preliminary business

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

Apologies

Apologies were received and accepted from Laura Smith, Director of Workforce, Organisational Development and System Development.

Item 2021-22 (23)

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.

Item 2021-22 (24)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2021-22 (25)

Discussion points:

Guardian of Safe Working Hours

The Guardian was unable to attend the meeting.

a) Quarterly report (Q4 2020-21)

The report was presented by the Executive Medical Director. The report for 2020-21 Q4 provided 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.

Outcome: the Board

- received this assurance regarding Junior Doctor rotas and working conditions within the Trust
- supported the GSWH and Deputy Medical Director in the work underway to understand the impact of the on-call rota on community paediatric training time without reliance on exception reports.

b) Annual report 2020-21

The Executive Medical Director presented the annual report for 2020-21 which included information on the issues affecting trainee doctors and dentists in the Trust, including morale, training and working hours.

The Board reviewed the report noting the no exception reports had been received during 2020-21. Noted that a concern was raised to the Trust on 28 April 2021 regarding whether the CAMHS Junior Doctor rota was complaint with their Terms & Conditions of Service. This was currently being explored, and immediate steps to rectify this will be taken if it is determined the rota does breach their Terms and Conditions of Service.

Outcome: the Board:

- noted the GSWH annual report for 2020-21.
- support GSWH with the work that has been started to ensure CAMHS ST rota gaps and locum cover arrangements are compliant with the Junior Doctor terms and conditions.

Item 2021-22 (26a,b,c and d)

Discussion points: Annual accounts, letter of representation and external auditors' opinion
The Executive Director of Finance and Resources stated that the Audit Committee had given full and proper scrutiny to the Trust's accounts for 2020-21. At the Audit Committee meeting on 7 June 2021, the Committee had also reviewed the letter of representation and the audit memorandum on the Trust's financial statements issued by the external auditors, Mazars.

The Executive Director of Finance and Resources confirmed that, as noted in the letter of representation, directors had provided confirmation that, to the best of their knowledge, all information relevant to the financial statements had been disclosed. The external auditors had confirmed their confidence that this had been the case.

Referring to the external auditors' opinion on the accounts, the Executive Director of Finance and Resources said he could report that the auditors would issue an unqualified opinion on the Trust's accounts. A list of the uncorrected misstatements was attached to the letter of representation as an appendix.

The Executive Director of Finance and Resources explained that the auditors did not agree with the management assessment and accounting treatment of the £1,124k redundancy provision for GP pharmacists which the auditors believed did not meet the requirement of IAS37 and should therefore be disclosed as a contingent liability only.

The Executive Director of Finance and Resources provided the rationale underpinning the accounting treatment of the redundancy provision and confirmed that the management view was that the effects of any uncorrected misstatements were immaterial, both individually and in aggregate, to the financial statements as a whole and did not plan to adjust in the accounts for 2020-21. He acknowledged that the financial risk related to the redundancy provision could change during 2021-22 but that he would take the auditors views into account on consideration of the 2021-22 budget and financial arrangements.

Non-Executive Director (KR), as Chair of the Audit Committee, reported that he was very satisfied with the opportunity the Committee had had to review the annual report and accounts and he extended his thanks to the Company Secretary, the Finance Team and the external auditors for their efforts in maintaining a robust process both throughout the year and for the year-end processes. This conclusion had been supported by the external auditors' opinion on the accuracy of the financial statements.

Outcome: the Board accepted the recommendations of the Audit Committee and:

- adopted the draft annual report, including the annual governance statement
- adopted the annual accounts, but noted the external auditors' opinion
- approved the letter of representation.

Item 2021-22 (27)

Discussion points: Quality account 2020-21
The Executive Director of Nursing and Allied Health Professionals presented the final version of the Quality Account report for 2020-21. This had been scrutinised and agreed by the Quality Committee prior to being presented at the Board. On the recommendation of the Quality Committee, there was a greater focus on the Trust's response to the pandemic in terms of quality of care provision.

Non-Executive Director (HT), as Chair of the Quality Committee acknowledged the work of the Clinical Governance Team in the production of the Quality Account.

Outcome: the Board

- approved the Quality Account 2020-21 for external publication.

Item 2021-22 (28)

Discussion points: CAMHS collaborative business case

The Executive Director of Finance and Resources presented the case. He explained that the Lead Provider Application for West Yorkshire Tier 4 CAMHS Provider Collaborative – Business and Clinical Case has been produced to support the Trusts', including Leeds Community Healthcare, application to move from the current New Care Model arrangement to a Provider Collaborative led by Leeds and York Partnership.

The Executive Director of Finance and Resources highlighted the financial risk for the Integrated Care System and described the benefits to patients across West Yorkshire, which outweighed the financial risk.

The case had been scrutinised by the Quality Committee focussing on the quality and clinical model aspects of the case and the Business Committee focussing on the finance case. Both Committees recommended approval to the Board.

Outcome: the Board

- approved the Business Case subject to confirmation of £1.71m funding from NHS England.

Item 20 21-22 (29)

Discussion points: Performance brief annual report 2020-21

The Executive Director of Finance and Resources introduced the report which focused on performance against the Key Performance Indicators (KPIs) agreed before the commencement of the financial year and before the start of the Covid-19 pandemic.

The Trust Performance on the KPIs during the year had been severely affected by the impact of the pandemic on services and the Trust's normal business. He explained that in that context, the document did not seek to present an in depth analysis of performance but to offer some comments to assist the Board in its assessment of the year as part of a suite of documents including the Annual report and Accounts, Assessment of Performance against Priorities and the Quality Account.

Non-Executive Director (AL) suggested that the Trust should review the data and aspirational targets set out to support the delivery of Workforce Race Equality Standard Indicator 1 to reflect the most up to date census data.

Director of Workforce, Organisational Development and System Development (JA) explained that the targets were based on data from the 2010 census and she confirmed that this would be reviewed when information from the 2021 census became available.

Outcome: the Board

- noted the year end record of performance against KPIs.

Item 2021-22 (30)

Discussion points: Assessment of performance against 2020-21 priorities

The Executive Director of Finance and Resources presented the report. Due to Covid-19 2020-21 had not been the year the Board envisaged when the Priorities were agreed at its meeting in March 2020.

He said that the Board would normally expect to receive a detailed year-end report on how well the Trust delivered against its agreed 2020-21 Priorities. As much of the envisaged work was stopped, delayed or slowed due to the Covid-19 response, a report measuring progress was not appropriate.

However, as part of the Covid response, reset and recovery and through business as usual, much excellent work had taken place and the report contained some observations on the extent to which progress was made on the Priorities, often in ways that were not envisaged when they were agreed. To avoid too much duplication, reference was made in the report to other sources of relevant information, particularly to the Quality Account where greater detail, service examples and patient and staff stories are presented that are relevant to the Priorities in this report.

The Board agreed that, in the most challenging of circumstances, staff had gone above and beyond throughout the year, delivering high quality care to patients whilst delivering against the Trust priorities in ways that were not envisaged at the start at of the year but have significantly contributed to the Trust being a better provider of care, a better employer and a better partner.

Outcome: the Board

- noted the assessment of performance against 2020-21 priorities.

Item 2021-22 (31)

Discussion points:

Any other business

No matters of any other business were raised.

Item 2021-22 (32)

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 3.00pm

Date and time of next meeting
Friday 6 August 2021 9.00am-12.00 noon
Virtual meetings and live streamed

AGENDA ITEM 2021-22 (36c)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 6 August 2021

Agenda Number	Action Agreed	Lead	Timescale	Status
11 June 2021				
	None to note			
28 May 2021				
2021-22 (10)	**Mortality Annual report-support for staff delivering end of life care:** a short briefing note to be circulated on the health and wellbeing support on offer to staff who are delivering end of life care – covering details on the Trust offer to staff and evidence of the staff uptake.	Director of Workforce, Organisational Development and System Development	As soon as possible post meeting by email	**Completed** 12 July 2021 Email
2021-22 (16)	**Leeds Primary Healthcare Collaborative – disbanding the joint Committees–in-Common:** Board members concerns about entering into a less formal arrangement in terms of the posts which were shared across LCH and the GP Confederation, the lack of clarity on governance and accountability and losing the strategic focus on integration with Primary Care. To be discussed with the CEO of Leeds GP Confederation and the outcome to be reported to the Board.	Chief Executive	6 August 2021	**Completed** Committees-in-Common will continue to meet – as per CEO Email

Actions on log completed since last Board meeting on 28 May 2021 and 11 June 2021	
Actions not due for completion before 6 August 2021; progressing to timescale	
Actions not due for completion before 6 August 2021; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 6 August 2021; not having met agreed timescales and/or requirements	

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (38)

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:

- Involvement in Long Covid study
- Listening to staff
- Integrated Pharmacy and Medicines Optimisation
- Signing up for anti-racism campaign
- Youth Board update (appendix one)
- Our role as an anchor institution

A further verbal update will be provided at the Board meeting, including the most up to date figures on infection rates and current operational pressures in LCH and the system

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 Long Covid study

The Leeds Covid Rehab Service led by Leeds Community Healthcare (LCH) will be one of 10 clinics and 8 Higher Education Institutes taking part in a new £3.4million study led by University of Leeds clinical academic lead Dr Manoj Sivan. The Leeds Service is an example of multi-disciplinary collaborative working; drawing on the expertise of professionals employed by Leeds based NHS organisations as well as a local Higher Education Institute. The place of LCH in leading the set up and delivery of the clinic in which the Chief Investigator is based has placed it in a key position to lead and influence the clinical input and interventions required for Long Covid so far. Involvement in this key study will enable its continued high profile in shaping care for the patients affected in the rapidly developing clinical speciality of Long Covid.

By being cared for by our service, the Long Covid patients of Leeds will be best situated to benefit from the latest evidence about care. This clinic, home and GP surgery based study will track where patients are being referred or not referred, and learn from the experience of clinics by interviewing patients and recording outcomes. Throughout, a focus on 'Healthcare Inequality' will seek to reach those not accessing clinics. The study will introduce a 'gold standard' for care that can be shared within England and the rest of the UK that will take account of both accessibility and cost effectiveness. Comparing findings across our partnership of ten Long Covid Clinics we will learn more about treatment, providing real-time education to other healthcare staff and patients.

4 Listening to staff

Every week members of the Senior Management Team are out and about either in person or currently virtually listening and learning from our staff and being alongside them. For the Executive Director of Nursing and Allied Health Professionals she may well be working a shift with them – for the rest of us this will be joining a meeting or shadowing staff.

This is something we have never formally captured in my CEO report but going forward I will be reflecting – briefly – on where I have been in particular and anything

I have learnt during these visits. These are not assurance events where we commonly ask a range of set questions and explore particular topics such as quality walks but meetings to hear from staff about how they are feeling, what's working well for them and what could be better if? In order to get feedback about Trust-wide communications, current pressures etc.

During the past period of time I have had weekly meetings with Leaders via Leaders' Networks talks which regularly have over 90 participants. Whilst this is a key cascade mechanism it also provides a forum for staff to ask questions and raise concerns. I have led two live sessions with all staff, taking questions before the event and also during the event on the subjects of vaccination programmes and return to the office and hybrid working.

I have joined the following teams for events or meetings to listen and learn:

- Infection prevention and control team
- Leeds Mental Wellbeing Service
- Mind Mate Support team meeting- the team that supports colleges/Uni
- Open Race Equality network
- Podiatry operational and clinical leadership meeting
- An open meeting for our nursing staff to talk about pressure (led by Executive Director of Nursing and Allied Health Professionals)
- CAMHS leadership team
- CAMHS urgent and emergency team
- A morning with the PHINS Clinical Triage Team at Thornton Medical Centre and shadowing a practitioner on visits

I have also spoken to several members of staff through the Freedom to Speak Up route and met regularly with the staff side chair in addition to of course regular attendance at JNCF and JNC.

In this report the two issues I would want to pick up overall are – the pride and positivity that staff have in what they are doing and what they have, and are achieving as well as the current pressure and tiredness they are experiencing as conditions are not alleviated.

Overall feedback is that staff are aware of and make use of our health and wellbeing offers and corporate communications is useful and accessible. Clearly there were also individual issues of either celebration or concern that were picked up in the meetings.

5 The Anchor Network

LCH continues to participate in the Leeds Anchor Network quarterly meetings. Anchor institutions are large locally rooted organisations with local headquarters. Because of their size, anchor institutions make a positive contribution to their local area. The way in which they operate and the decisions they take as …

- an employer
- procurer of goods and services
- manager of buildings and assets
- provider of services
- leaders and managers

… can make that contribution, and the impact on growth and inclusion, health and well-being, climate change and environmental goals, far bigger.

Leeds Anchor Network comprises Leeds City Council, FE colleges and universities, NHS providers, Yorkshire Water, and new members this year, the British Library and Northern Gas Network.

LCH recently completed the annual self-assessment against the Network's Progression Framework, which sets out benchmarks for excellence for the functions bulleted above. We identified the following as our priority Framework focuses for 2021/2022:

- as an employer
    - ✓ workforce strategy 2021-25 - drawing a stronger line to Health Equity and the wider determinants for health and well-being through
        - employment focus with disadvantaged communities – targeted work with Neighbourhoods and prospective minority and ethnic candidates
        - focus on staff well-being, including diversity and inclusion
    - ✓ pro-active approach to drive take-up of pension among lower paid staff
- a procurer of goods and services
    - ✓ refresh the procurement strategy aligning it to the Network framework focuses and standards – to do in partnership with Leeds & York NHS Partnership Foundation Trust who provide procurement systems and functions for LCH, LCH having a slimline procurement function of its own
    - ✓ embedding the recently published NHS Social Value procurement regulations – there is commitment to share learning across Anchor Network NHS providers
- manager of buildings and assets
    - ✓ Establish our carbon reduction ambition (September Board workshop) and subsequently agree an implementation plan – we anticipate being able to learn from Anchor partners whose strategies and plans are more developed
    - ✓ Establishing carbon emission data
    - ✓ Raise awareness and create a long-term behavioural shift by enhancing our social movement around Climate Change and environmental issues.
- provider of services
    - ✓ collecting data in relation to health outcomes to underpin focus on improving health equity
    - ✓ further developing partnership working with 3rd sector to strengthen focus and impact on health equity
- As leaders and managers
    - ✓ our greatest focus will be focus on staff health and well-being, with a diversity and inclusion lense for both current and prospective staff
    - ✓ As an Exec team and Board we embed Anchor Network aspirations in our culture, approach and processes: most front line staff won't be familiar with Anchor institutions

6 Integrated Pharmacy and Medicines Optimisation

Medicines remain the most common therapeutic intervention in the NHS, with 48% of adults having taken a prescription medicine each week. The Leeds place spend on medicines in 2019/20 was approximately £324 million with 16 million items dispensed by community pharmacy. During 2020/21, Pharmacy Leaders across the city met regularly to provide peer support for medicines related issues that arose from the coronavirus pandemic. The close collaboration led to the agreement and drafting of a single vision, purpose, values and strategic intentions for pharmacy and medicines optimisation across the City.

A proposal to develop an Integrated Pharmacy and Medicines Optimisation across the city received support at the Partnership Executive Committee in July 2021. A provider alliance is proposed which includes the current CCG medicines optimisation teams along with Leeds Teaching Hospitals Trust, Leeds Community Healthcare Trust, and Leeds and York Partnership Foundation Trust and with close collaboration with community pharmacy, practice, Primary Care Networks and health and justice colleagues. A programme of work has been outlined that will support delivery of medicines and pharmacy integrated care across Leeds that is consistent with city wide discussions. This will support pathway integration, value for money prescribing (including identifying efficiency opportunities e.g. stoma and appliances, wound care etc), medicines safety initiatives and optimising medicines across transitions of care. We are committed to a single vision, purpose, values and strategic intentions for pharmacy and medicines optimisation across the City. The shared vision is to *"ensure the best, safe and optimal use of medicines across the City, to improve the health and wellbeing and reduce health inequalities for the people of Leeds focusing on what matters most to them".*

Strategic intentions seek to:

1. Consistently deliver the Royal Pharmaceutical Society (RPS) Medicines Optimisation Principles: '*Helping Patients make the most of medicines'* across pathways of care
2. Embrace innovation and innovative practice
3. Empower visible leadership at all levels
4. Foster strong partnerships
5. Be research active
6. Develop a confident and capable workforce

7 Youth Board update

(See Appendix One)

8 The new quarterly staff survey

In July 2021 we launched our first Quarterly Staff Survey (QSS). The QSS is a simple feedback tool, administered by an independent provider commissioned by the Trust, which allows staff the opportunity to feedback their views of Leeds Community Healthcare NHS Trust (LCH) as a provider of care and as a place of work.

NHS organisations across England are now undertaking similar quarterly surveys. It is hoped that this will help promote a culture in the NHS, which we believe we already have at LCH, where staff have confidence to speak up and where the views of staff are increasingly heard and acted upon. All staff can provide their feedback via the QSS (formally Staff Friends and Family) three times each year in Quarter one, Quarter two and Quarter four, it is not run in Quarter three when the NHS Annual Staff Survey takes place.

This first QSS contains 9 mandated questions aligned with the annual NHS Staff Survey's engagement questions, and three further Staff Survey-aligned questions focusing on leadership, appraisal and health & wellbeing. The survey closed on 2 August 2021 and we expect to receive and report on its results shortly afterwards.

9 Anti-racism campaign

In June 2021, the Trust signed up to the West Yorkshire and Harrogate Health & Care Partnership, Integrated Care System (WY&H ICS) anti-racism movement, which will be launched at the end of August 2021. Its objective is to unite WY&H ICS colleagues and organisations in shining a light on racism issues and prompting individuals and organisations alike to take action, in order to tackle health inequalities for our minority ethnic populations. A key ingredient of the movement will continue to be the WY&H ICS Racial Inequalities training offer which was first delivered during Black History Month in October 2020, and which was developed in conjunction with colleagues from the Trust's Race Equality Network (formerly the BAME (Black, Asian and Minority Ethnic) Network).

10 Pride Month June 2021

Pride Month both supports our communities, as well as educating and informing wider society about the harm and damage homophobia, biphobia and transphobia has on all of us. We want LCH to become a truly inclusive organisation and during Pride month some of our colleagues shared their personal stories.

11 Engagement champions celebration event

The Engagement Champion Celebration Event was held on 30 June 2021, with guest speakers from the LCH Youth Board, NHS England & Improvement Always Events and Co-Production. Steph Lawrence, Executive Director of Nursing and

Allied Health Professionals highlighted some of the champions work over the past year and talked through some of the Trust's engagement priorities for the coming year.

Two workshop sessions were held: one around the key principles and implementation of Accessible Information Standards and an interactive session that allowed the Engagement Champions to reflect on the past year, their role as champion and their priorities for the next 12 months, that will help to shape the meetings and priorities moving forward.

Attendees completed an evaluation survey and feedback was hugely positive;

- "Well-organised, plenty of breaks and moving well between different sessions, all the while maintaining a relaxed and engaging atmosphere."
- "Thought it was a great review of what has been happening over the last 12-18 months and some real ideas about what next. Great speakers"
- "Challenged some assumptions I had and helped me to understand Patient Engagement Champions priorities and interests - it will be interesting to explore further if these are the same as management / service priorities for engagement."
- "I felt most of the day was very useful and definitely learnt lots from the day. Youth board got me thinking about interviews because I really want patient's and parents involved in our interviews."

Champions also said they wanted to know more about at future meetings, including more on Accessible Information Standards, Digital Inclusion and Health Equity and future workshops are being planned.

12 'My LCH' the Trust's new staff website

The Communications Team led on launching a new staff intranet 'My LCH' in June 2021 and we said goodbye to our former Intranet 'Elsie'. My LCH is a big upgrade on Elsie and can be accessed by staff absolutely anywhere on any smartphone, tablet or computer. It has a modernised look and feel, a simplified intuitive navigation, a 'smart' search function, an events booking system and a live staff directory. My LCH also offers a much more interactive experience for staff including social features - such as timelines, liking, and commenting on posts and content. So far we have seen especially high engagement with our revamped Workforce pages and forms, along with the blogs from staff to celebrate Pride Week. Within the first 24 hours of launching over 50% of the LCH Workforce logged onto the new platform and daily login and engagement rates have remained much higher than on our previous systems.

13 Yorkshire Three Peaks

We are very proud of the team of LCH staff took on the Yorkshire Three Peaks challenge on Saturday 26 June to raise money for our very own LCH Charity. The challenge encompassed the peaks of Pen-Y-Ghent, Whernside and Ingleborough in the Yorkshire Dales and can take up to 12 hours to complete. Some team members actually ran the 24 mile route. Donations can still be made on our fundraising page

and are gratefully received. Our LCH Charity provides funds for projects that enhance patient care and support staff across our Trust.

14 Recommendations

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

Children's Business Unit
Youth Board Update
August 2021

Author, Chris lake

Youth Board

We currently have 24 young people involved in the Youth Board. The Youth Board is still facilitated by myself (Chris Lake) and Amanda Jackson and we are also regularly joined by other staff from across our children's business unit at our meetings.

We continue to meet monthly and since the onset of the pandemic have met virtually via Teams. We have also started to introduce hybrid meetings from June and have used the Board Room for this as well. The option of meeting virtually has brought enormous benefits to how we meet and work and the greatest benefit is that our virtual meetings are easily accessed by our group who live across the Leeds area. Some of our group can be anxious around attending meetings for the first time and we have found that virtual meetings can offer a graded approach to this as some choose not to have their cameras switched on or have joined with a parent or carer.

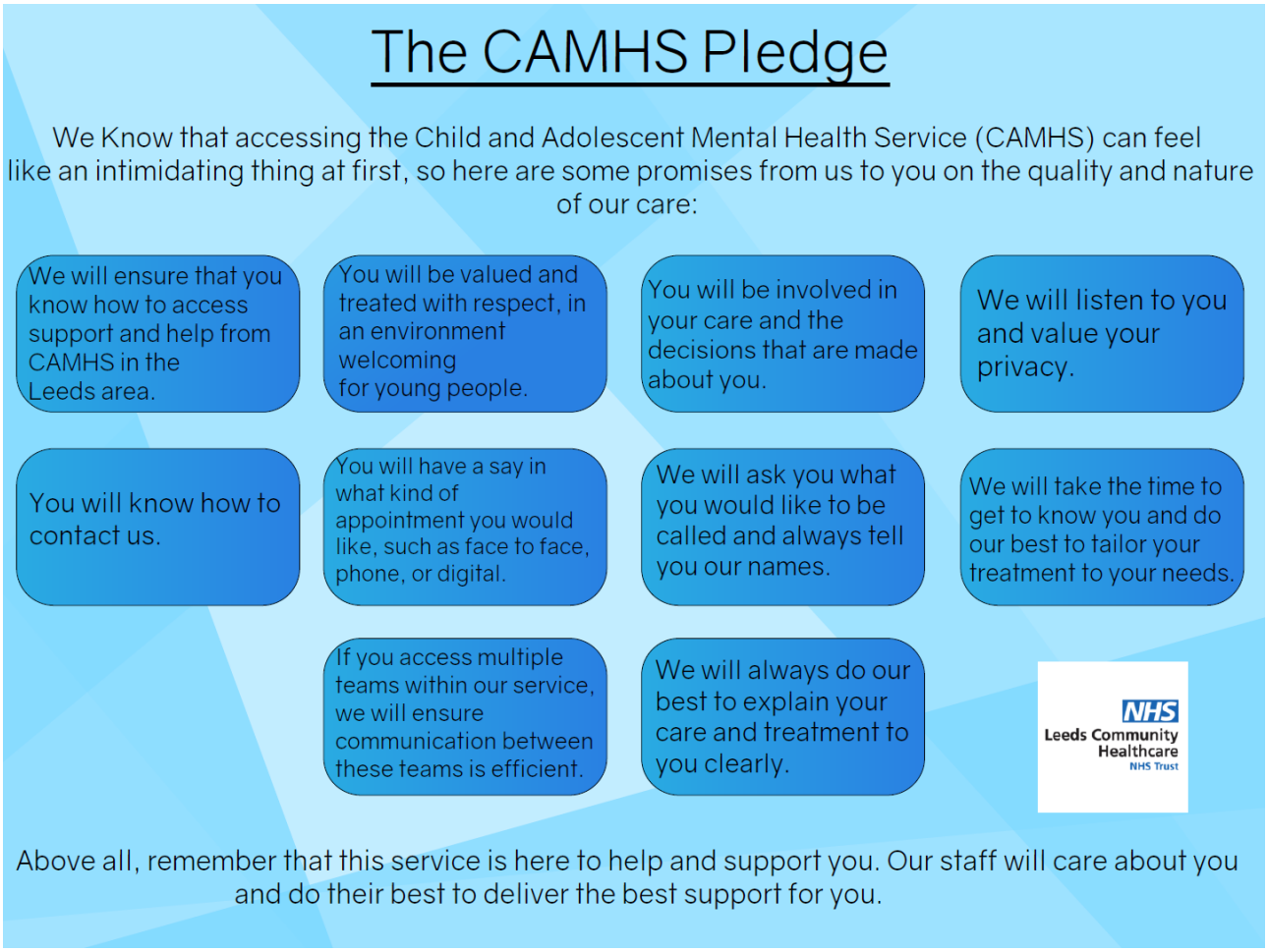
Some of our group met face to face for the first time since the beginning of the pandemic in May when they took part in a staff recruitment event for PHINS at Heart. It was also an opportunity for us to wear our hoodies that were kindly funded by our Trust`s charity.

One of our founder members Erin has completed a short video that she would like to share around why she became involved but also wrote (to be circulated to Board members separately).

‘I joined the Youth Board because I strongly believe that patients should be able to help shape the services they use with their input and I wanted to make my ideas heard in a way that could make a difference. Since joining, the Youth Board has helped me do this in many ways and offered many amazing opportunities!
Helping with recruitment interviews has also been extremely valuable and fun. The Youth Board so far has been an incredible experience and I can’t wait for future projects.’

Our Recent Projects

- We were asked to design a youth charter for Leeds CAMHS. Our group designed the charter but preferred the title “The CAMHS Pledge” as this would be a list of promises made to children and young people who access services provided by CAMHS.



- Developed a guide for our staff around involving children and young people in staff recruitment. The guide gives an overview of

the different options of how we involve children and young people and includes templates such as certificates, scoring sheets, letter to school and examples of questions.

- Designed Youth Board hoodies.
- Some of our group recently attended a staff involvement champions celebration event and spoke about the Youth Board and the importance of co-production.
- Continue to be involved in consultation around Red Kite View. They have taken part in consultation around the building, furnishings and the name Red Kite View was our group's idea.
- Took part in young person panels for some of our staff recruitment events.
- Leaflet design and consultation.
- Reviewed the CAMHS new care plan that was designed initially by the group.
- Consultation around safeguarding.
- Social media take over event for PHINS.
- Took part in a recruitment video for CAMHS.
- Designed T shirts for the three peaks challenge for the LCH charity.

We are working on …….

- Developing links with Leeds City Council around support in school and college around health. Members of Leeds City Council have already attended a meeting with myself and Amanda and will be attending our September Youth Board meeting.
- Consultation around speech and language therapies Communication offer.
- Developing a record of achievement for our members. This is a record of the projects and meetings that our young people have taken part in and can be used as evidence for their cv`s.
- Social media development.
- Developing links with community groups and organisations.

We are also pleased to share with you some of the wonderful things that a few members of our group have achieved recently:

Erin was successful in applying for the position of young person representative for Quality Network for Inpatient CAMHS – QNIC. Erin also sits on the LCH Charitable Funds Committee subgroup.

Haris is now a member of the national NHS youth forum and has been working on bringing youth board facilitators together for regular meetings and networking. Haris will be leaving the Youth Board later this year to commence medical school.

Caitlin has secured a place at medical school which commences this year. She would like to continue with the Youth Board virtually as she feels passionate around developing health in Leeds.

Chris Lake
Involvement Lead
Children's Business

Trust Board meeting held in Public: 6 August 2021

Agenda item number: 2021-22 (39a)

Title: Charitable Funds Committee June 2021: Committee's Chair assurance report

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Category of paper: For assurance
History: N/A

Responsible director: Executive Director of Nursing and AHP's
Report author: Executive Director of Nursing and AHP's

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1 Introduction

The Charitable Funds Committee is a subcommittee of the Trust Board. The Committee oversees the strategic director of the LCH Charity and provides assurance to the Trust Board following each quarterly meeting.

2 Background

The paper is presented to the Trust Board only following each Charitable Funds Committee meeting.

3 Current position/main body of the report

3.1 Charitable development updates

- Progress has been positive to raise the visibility of the charity internally and externally
- Clear processes have been implemented and relationships have been strengthened across teams such as Communications and Finance
- The LCH Charity Operational group has met monthly and continues to develop
- We have used our NHS Charities Together membership to support the growth of the LCH Charity
- There have been 15 successful applications for funding to the charitable funds
- The impact of charitable funds across the Trust is starting to be collected to evidence the difference being made by LCH Charity
- Planning for fundraising activities for 21/22 is well underway
- The report that was taken to the charitable funds committee is attached as an appendix to this paper for information.

The committee agreed to the charitable funds administrator post being made a substantive post as it is now clear that this is needed and the progress made since the inception of the post is evident.

Discussion about a comms strategy for the charity and future plans were discussed. These will be discussed at the operational group and a plan returned to the committee for consideration.

3.2 Finance Report

The Director of Finance presented the finance report. There were no queries in relation to this and the committee accepted this as a true report.

Draft LCH Charitable Funds and Related Charities Annual Report & Accounts 2020 was discussed and agreed by the Committee for recommendation to the Audit Committee.

4 Impact:

4.1 Quality

The work of the Charitable Funds Operational Group and Committee is hoping to enhance the quality of care the Trust provides through use of funds to enhance patient care but also to ensure staff are supported in terms of their health and wellbeing.

4.2 Resources
Nothing to report.

4.3 Risk and assurance
No risks identified.

5 Next steps
N/A

6 Recommendations
The Board is recommended to:
Receive this assurance report and appended update report from the Charitable Funds Committee and note the progress made by LCH Charity over the last six-month period

Appendix 1

LCH Charity Update Report

Executive summary (Purpose and main points)

Purpose

The purpose of this report is to provide a six-month update to the Charitable Funds Committee on Leeds Community Healthcare Charitable activities between January - June 2021, including:

- Promotion of the LCH Charity
- LCH Charity Operational Group
- NHS Charities Together
- Applications to LCH charitable funds
- Impact of charitable spending
- Fundraising

The focus over the last six months has been on increasing the visibility of the charity (particularly internally to encourage applications for funding), establishing processes, building relationships, and capturing impact. Fundraising opportunities have also started to be established. The values and behaviours of the Trust are embedded within these priorities.

Main Points

- Progress has been positive to raise the visibility of the charity internally and externally
- Clear processes have been implemented and relationships have been strengthened across teams such as Communications and Finance
- The LCH Charity Operational group has met monthly and continues to develop
- We have used our NHS Charities Together membership to support the growth of the LCH Charity
- There have been 15 successful applications for funding to the charitable funds
- The impact of charitable funds across the Trust is starting to be collected to evidence the difference being made by LCH Charity
- Planning for fundraising activities for 21/22 is well underway

Leeds Community Healthcare Charity
Registered charity no. 1135654

1 Introduction

The LCH Charity was introduced to enhance and improve patient care – providing grants to projects that are over and above government funding. Leeds Community Healthcare Charity aims to make a difference by investing in new equipment; improving patient environments; or providing additional support for staff training. The Charity is in place to provide grants to existing or new projects that are over and above those served by government funding. It has the capability to make a difference to patients, their families, and staff of the Trust.

2 Background

In January 2020 a meeting was held to review the purpose and aims of a Charitable Funds Group. This was followed by reallocation of operational oversight of the LCH Charity to sit within Quality and Professional Development (QPD) and the post of Charitable Funds Administrator (CFA) put in place for a 12-month period.

The LCH Charity has been supported by the role of the Charitable Funds Administrator for 15 hours per week since November 2020, with guidance from the Patient Experience and Engagement Lead. The first Charity Operational Group meeting within this new structure took place in November 2020 and they have since occurred monthly.

3 Current position

3.1 LCH Charitable Funds

A dedicated area on the staff intranet has been created to keep LCH staff up to date with charity news and events. It has provided a central place for staff to be signposted to for further information on the charity; an example of this is during the registration period for the Three Peaks event where a web form was used to gather information from participants and provide a formal registration process. An application form for charitable funds and guidance notes can be accessed via the Intranet page, and links to external pages such as the charity fundraising pages and the Trust external website are provided. The intranet pages are regularly updated and each new update is highlighted in the Midday Briefing to raise the visibility of LCH Charity across the Trust and encourage staff participation and applications to charitable funds.

Relationships between LCH Charity and the Communications Team have been strengthened through regular meetings between the Charitable Funds Administrator and the Communications Project Lead. Communications regularly post updates on Twitter and Facebook on behalf of LCH Charity, and the Charitable Funds Administrator provides social media plans to facilitate this. Further exploration of a dedicated social media page for the charity will take place over the coming six months.

Monthly meetings take place between the Charitable Funds Administrator and the Financial Accountant to monitor the progress of approved charitable funds applications in terms of spending and identifying where support can be offered.

Processes within LCH Charity have been established to approve applications, communication with applicants, and feedback of information between the Operational Group and the Charitable Funds Committee. Spreadsheets have been

developed to monitor the progress of applications and monitor spending. This has resulted in the day-to-day running of the charity becoming much more efficient and transparent.

3.2 LCH Charity Operational Group

The purpose of the LCH Charity Operational Group is to provide a forum for a more detailed consideration of charitable matters and this works well to produce ideas, share expertise and reach consensus on issues. Actionable tasks are produced every month as a result of discussions. These have included disseminating information, exploring fundraising ideas in more detail and sourcing donations. Fundraising has so far been the biggest focus of discussion within the group due to the amount of planning involved.

The Charity Operational Group has benefitted from the addition of a member of the LCH Youth Board and the LCH CBU Involvement Lead. This addition to the membership of the group have helped to ensure that people's voices are at the centre of the charity work and provides insights from a young person's perspective. The Youth Board have also contributed to the design of the t-shirts for the Yorkshire Three Peaks fundraiser.

3.3 NHS Charities Together

Through a number of applications to NHS Charities Together LCH have received funds which have been used specifically to provide LCH staff with additional support during the Covid-19 pandemic, including the provision of psychological support for staff wellbeing, lunches, fruit and refreshments for staff Trust-wide, and several team specific resources such as fitness equipment, wellbeing boxes, stress-management training.

An application to NHS Charities Together has been submitted to secure continued funding for Psychological Therapy support for staff, the outcome of this application is expected over the coming month. LCH have also partnered with Third sector colleague to support an application to NHS CT for ICS based funding to support a programme of Digital support across the City, we expect to receive an update from this application in July 21.

3.4 Applications

There have been 15 approved applications to charitable funds since the beginning of 2021, including:

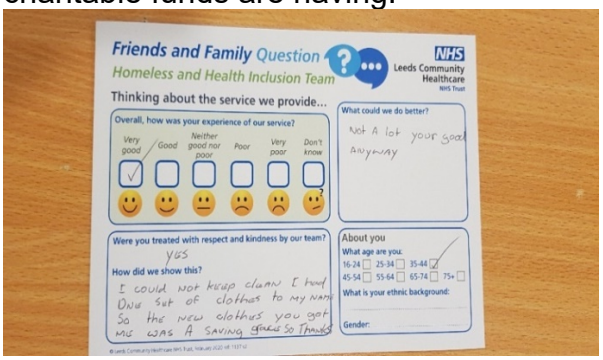
- Netflix subscription for CAMHS inpatient facility
- Winter Arts and Wellbeing Week for Trust staff provided online
- Farewell gifts for staff moving to LYPFT
- Fridge for a service user in need
- Sensory pod for CAMHS patients
- Furniture for a 'Take 5' room for Meanwood Neighbourhood Team
- Summer activities equipment for the children at Hannah House
- Play equipment and toys for the ICAN service (funded by an external grant)
- Coffee machine for staff at ICAN service
- Sensory and AV equipment for Hannah House
- Basic items (personal hygiene etc.) for homeless service users through Homeless & Health Inclusion Team

- Third round of staff lunches / fruit / refreshments
- Wellbeing packs for staff in the Podiatry Service and the Diabetes Service

The total amount of charitable funds approved for 2021 to date is £36,880. Increasing the number of applications to charitable funds is an ongoing aim of the charity which is being pursued through raising the charity's visibility across the Trust by improving communications.

3.5 Impact

Feedback has been received and photos have been supplied from various recipients of charitable funds which allow the charity to show the impact that charitable funds are having.



Homeless and Health Inclusion Team

"I applied for the funding so that we could provide essential items to our homeless and vulnerable population. We decided to convert the donation received into vouchers so we could purchase the basics, examples include food/drink, sweet/snacks, toiletries and sanitary items alongside basic clothing such as underwear, shoes, warm layers and hats/gloves.

We do not give the vouchers to our clients however we will purchase items they request. These have been hugely beneficial already in providing our patients with much needed basics, but also dignity and respect in allowing them to request items that are size appropriate rather than provide donations.

We initially had £600 and have used approximately £200 to date with an anticipation of providing extra clothing now the weather has reached severe weather protocol temperatures."

LCH Youth Board Hoodies

Community Diabetes Service

“Well the feedback has been fantastic! I made everyone a "pack" and they had something to open each day over the week. We started with a thank you card and stress ball on Monday, then Tuesday was some stationery, Wednesday was "Wellbeing Wednesday" everyone received a fancy hand cream, bath bombs and relaxing tea bags, Thursday was "Treat Thursday" which was a box full of biscuits, chocolate and sweets. I almost ran out of money by Friday, so this was a personalised thank you card with a hand sanitiser and some biscuits. The feedback I had was that it was very appreciated.”

CAMHS Inpatient Facility

“Having the Netflix account in particular has been super helpful for the service. As you can image a streaming service is somewhat of an essential item for the young people in today's society and was a particular source of comfort for one of our young people. She struggled with communication and unfortunately our WiFi wasn't good enough for her to use her personal games console, so using the Netflix account was an option for her to watch things that she was familiar with whenever she wanted. Netflix also brings with it the option to pause, go back or re-watch things - again a luxury our young people take for granted but we don't. It helps to avoid distress in our young people being able to pause what they are watching to provide a medication intervention or have a discussion, which again helps build relationships. We have some recommendation charts in the service that we discuss each morning as part of our community meeting, on for what to read, another for what to listen to and another what to watch. It really helps to bring the community together when we have had a recommendation for something to watch on Netflix and it's then something our young people and staff can watch together. Our OT also organises movie nights sometimes where our young people watch a movie together and discuss it. As I've said, it's really helped with the sense of community and normal life (particularly during lockdown).”

3.6 Yorkshire Three Peaks Challenge

The main fundraising event planned by LCH Charity is the Yorkshire Three Peaks challenge, taking place on Saturday 26th June. 38 walkers and runners made up of staff and their family / friends are taking part and most participants plan to fundraise for the event. Each participant has paid a £10 registration fee which has covered the majority of expenses including t-shirt printing and walkie-talkie hire. To date £580 has been raised across the Team LCH fundraising page and individual team member pages. Our fundraising target for this event is set at £5000 and it is expected that much of this will be raised on the day and in the days immediately before and after the event.

Several donations have been sourced to support Team LCH during the event including 200 t-shirts from Nutmeg at Morrisons; 100 energy bars and 100 bottles of water from Asda; and 6 compasses, 4 whistles, 4 emergency shelters and 5 first aid kits from Cotswold Outdoor. Photos will be taken of the team using the donations during the event so they can be shared in the donator company newsletters and on the LCH website / social media / intranet.

A competitive quote was sourced and the LCH Charity t-shirts have been printed, with 50 being for the Three Peaks event participants and volunteers, and 150 being printed with the charity logo. Having these t-shirts is an asset because it enables

individuals and groups to fundraise in the future while promoting the charity at the same time. If staff attend events or visit locations in the community, they can also be worn to strengthen the LCH Charity brand.

x 50

x 150

3.7 Other fundraising plans

The NHS Big Tea is planned for Monday 5th July. This is a nationwide annual event to celebrate the NHS 73rd birthday. Teams across our Trust are being encouraged to hold (Covid-secure) gatherings either in person or virtually to enjoy a break and a cup of tea together. Staff can use this opportunity to fundraise if they wish, however they are not being expected to. A social media plan has been put together to publicise the event externally and groups in the community are being encouraged to have their own Big Tea events to raise money for LCH Charity. LCH Charity are planning a Trust-wide virtual event (e.g. cake competition) to raise money and visibility.

Enquiries are currently being made with local schools to explore potential Big Tea related fundraising activities, such as non-uniform days, and Community Champions in local Morrison's stores are being contacted to organise children's, 'design a teapot', competitions. It is anticipated that having the Big Tea as a theme will help LCH Charity make these links in the community and boost our fundraising efforts.

A program of events during the Autumn/Winter period is in the early stages of development with an abundance of ideas being put forward at the most recent Operational Group meeting. These will be explored in greater detail at the next Operational Group to ensure that momentum is maintained following The Three Peaks and The Big Tea.

4 Next steps

Priorities for LCH Charity going forward are:

- **Demonstrating impact:** Gathering more feedback using different formats (e.g. video and audio) to continue to demonstrate impact
- **Fundraising:** A target of £10,000 has been set for the end of 2021 and a calendar of events is currently being planned to take the charity through to Christmas.
- **Raising our profile:** Planning for a promotional video is underway to share at Trust induction and to promote the charity both internally and externally.

5 Risk and assurances

Funding for the Charitable Funds Administrator post is in place until October 2021. There is a risk that if this post is not continued or developed the work of the charity will not be sufficiently sustained in the future.

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (39b)

Title: Audit Committee Chair's Assurance Report 23 July 2021

Category of paper: for assurance
History: Not applicable

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

Meeting summary

Internal audit

The Head of Internal Audit reported that their opinion was one of reasonable assurance given that there were adequate and effective risk management and internal control processes to manage the achievement of the Trust's objectives. They also stated that whilst they haven't completed all the planned work due to the pandemic, this had not impacted on their overall assessment.

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. These were Estates (limited assurance), Children's Safeguarding (substantial assurance) and the Data Security and Protection Toolkit (part two) which gave an overall confidence rating of high and an overall risk rating of substantial. It was confirmed that the two amber rated standards within the Data Security and Protection Toolkit report would be concluded by the submission date.

The Committee received an update on progress with the actions identified in previous internal audits. The Committee concluded that satisfactory progress was being made.

Annual Audit Letter (External audit – KPMG)

KPMG provided an unqualified opinion on the financial statements and use of resources (VFM). There were no high risk recommendations arising from their 2020/21 audit work. There were no audit differences reported or significant weaknesses and the auditors made no recommendations in respect of management action.

Counter Fraud

The Committee received the Counter Fraud annual report 2020/21. The report concluded that no potential frauds were subject to investigation that met the materiality threshold for referral to the Trust's external auditors. There had been no fraud referrals during 2020/21. The Trust had completed its self-review tool for 2020/21 and submitted its rating to the NHS Counter Fraud Authority prior to the 31 May 2021 deadline. Two standards were rated amber (partially met): (1) completing fraud bribery and corruption risk assessments, and (2) having a system for recording and reporting identified loss. One standard was rated red (not met): processes for identifying and reporting on annual outcome based metrics. This is a new standard and compliance against this will be progressed in 2021/22.

Security annual report

The Committee received the annual report on the Trust's security management arrangements. This was presented by the Local Security Management Specialist (LSMS) and detailed the types and management of security related incidents. There were fewer incidents reported during 2020/21 and fewer home visits were deemed necessary. The report concluded that this was due to the effects of the pandemic on services and how they were delivered during this period. The Committee recognised the valuable support that he provided to staff regarding risks and incidents and the proactive work he carried out.

Information Governance Report
The Head of Information Governance & Data Protection Officer attended the meeting to present the report. It was confirmed that the Trust has progressed an action plan to ensure the Trust complies with the EU's requirements to ensure data can safely flow between the UK and EU. This action plan is near to completion.

The report provided some analysis of information governance incidents and the Committee explored the incidents causes described in the report as well as ways of mitigating the risk of future occurrence. The most common incident was incorrect recording of patient information in clinical systems.

Charitable Funds annual report and accounts
The Committee was provided with the Leeds Community Healthcare Charitable Trust and Related Charities draft annual report and accounts for 2020/21 together with the findings of the independent examination. The independent examiner noted there were no significant weaknesses and the Committee will recommend the adoption of the accounts by the Charitable Funds Committee at its next meeting.

Standing Orders/ Standing Financial Instructions
The Committee reviewed the proposed amendments to the Standing Orders and Standing Financial Instructions and agreed to recommend that the Board approves these at its meeting in August 2021.

Board Assurance Framework (BAF) review of process
The Committee evaluated the effectiveness of the Board Assurance Framework process that has been in place since September 2020 and agreed that the revised process was robust and effective.

The Audit Committee has been assigned BAF risk 2.4: 'If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber-attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage'. The Committee reviewed the sources of assurance presented at the meeting for this risk (sources included Information Governance Report, Data Security and Protection Toolkit (part two), Information Governance Group meeting minutes (2 sets)) and agreed that collectively they provided **reasonable** assurance that the risk was being managed.

Trust Board Meeting held in public 6 August 20921:

Agenda item number: 2021-22 (39ci)

Title: Quality Committee Chair's Assurance Report 21 June 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 21st June 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:

Escalation of key issues from QAIG

A verbal update was provided by the Executive Director of Nursing and AHPs on the most recent workshop which focussed on learning and development. The primary area being progressed is how we get more students (Nurses, AHPs, Medical) in to our services through new and creative approaches to placements across LCH and Primary Care.

Closed culture progress

A verbal update was provided by the Executive Director of Nursing and AHPs around ongoing work in to identifying and addressing closed cultures across the Trust. This will include some slight amendments to the Quality Walk questions as well as changes to the performance and workforce dashboard to support triangulation of data to raise early indicators, with an anticipated timeframe of 2-3 months. An update will be provided at the September Committee.

Covid-19 update including Delta variant update

An update was provided by the Executive Director of Operations. Positive cases in Leeds are increasing with the biggest growth of transmission in 17-24 year olds. An enhanced testing and vaccination approach is being employed to address the deficit in unvaccinated individuals in cohorts 1-9, specifically in areas of deprivation, in addition to over 18's age group. There is no significant impact on hospital admissions at present and the current evidence is showing the second vaccine is fundamental in preventing admissions. Elland Road vaccination centre will be closing on 31st July and will be replaced with pop up / satellite centres.

Reset and recovery update from last month

The Committee received a verbal update from the May position from the Executive Director of Operations. The key issue noted was that an extended performance panel was scheduled for 9th July to focus on each service backlog position. The Trust has set an ambition to have all backlogs cleared by September if possible before heading in to winter, but definitely by the end of the calendar year. A more detailed update will be provided at July Committee.

Adult Speech and Language Therapy: The Speech and Swallowing Team spotlight

The Executive Director of Nursing & AHPs introduced the presentation by the Adult Speech & Swallowing Team. The service presented an overview of the citywide service, nature of referrals, how the team are meeting the challenge of seeing urgent patients and the ongoing challenges. Referrals are triaged through a clinical prioritisation tool in to urgent or routine categories, defined by medical risk. Urgent referrals have increased through 2020/21 and on review of capacity and demand shortfalls in relation to the 2 week response time for urgent patients and 6 weeks for routine were identified. Collaboration with Business Intelligence enabled a detailed

exploration of data to support a successful response to urgent referrals. However it was noted that the team continues to be challenged by the capacity to see the routine demand. Initiatives including re-referral for patients who have deteriorated so they are seen on an urgent pathway and duty line for care homes have been implemented. Further conversations to be taken forward with the Executive Director of Operations in relation to 52 week waits, productivity and efficiency in the service and feedback will be provided to the next Committee.

Risk register
The report was presented by the Company Secretary acknowledging that 3 new risks have been added since the May report. The limitation of phone lines going in to Leeds Sexual Health service has resulted in a number of calls not being answered, this is expected to be a transient risk as a new telephony system is being put in place. Likewise an update was provided by the Executive Director of Nursing & AHPs identifying the issue with PCMIS in LMWS is an expected transient risk.
In addition there are 2 de-escalated risks and 2 escalated risks, 1 related to increasing demand on the Diabetes service and 1 related to demand on the Adult Speech & Language Service as heard in the spotlight.

Safeguarding strategy update
The update report was presented by the Executive Director of Nursing & AHPs and the Committee was joined by the Head of Safeguarding as we embark on National Safeguarding week 2021. The positive work of the team over the past 6 months has been recognised. Currently the Trust has 22 people trained and able to offer safeguarding supervision training to adult services and this number of trainers needs to continue to increase. Clarity was again provided that the geographical changes in Children's Looked After service areas has had no detrimental effect on Children and service provision is maintained by the most appropriate geographically located service.

Recommendations
The Board is recommended to note this information.

Quality Committee assurance levels – to be determined at the meeting

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?**	• QAIG summary report • Risk register • Safeguarding strategy update	Reasonable assurance	Safeguarding strategy update provided a continued level of substantial assurance
Risk 1.2 Are there **sufficient clinical governance arrangements in place for new care models?**	• No information presented to this meeting	N/A	
RISK 1.3 Is the Trust maintaining **and continuing to improve service quality**?	• Reset and Recovery update • COVID19 update • QAIG summary report • Adult SALT urgent referral pathway	Reasonable assurance	Limited assurance was provided in relation to the Adult SALT pathway from today's conversation. Additional information has been requested for next Committee via the Executive Director of Nursing & AHPs and Executive Director of Operations which will also reflect and be updated within the existing risk
RISK 1.4 Is the Trust **engaging patients and the public effectively?**	• No information presented to this meeting?	N/A	
RISK 1.5 Is the Trust's **altered (COVID19) capacity affecting the quality** of service delivery and patient outcomes	• Covid-19 update • Reset and Recovery update	Reasonable assurance	

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22(39cii)

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

Category of paper: For Assurance

History: N/A

Responsible director: Quality Committee Chair

Report author: Quality Committee Chair

Executive summary:

This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 26 July 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:

Recommendations
The Board is recommended to note this information.

Community Cancer Support Service (CCSS)
The Committee meeting was attended by managers from this relatively new service. They explained that it had been commissioned by the CCG and McMillan initially for two years. This is the Trust's first partnership with McMillan. The CCSS acts as a key link between primary, secondary and third sector services to bring together services for patients in a more integrated and targeted way. The Committee was keen to understand the approach taken to select the geographical areas for this new service, and suggested that data could be looked at in a number of other ways to determine need. The Committee recognised the huge benefits that this kind of collaborative service brings to people with cancer, and could bring to others with long term conditions.

CQC improvement plan
The remaining actions on the CQC improvement plan have now been completed.

Annual Medical Directors report (including statement of compliance)
The Committee reviewed the information supporting the statement of compliance and agreed to recommend that the Board approves its submission.

Asymptomatic testing report
NHS England/Improvement wrote to all NHS trusts on 29th June 2021 to advise them of the new system for lateral flow device distribution for asymptomatic staff testing and to instruct trusts that they must monitor compliance with testing regimes. The Quality Committee is monitoring compliance on behalf of the Board. An update was provided on progress with the transfer from our in-house testing system to the national testing system. Staff compliance* with the required testing regime was also reviewed and it was explained that there were medical reasons why some staff were unable to comply. Where this is the case, a risk assessment is conducted and staff are allocated appropriate duties to ensure that patient safety is not compromised.
*A verbal update will be provided at Board by the Chief Executive.

Safe staffing report
The report is based on a statutory requirement to assess inpatient units and determine if they are being staffed safely. As the Trust has few inpatient units, the report has been expanded to include all our community services. The Committee acknowledged that essential care was being provided, however it was agreed that the report gave a limited picture. The Committee asked for more information to be provided at the next meeting in order to triangulate this assessment of safety with other sources of information.

Performance Brief
The Committee was pleased to see more granular detail in the Performance Brief regarding business unit incidents. The recent move to bi-monthly Performance Brief production provided more opportunity to focus on themes and learning. The Committee discussed the increased number of no and low harm incidents at Wetherby Young Offender's Institute, the number of pressure ulcers that had occurred due to our services lapses in care, which was an improving situation, and the ongoing work to reduce the frequency of medicines management incidents. The Committee was advised that the Friends and Family test had been translated into the five most common languages spoken in Leeds to improve engagement with the communities we serve.

Patient Safety Report
This themed report provided themed information about learning from incidents and provided a an update on the work done to implement the Patient Safety Strategy. The Committee was pleased to note the work being done jointly between the Trust and Leeds Teaching Hospitals Trust to understand and reduce the number of discharge incidents reported. The Committee discussed the early warning signs for service issues and agreed that the recently reinstated Quality Walks would support this.

Quality Strategy
The Committee reviewed the draft Quality Strategy and were supported of it being presented to the Board in August 2021. It was recommended that engagement with the public and staff should flow throughout the document and this will be included in the version presented to the Board.

Trust Priorities 2021/22 – quarterly position
The Committee received an update on progress with the Trust's priorities. The Committee requested that in future reports, measurements for improvement should be included in order to provide greater assurance. The Committee discussed the current take-up of the Covid vaccine and were given further examples of how the City was providing additional and varied walk-in opportunities for people to receive their vaccines.

Safeguarding Annual Report 2021/21 (draft)
The Committee reviewed the annual report in draft prior to the Trust Board receiving this at its August 2021 meeting. The annual report provided information about the Safeguarding Team's achievements and challenges in 2020 – 2021 and outlined key ambitions for 2021-22. The Committee was content with the information provided in the report.

Risk register
The Committee discussed the newly recorded risk concerning compliance with the changes to National Standards of Healthcare Cleanliness. The Committee was advised that the Trust would need to invest in a further layer of assurance to monitor compliance.

Quality Committee assurance levels

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?**	• Performance Brief (effective) • QAIG minutes • Clinical Governance report • Risk register • Mortality Report • Medical Directors Annual Report • Safe staffing report • Clinical audit annual report • Patient experience 6 monthly update	Reasonable	The statutory safe staffing report provided limited assurance as it currently isn't triangulated with other information.
Risk 1.2 Are there **sufficient clinical governance arrangements in place for new care models?**	• Community Cancer Support Service	Reasonable	The service is still in the early days of delivery, but has made an impressive start.
RISK 1.3 Is the Trust maintaining **and continuing to improve service quality**?	• Reset and Recovery update • Covid update • Performance Brief (safe) • QAIG minutes • Clinical Governance report • Community Cancer Support Service • Serious Incident 6 monthly report • CQC Quality Improvement plan • Research & Development strategy update • Patient experience 6 monthly update • Safeguarding Committee minutes	Reasonable	
RISK 1.4 Is the Trust **engaging patients and the public effectively?**	• Performance Brief (caring) • QAIG minutes • Patient experience 6 monthly update • Clinical Governance report	Reasonable	
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 • Performance Brief • Clinical Governance report • Serious Incident 6 monthly report • Process for reporting asymptomatic testing • Community Cancer Support Service	Reasonable	The asymptomatic testing process paper provided limited assurance however the discussion surrounding the paper provided more assurance.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (39di)

Title: Business Committee Chair's assurance report 23 June 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 23 June 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 / reset and recovery update
The Committee received an update on the local situation including the current increased infection rate for Leeds, the number of patients locally in hospital with this disease, and the latest information on the vaccination programme.

The Trust has allocated some non-recurrent funding in order to clear services' backlogs by the end of the year. All services had submitted plans on how to achieve this. The backlog situation for the Podiatry service backlog remained a particular concern exacerbated by a recent commissioning decision on service scope. A dashboard of current waitlist information would be presented to the July 2021 Business Committee meeting.

Seacroft Business Case
The Committee considered a business case to address condition and functional suitability issues at Seacroft Clinic, alongside a request from Leeds CCG that LCH consider surrendering its lease of rooms at Park Edge Clinic to them, to facilitate primary care expansion. The Committee was supportive of the option for a full refurbishment of Seacroft Clinic with the clinical space reconfigured to increase its capacity and patient flow. The Committee gave its approval for spend on fees and surveys to allow detailed design work and tendering to proceed. It will also recommend to Trust Board that the remaining capital implications of the scheme be supported over two financial years as set out in the Financial Case. The business case will be presented to the Board in August for full approval.

Premises Assurance Model (PAM)
The NHS Premises Assurance Model (PAM) is a governance tool that allows NHS organisations to better understand the efficiency, effectiveness and level of safety of estates and facilities (and related) services, including how that links to patient experience. This year Trusts are required to complete the safety and patient experience elements of the model, with a deadline by 23 July. The Estates Team took the lead the collection of data and the scoring process and presented the current version to the Committee. It was noted that there were areas which still required responses as well as areas that required improvement. The PAM was very acute trust focussed and not all sections were completely relevant to this Trust. The Committee had some concerns about the gaps in evidence in the PAM however the Committee was advised that more work was being done to remedy this situation and further information would be presented to the Committee in due course.

Estates Audit
The purpose of the audit was to provide assurance that the organisation has robust controls in relation to the maintenance of its buildings. The concluding audit opinion was that assurance was limited with seven important and one routine recommendation. These concerned documented compliance with water quality monitoring, gas safety, asbestos management, fire and electrical safety remedial

actions, and evidence of leased properties' compliance. The Executive Director of Finance and Resources provided the Committee with details the actions that would be taken to remedy the gaps highlighted in the estates audit. The Committee noted the short timescales allocated which should ensure that this work is completed quickly.

Risk report (IT/digital focus)
The Committee received the risk register report which had a particular focus on IT/digital systems risks as this had been identified as a theme in the May 2021 Board and Business Committee risk register reports. The Assistant Director of BI, Clinical Systems and IT was in attendance to discuss the IT/digital systems risks and the mitigation that was being put in place. The Committee was advised about the new telephony system that was being installed, which would have better functionality and would also be able to monitor demand and support callers. There was an ongoing recruitment campaign for more IT helpdesk staff, laptops were now being advance-ordered so that they could be quickly allocated to new staff and improvements to smartcard processes were being introduced. There was also progress towards an arrangement with Leeds City Council to provide some out of hours IT support. The Committee was explored possible additional sources of assurance that could be provided once the new telephony system was in place.

Internal audits scope
The Committee received details of the audit scopes for this year's internal audit programme and how they aligned with the strategic risks on the Board Assurance Framework. The Committee asked that Directors and the Trust's internal auditors work together to ensure that there is consideration of the relevant strategic risks when setting the scope of each audit to support the Board Assurance Framework.

Workforce Strategy 2021/25 update
The Committee received an overview of the next Workforce Strategy (2021/25), which is currently being drafted as well as a look back at the previous strategy (2019/21) and the measureable outcomes that have been achieved. The Committee was keen to be involved in the shaping of the new strategy's priority areas. It also agreed that productivity and agility should also be key features of the Workforce Strategy, and the main focus should be on enabling staff to deliver high quality care. The first draft of the 2021/25 Workforce Strategy will be presented at the August 2021 Board meeting.

Future reporting – change programmes
The Committee recognised the need for the move towards agreed governance structures and regular reporting for critical change programmes, to bring together information, including hotspots, about the various projects involved in these programmes. More information and discussion is to be scheduled for the October Committee meeting.

Recommendations
- The Board is recommended to note the assurance levels overleaf

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 2.6 Is the Trust investing in and creating the capacity and capability to respond to the increasing dependency on digital solutions?	• Operational and non-clinical risk report (with focus on digital)	Reasonable	Measures to improve IT support services, which is a challenging and pressured area, are being worked on and are providing mitigation for this risk.
RISK 3.1 Does the Trust have suitable and sufficient staff capacity and capability and is it maintaining a low level of sickness absence	• Covid update • Reset and Recovery • Workforce Strategy 2021/25	Reasonable	
RISK 3.5 Has the Trust developed and embedded a suitable health and safety management system?	• Premises assurance model • Estates internal audit • Health and Safety Group minute	Reasonable	Some concerns about the gaps in evidence in the Premises Assurance Model but was reasonably assured overall that the Trust's Health and Safety management system was improving.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (39dii)

Title: Business Committee Chair's assurance report 28 July 2021

Category of paper: For assurance
History: Not applicable

Responsible director: Business Committee Chair
Report author: Business Committee Chair / Company Secretary

Executive summary (Purpose and main points)
This report identifies the key issues for the Board from the Business Committee held on 28 July 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 / Reset and Recovery Update
The Committee received an update on the local situation including the current increased infection rate for Leeds, the number of patients locally in hospital with this disease, and the latest information on the vaccination programme.

The Reset and Recovery Report provided a specific focus on the reducing Covid-related backlogs initiatives that are currently underway in the organisation. The Committee was informed of the ongoing cross- cutting patient flow and prioritisation programme of work. A summary of the service level plans, and current progress was also provided to the Committee. In the first instance services were being asked to clear backlogs by the end of the calendar year, however there was flexibility to extend this to the end of the financial year if required, the key being the availability of staff. The Committee received assurance that there was sufficient mitigation in place to keep patients safe if they were waiting for appointments. There were risks to clearing the backlog: namely recruitment issues and these were being worked through.

Performance Brief
The Committee recognised that turnover of staff had been artificially depressed during 2020/21 and some movement of staff was now being experienced. Sickness absence was also seeing some increase but not to concerning levels. More statutory/mandatory training topics were now being monitored and services were managing to maintain reasonable levels of compliance. Appraisal levels have been impacted by intense service pressures. Staff and managers are being encouraged to conduct short, focussed appraisals as this is important for staff wellbeing and development.

The Committee discussed how the waitlist information in the Reset and Recovery item should be incorporated into the Responsive section of the Performance Brief but agreed that a standalone report on waitlist concerns was currently invaluable given the challenges being experienced by services.

Uncertainty remained about the finance regime for the second part of the financial year, and about the implications of the pay award for Trust finances. The Trust was currently reporting a surplus**.**

Relocation from Stockdale House – Strategic Outline Case
The Strategic Outline Case set out the case for change in relation to proposals around the future 'Headquarters' Building for Leeds Community Healthcare NHS Trust. This change was necessitated due to the Landlord for the existing headquarters building indicating that they planned to terminate all four leases that the Trust has on the building in October 2023. The Committee approved the Strategic Outline Case and the further work that was indicated, which should lead to the development of a Business Case to be presented to Board in early 2022.

Premises Assurance Model (PAM)
The Committee received a verbal update on the NHS Premises Assurance Model (PAM) which has now been submitted to NHS England/Improvement. Further action had been taken since the Committee saw the initial assessment in June 2021 and a further update would be provided as the action plan progressed.

Third Sector Strategy
The Steering Group, wider third sector organisations and Trust colleagues have developed an implementation plan to deliver the strategy. The plan sets out work to be progressed in years 1, 2 and 3, and builds on considerable engagement with the third sector and Trust staff in developing the strategy to identify priorities for action. The Committee heard that there was a lot of enthusiasm within the Steering Group, which had led to an ambitious plan for the Strategy's delivery. The Committee discussed how this work could be prioritised given the pressures on the system and agreed that there were many opportunities to work with the third sector to alleviate such pressure, with the Leeds Mental Wellbeing Service being a great example of this. The Business Committee approved the implementation plan.

Oversight Framework
The NHS System Oversight Framework describes to ICSs, trusts and commissioners how NHS England and NHS Improvement will monitor performance; sets expectations on working together to maintain and improve the quality of care and describes how support to improve standards and outcomes will be co-ordinated and delivered. The set of 81 metrics will be aligned to the five national themes: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability plus a sixth theme: local strategic priorities. Some metrics are not applicable to community trusts. A number of actions are required to ensure reporting compliance and the Committee received initial information on the good progress being made against these.

Health and Safety Compliance Report
This report provided the Committee with information on the current level of compliance with health and safety legislation and policies. It also provided an update on the developments and effectiveness of the Trust's health and safety management system. The Committee recognised that the Trust's health and safety culture needed further embedding in services and that steps had already been taken to begin to address this. The Committee agreed that the management system was now much more robust due to the hard work of the Risk and Safety Team Leaders.

Priorities Report
The Committee received an update on the Trust Priorities for Quarter One. The Committee recognised that whilst times are very challenging, staff have continued delivering high quality care to patients whilst delivering against the Trust priorities. The Committee requested additional evidence of the impact that the various actions described in the report were having on the priorities for future reports.

Recommendations
- The Board is recommended to note the assurance levels overleaf

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 2.1 Is the Trust delivering on its **major change programmes**?	• Reset and recovery programme • Stockdale House strategic outline case • Trust Priorities update	Reasonable	
RISK 2.2 Is the Trust delivering **contractual requirements?**	• Performance brief and domain reports • Operational and non-clinical risks register • Reset and Recovery update (*waiting list heat map*)	Reasonable	
RISK 2.3 Is the Trust **improving productivity, efficiency and value for money**?	• Procurement strategy update (annual) • Financial regime update	Reasonable	
RISK 2.5 Is the Trust delivering on its agreed **income and expenditure** position?	• Performance brief and domain reports (Finance) • Procurement strategy update (annual) • Financial regime update	Substantial	In the context of the uncertainties of the financial regime, the Trust is managing its finances well and there is a YTD surplus
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) • Covid update • Reset and Recovery • Trust Priorities update • Workforce Quarterly report • Safe staffing report	Reasonable	Services are stretched - with the impact of increased demand, higher complexity of care and less staff available in some areas. This is being mitigated through active patient risk monitoring and greater use of bank and agency staff and working with partners.

RISK 3.2 Is the Trust creating and embedding a **culture of equality and inclusion**?	• Performance brief and domain reports (Well-led) • Trust Priorities update • Workforce Quarterly report	Reasonable	
RISK 3.3 Is the Trust **engaging with and involving staff**?	• Workforce Quarterly report •	Reasonable	
RISK 3.4 Is the Trust investing in developing **managerial and leadership capability**?	• Workforce Quarterly report	Reasonable	
RISK 3.5 Has the Trust developed and embedded a suitable **health and safety management system**?	• Health and Safety Compliance Report • Performance brief and domain reports (staff safety incidents (Safe) and RIDDOR incidents (Well led)) • Trust Priorities update • Premises Assurance Model (PAM) update	Reasonable	This is an improved picture however further work is needed to fully embed a health and safety culture across the organisation.
RISK 3.6 Is the Trust maintaining **business continuity** in the event of significant disruption?	• Reset and recovery • Covid update • Risk register • Trust Priorities update	Reasonable	The targeted measures described provided assurance that the risk was being managed in the face of significant challenges and pressure.
RISK 4.2 Does the Trust have robust agreements and clear **governance arrangements for complex partnership** arrangements?	• Third Sector strategy update	Reasonable	The Third Sector update demonstrated the good work being done to improve partnership working across the City.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in Public: 6 August 2021
Agenda item number: 2021-22 (39e)

Title: Nominations and Remuneration Committee – 2 July 2021: Chair Assurance Report

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Category of paper: for assurance
History: not applicable

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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting held on the 2 July 2021.

This was a regular quarterly meeting of the committee which had last met in February 2021.

Items discussed:

Chief Executive's and Director Pay Disclosure:
The Committee noted that this had been included in the Trust's Annual Report which had been approved by the Trust Board at its meeting on 11 June 2021.

Chief Executive and Director Appraisal / Performance:
The Committee discussed assurance relating to Directors' and the CEO's appraisal, all of which have recently been carried out, as well as considering any suitable bonus payments as might be payable. In what had been an extraordinary year, all Directors have delivered their objectives to a good standard.

VSM Pay Benchmarking Exercise:
The Committee considered as part of its annual work plan, the available VSM pay benchmarking information noting that updated pay benchmarking and recommendations from the Senior Staff Pay Review Body were due later in the calendar year. This information was noted by the Committee in the context of existing Director salaries.

Extension to temporary policies (introduced as a result of the COVID-19 pandemic):
The Committee approved a further extension to 30 September 2021 to the Trust's Approach to Temporary Changes to Policy, the increase in paid Carers Leave for all staff for this period, and payment of additional hours at plain time for Band 8a and above staff working in the Virtual Frailty Ward.

Proposal to Create a GP Salary Scale:
The paper outlined the rationale for the creation of a GP salary scale and included further data on benchmarking, as well as a more detailed exploration of the need for this salary scale and as requested by the Committee at its meeting in February 2021.

The Committee approved the proposed payment structure for GP employment at LCH initially for a period of 12 months pending review and evaluation of both use and efficacy. The Committee further approved the use of the locum backfill proposal to GP practices for the release of their GPs for work in the community.

Recommendations

The Board is recommended to note this information.

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (40i)

Title: Performance Brief

Category of paper: for assurance
History:
Senior Management Team – 21st July 2021
Quality Committee – 26th July May 2021
Business Committee – 28th July May 2021

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

Executive summary (Purpose and main points)

Performance against KPIs is reported for the first quarter against a backdrop of continued pressure on our services, our staff and our partners in the health and care systems that we are part of. The Board will of course consider this on their agenda. The Performance Brief is presented in this extremely challenging context.

The main points for consideration are on page 2 of the Performance Brief

Recommendations

The Board is recommended to note the performance against KPIs.

Performance Brief – June 2021

Leeds Community Healthcare NHS Trust

Purpose of the report

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

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

Performance against any of the indicators has been adversely affected by the impact of the pandemic on services and the Trust's normal business and this is explained, where relevant.

This report does not seek to describe how service delivery is recovering nor how the current Covid related pressures are having a further impact; that is covered elsewhere on the agenda.

Committee Dates

Senior Management Team – 21st July 2021
Quality Committee – 26th July May 2021
Business Committee – 28th July May 2021
Trust Board – 6th August 2021

Recommendations

Committees and the Board are recommended to:

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

Main Issues for Consideration

Performance against KPIs is reported for the first quarter against a backdrop of continued pressure on our services, our staff and our partners in the health and care systems that we are part of. The Board will of course consider this on their agenda. The Performance Brief is presented in this extremely challenging context.

In the **Safe** domain the continuing reduction in patient safety incidents in the Childrens Business Unit is noted, from October through to March this was due to the change in the patient profile at Little Woodhouse Hall and then its transfer on 1 April. The further reductions in incidents in the first quarter are good news but the numbers will be watched closely to ascertain any post LWH changes in the data. An increase in June in the Specialist Business Unit is accounted for by an increase in no/low harm incidents at the Young Offenders Institute linked to the caseload complexity previously advised to Committees and the Board.

The report shows that where incidents do occur the Trust has the systems and processes in place to learn from them as evidenced by the rapid Review meetings, the Serious Incident investigations and the descriptions of the work taking place in the Business Units.

In the **Caring** section, the fact that the vast majority of patient feedback continues to be positive is noted. The report shows that even where very small numbers of complaints are received, our services take the complaint as an opportunity to learn and improve.

The quarterly report on the **Effective** KPIs notes how the Trust reviews NICE guidance, the impact of the pandemic on achieving full compliance and how risks are assessed where there is only partial or non-compliance. Necessarily during the continued response to Covid, progress in developing and using outcome measures in some services has been slower that had been anticipated. However, it is pleasing to describe how outcome measures have helped services plan future service delivery and how it is now recognised that use of outcome measures across pathways may bring greater benefits.

Board members will already be aware of the Trusts role in the successful £3.4m University of Leeds led NIHR bid which is noted in the report.

Unfortunately, like most of the NHS, the Trust is reporting performance against **Responsive** KPIs well below expectations. Particular issues in Paediatric Neurodisability are reported and the Trust's response in identifying additional locum capacity and in-house changes that will help improve performance.

Continued good performance on the IAPT targets within the LMWS service is welcome.

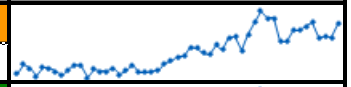
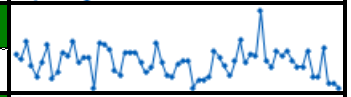
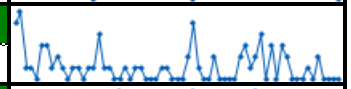
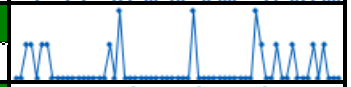
The **Well Led** sections discussed the KPIs where the pressures on many staff's time has led to lower performance on appraisal and training rates. Recovery actions in these areas are explained in the report. A slight upturn in sickness levels is noted but overall, the Trust's continued focus on the health and well-being of its staff during phases of the pandemic is reflected in sustained improvements in sickness levels compared to last year.

The **Finance** section reports a £2m year to date underspend. The expenditure profile is heavily weighted towards the second half of the year as the staffing and external capacity is sought to address the backlog of patients waiting.

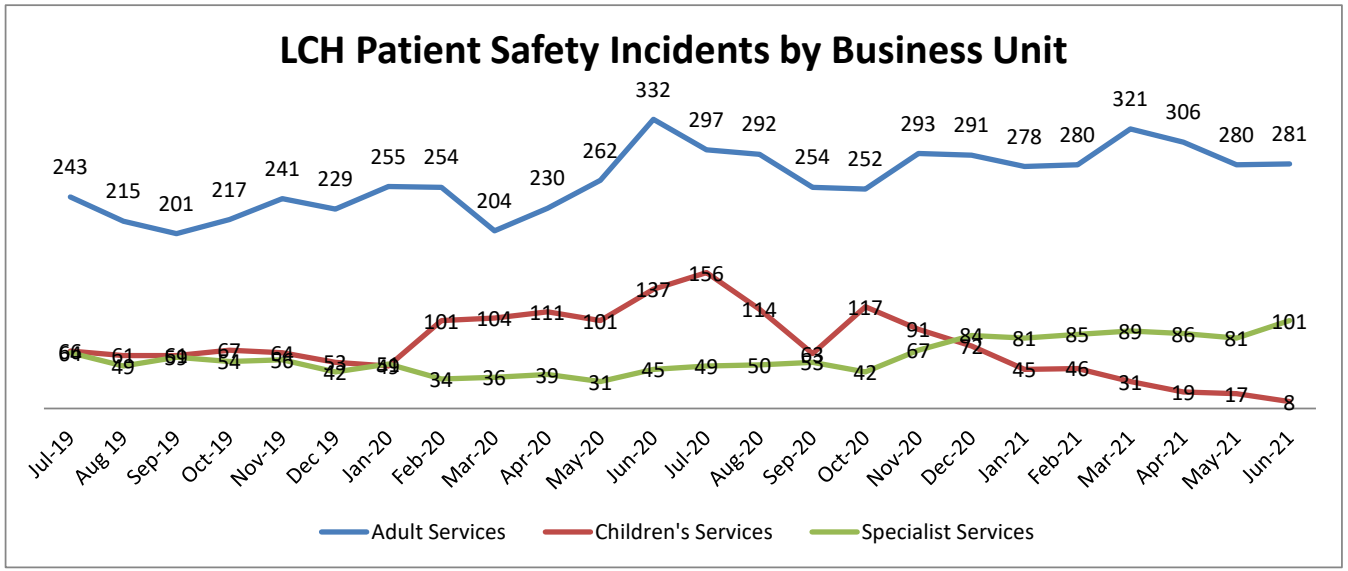
Safe – June 2021

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

Leeds Community Healthcare NHS Trust

Safe - people are protected from abuse and avoidable harm	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Apr	May	Jun	Time Series
Patient Safety Incidents Reported in Month Reported as Harmful	SL	1.06 to 1.73	1.82	●	2021/22	1.72	1.71	2.05	
					2020/21	1.80	2.13	2.39	
Serious Incident Rate	SL	0 to 0.1	0.01	●	2021/22	0.01	0.01	0.00	
					2020/21	0.05	0.04	0.07	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	TBC	0	●	2021/22	0	0	0	
					2020/21	0	3	0	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	0	●	2021/22	0	0	0	
					2020/21	0	0	1	
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	TBC	0	●	2021/22	0	0	1	
					2020/21	2	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	63%			

The Trend of LCH Patient Safety Incidents by Month and Business Unit



During this reporting period, 768 LCH patient safety incidents were recorded in Datix. The Adult Business Unit (ABU) reported 559 (72.7%); Children's BU (CBU) 25 (3.3%) and Specialist BU (SBU) 182 (23.6%).

The decline seen in CBU is due to the change in patient profile of the young people at Little Woodhouse Hall and then the subsequent transfer of the service to LYPFT on 1 April 2021. June saw an increase in low harm / no harm incidents of self-harming behaviour reported in Wetherby YOI, this is linked to the complexity of the current caseload as reported previously to Quality Committee.

LCH Patient Safety Incidents Occurring in May & June 2021

There were 1377 incidents recorded in Datix in this reporting period. Of these, 768 (55.8%) 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	
Jun-21	344 (88.2%)	43 (11.0%)	3 (0.8%)	390
May-21	348 (92.1%)	28 (7.4%)	2 (0.5%)	378

**June figures may be subject to slight change as incidents occurring in the 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 May & June 2021):

There were 71 moderate harm incidents reported. Incident categories are as follows;

- 49 x Skin Damage (39 x Pressure Ulcers, 8 x Traumatic Skin Damage, 2 x device related)
- 14 x Falls
- 2 x Implementation of care
- 1 x Medical Device
- 1 x catheter-related incident
- 3 x Self Harm
- 1 x Access/Appointment/Admission/Transfer/Discharge

Summary of Major Harm Incidents

5 major harm incidents were recorded this reporting period.

- 4 x falls (pending review).
- 1 x Category 4 pressure ulcer reported by the Seacroft Neighbourhood team, a review at the rapid review meeting confirmed the patient was not under LCH care. Information and learning have therefore been shared with the partner organisation and GP.

Rapid Review Meeting Outcomes in May & June 2021

82 incidents were reviewed at the Rapid Review Meeting, chaired by the Assistant Director of Nursing, Assistant Director of AHPs, Head of Clinical Governance or Quality Leads; the outcome is shown in the table 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
82	48 (58.5%)	9 (11.0%)	2 (2.4%)	4 (4.9%)	17 (20.7%)	2 (2.5%)

The learning and good practice from the concluded reviews have been shared with the reporting teams and will be shared more widely where applicable; these are:

- Learning around the Importance of thorough triage of clinical information is required as the potential for a missed opportunity on the day of patient discharge for a community matron review.
- Missed opportunities for reporting pressure ulcer development as a Deep Tissue Injury.
- Lying to standing Blood Pressure to be recorded after 1 and 3 minutes to identify any postural drop.
- Valid consent for care to be completed for all elements of care delivery and updated when there are any changes to capacity/care delivered in best interests.

- Staff to seek advice from Wound Management regarding review of current care, wound management and ongoing pressure ulcer prevention
- Following up on equipment requests.
- Ensure conversations had with the Specialist Tissue Viability Nurse if any deterioration or no improvement was noted.
- To ensure evidence of re-positioning is documented.
- Improve Communication with care homes.

There is noted recurrent themes from learning identified at rapid review meetings. There is an organisational Pressure Ulcer and Falls Improvement Plan via the respective steering groups. Themes are shared from the rapid review into those groups. This process will be strengthened to ensure all themes are considered for the formalised improvement plans required in the future as requirements of the Patient Safety Strategy and Quality Strategy.

Serious Incidents (SI) Investigations May-June 2021

Of the 82 incidents reviewed at the rapid review meeting, four incidents progressed to a serious incident and were reported on StEIS. These are:

- 1 x fall resulting in a femoral mid-shaft fracture reported by Yeadon Neighbourhood Team. Contributing factors included lack of Communication between the hospital and the NT and an absence of a personalised care plan to manage the patients' needs.
- 2 x unstageable PU by Yeadon and Holt Park NT
- 1 x unexpected death reported by Seacroft Neighbourhood Team. This identified learning around escalation of a deteriorating patient. There were also some recurrent themes about infrequent registered Nurse visits and not following the wound infection prevention framework, however, this remains under investigation and the only incident of concern at present.

All four remain under investigation; the learning will be shared in a future SI report

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

The Serious Incident management process has been reviewed within the Clinical Governance Team with the support of the Organisational Development Team. A Standard Operating Procedure (SOP) is in the development process and will be shared with teams for clarity.
LCH was 100% compliant with the Statutory Duty of Candour regulation this reporting period and 3 of the 4 incidents resulted in an initial letter within the LCH standard of 10 days, the final one within 11 days.

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

Business Units Updates

Adult Business Unit (ABU) - Themes

Medicines Management

There were 88 medication incidents recorded this reporting period, 52 in June (compared to 36 in May). Of these, 83 (94.3%) were no harm, and 5 (5.5%) were minimal harm. The predominant category with 70/88 incidents is the administration or supply of medicine from a clinical area. This is followed by monitoring or follow up of medicine use (15) and preparation of medicines / dispensing in pharmacy (3).
The medicine management team has successfully concluded a review of the medicine incidents within the Seacroft Neighbourhood Team (NT), which has led to monthly medicine incidents review meetings with ABU. Due to the success of this model ABU will now adopt this approach to support any neighbourhood team where there is an identified theme around increasing medication incidents. Seacroft NT have experienced a 100% increase in medication incidents from 5 to 10 however, this remains within expected levels for the team which has one of the largest caseloads in the city and a significant proportion of patients with very complex care needs. There is still an overall reducing trend for this type of incident with 45 incidents reported in Q4 20/21 and 24 Q1 21/22. Weekly medicines review meetings will resume within the team. The Quality Lead will provide continued oversight of trends to monitor for a sustained improvement and Medicines Management will increase oversight if required.

Hospital discharge related incidents

Quality improvement meetings are in place with the Director of Nursing at Leeds Teaching Hospitals (LTHT), the Quality Lead (QL) for ABU and the Incident Manager. This has contributed to the decrease in inappropriate hospital discharge incidents seen this reporting period, with 8 recorded May-June compared to 29 in March-April.

Meatal Tears

The identified contributory factors of lack of catheter fixation devices and patient education on hospital discharge have been shared with LTHT. CUCS are updating the SystmOne catheter template to enhance clinical pathways and documentation around initial skin inspections and advice for individuals with catheters. LTHT and CUCS have also developed a patient education leaflet to be given to patients in the hospital whilst preparing for discharge to promote self-care.

Morley Neighbourhood Team

Issues around communication within the Morley Neighbourhood Team have been identified for action. Improvement actions have been put in place by senior managers, including:

- A dedicated day a week for staff via MS Teams to contact leaders for work and social issues
- Protected time for the leadership team to undertake visits with staff
- A team monthly newsletter has been developed
- A new QR code has been introduced to make the Friends and Family test more accessible
- Portfolio meetings have been reintroduced

Yeadon Neighbourhood Team

The Yeadon team completed a deep dive thematic review this month following an increase in Moisture Associated Skin Damage (MASD) incidents. This confirmed that all cases of MASD were correctly categorised with a moisture source identified and appropriate actions taken by the staff. No new learning identified; however, ongoing monitoring by the team will continue.

There has also been a theme identified related to delays with safeguarding referrals. The Named Safeguarding Nurse supports the team with training and supervision and the Organisational, Development and Improvement (ODI) team to strengthen the Clinical Leadership Team. A local improvement plan is in development. This is being temporarily supported by increased monitoring of weekly patient safety incidents with oversight from the senior leadership team and Quality Lead for ABU.

Seacroft Neighbourhood Team

There are some potential early warning indicators for the Seacroft Neighbourhood team reflected in this report. The team is undertaking some work using an evidence-based patient complexity tool to understand how known geographical and demographic data may contribute to high reporting of incidents for the team. Updates will be provided in the next reporting period

Category 4 Pressure Ulcer update

A category 4 pressure ulcer reported as a serious incident in Armley NT in Q4 concluded that those actions arising from daily handover meetings must be allocated to an appropriate responsible lead, and actions must be documented in the patient record and handover log. This will ensure robust monitoring to ensure actions are completed. All patients on caseload to have an identified clinical case manager, which will be reviewed monthly and amended according to clinical need to ensure the most appropriate level of professional oversight is provided for the patient. Effective task management to ensure urgent information is escalated appropriately

Children's Business Unit – Themes

A deep thematic dive performed by the ICAN service identified gaps in the processing of blood samples sent from ICAN to LTHT, including the labelling of blood samples. Plans are now in place to ensure effective communications with partner organisations to ensure best practices are embedded.

Incidents

The CBU reported 25 incidents in May & June 2021; 22 (88%) were no harm, and 3 (12%) were minimal harm incidents; no moderate or major harm incidents were recorded.

To support a good reporting culture, the 0-19 and CAMHS service has contacted the safety team to access further Datix Training, and the Patient Safety Drop-in has been promoted.

A theme of incorrect Datix recording has continued in June, and a meeting will be established to decide the next steps and develop a support plan for the Business Units.

Specialist Business Unit (SBU) – Themes

WYOI
There is a notable increase in incidents in the last two months in WYOI; recommendations and action plans have been created to support improvement. This trend will continue to be monitored. This is related to a group of highly complex young people who are awaiting transfer to mental health beds.

Podiatry
A deep dive exercise covering moderate and major harm incidents has concluded. An improvement plan has been created using the action plan from all incidents reported, including low harm and minimal harm. This plan will be monitored by the service with the support of the Quality Lead.

LMWS
A deep dive has been completed following an unexpected death in LMWS and concluded no lapses in care. However, there are plans to support learning identified around the need for an accurate and complete risk assessment, establishing a competency framework for Mental Health Support Workers and a regular review of Mental Health support workers documentation.

Neuro/Stroke Team
An audit of the postural Blood Pressure (BP) assessment in Community Neurological Rehab Services and Stroke Team identified learning about BP equipment availability and accessibility; enhanced documentation and escalation for follow up when postural BP could not be assessed at an initial assessment and a review of learning needs assessment.

Central Alert System (CAS) Notifications

There were 15 CAS alerts received for the reporting period (see Appendix 2). Three did not apply to LCH, and four were for information only. There were eight alerts for review or action by LCH, seven completed, and 1 has an action being completed for the due date of 19 August 2021 to develop a pathway for the ingestion of super strong magnets.

Medicines Code Assurance Checks

The target runs over a two-year (eight quarter) period, so we are exactly where we would expect to be at the end of the fifth quarter.

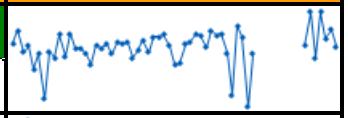
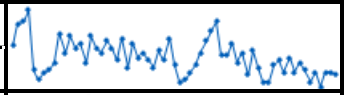
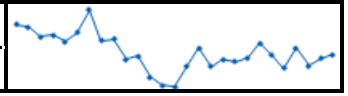
There are six areas were the return was over-due as at 30 June 2021:

- SBU – Community Parkinson's Disease Service – following up with Community Neurology Team to establish restart status and current medicines handling within the service
- CBU – Community CAMHS (Parkside), 0-19 Service x 3 (Thornton, Seacroft & Reginald Centre) – clinical teams prioritising completion during July 2021
- ABU – Woodsley NT (was delayed due to the absence of the Neighbourhood Clinical Quality Lead. Return has since been completed in July 2021)

Caring – June 2021

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

Leeds Community Healthcare NHS Trust

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Apr	May	Jun	Time Series
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%	96.9%	●	2021/22	**96.7%**	**97.5%**	**95.9%**	
					2020/21	-	-	-	
Total Number of Formal Complaints Received	SL	No Target	23		2021/22	**8**	**8**	**7**	
					2020/21	4	4	11	
Number of Compliments Received	SL	No Target	237		2021/22	**69**	**81**	**87**	
					2020/21	40	38	70	

Friends and Family Test (FFT)

Overall, in May and June 2021, 96.26% of Community patients reported their experience as good or very good. 682 total responses were received in May and June as services continue to reinstate the FFT, but this remains low in comparison to pre-covid-19 response rates. Work to increase the numbers of responses is ongoing.
These figures show that the vast majority of feedback is positive, however, the organisation is keen to learn from the feedback that is less positive and some of this is highlighted below.

Feedback received in May and June 21

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.
The service responded – "*The above feedback has been fed back to the service manager and will also be fed back to the team at Meanwood Health Centre. All our telephone appointments are 30 minutes and our face to face appointments are 45 minutes currently, which is longer than before Covid.*

All patients are given an open access appointment and this was recently discussed during a staff meeting, so all staff should now be aware if they weren't before that this is the case. An AccruX template has also been created so that staff can send this out at the end of the initial assessment to patients so they are aware of the next steps in their care and have our contact numbers to hand."

Health Visiting

Negative responses to FFT were received for the 0-19 Public Health Integrated Nursing Service relating to a feeling of lack of support and communication, particularly with new parents. Following similar feedback in recent months, the Patient Experience Team (PET) have fed back again to the service and offered support around engaging and communicating the service offers available with parents and carers where needed.
The service responded – "*We have revised our 0-19 PHINS service offer leaflet so this should hopefully clarify what to expect and when for our parents and carers. This is now also available on our website. We have also increased our social media input to help clarify our current service offer and we will also look into a 'you said we did' poster in order to highlight changes made as a result of parent and carer feedback."*

Health Visiting Inner East team

The Inclusion Nursing Service identified two comments from their FFT feedback this month that could lead to some improvements in ensuring clinical procedures are being carried out consistently by staff. Support has been offered to the service to continue to measure feedback to understand any ongoing themes with the potential for a 'you said, we did' approach demonstrate our learning approach to feedback within our services.

Specialist Weight Management Service

In June, there were 3 poor FFT responses with comments that pertained to service users feeling that a more individual approach is required in relation to diet plans and virtual group sessions.
This has been highlighted to the service Engagement Champion and SBU Quality Lead and we are awaiting a response from the service.

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 team and we are awaiting a response to this action.

Engagement Work

Leeds Integrated Discharge Service

In May, a new service specific survey has been set up for the Leeds Integrated Discharge Service as part of their new ways of working. The service aim to capture patient and carer feedback, and people's experiences of being discharged from hospital and into community care. The aim is to understand what could have been done differently or better. PET will continue to liaise with the service to capture insights and developments as result of feedback gathered.

The Respiratory Service

The service has set up a survey for patients who have not opted into the new Pulmonary Rehabilitation offer, to understand any barriers and to help the service develop the future rehab offer. Work is also ongoing to support both the Cardiac and Respiratory Teams to develop further patient surveys to assess the impact of the home exercise programmes and virtual rehab offers from both services. Feedback captured will be used to help shape and develop future exercise and rehabilitation sessions.

Musculoskeletal Service (MSK)

In June, the MSK Service hosted a Focus Group with service users to review their new service website. Feedback from the group was positive; they felt the information was comprehensive, accessible and information offered around self-management was particularly useful. MSK have also developed a small reader group with service users, who have recently reviewed new service leaflets for clarity and accessibility.

Engagement Champions

The Engagement Champion Celebration event took place in June with 20-30 Champions attending throughout the day. Sessions were delivered by the NHS E/I Always Events team, the LCH Youth Board, PET on Accessible Information Standards and via a patient story from the Leeds Community Pain Service.

Accessible Information Standards

The SystmOne communication template to embed the Accessible Information Standards across the Organisation and to include digital literacy will go live from 19th July 2021. 100% Digital will deliver training sessions to the LCH Digital Champions to support with the implementation of this. Compliance reporting will sit within PIP and on the performance dashboard with an expectation that services who use SystmOne will be fully compliant with the Accessible Information Standards by end of October 2021. Roll out for other patient systems will follow.

Complaints, Concerns and Claims

There were 15 complaints received in May and June 2021. Those for consideration include:

Leeds Sexual Health

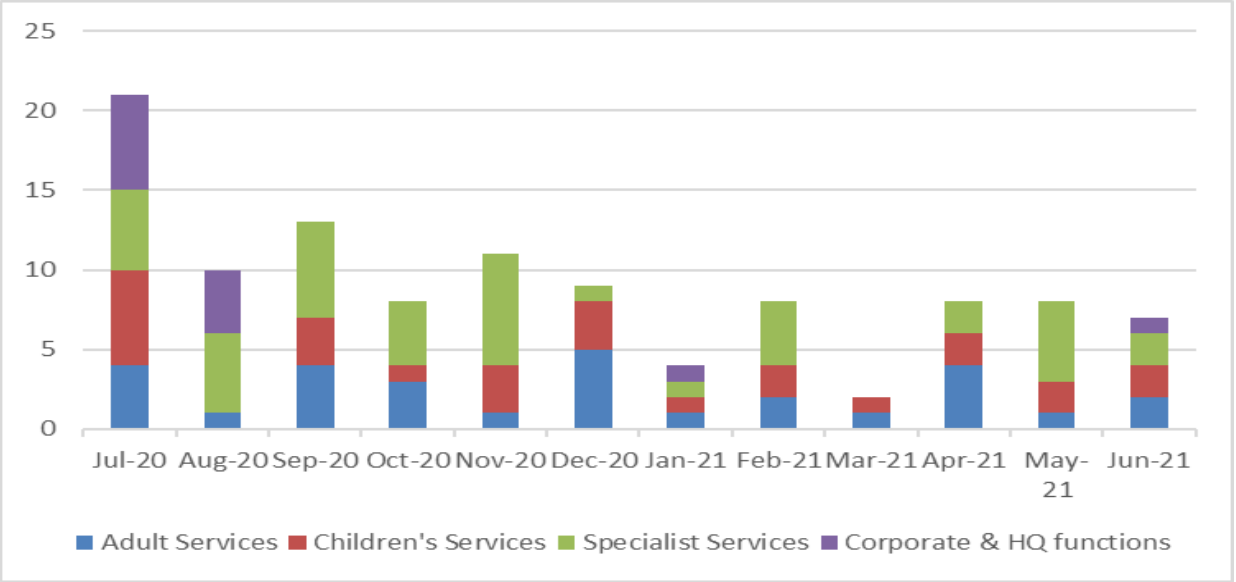
3 complaints were received for Leeds Sexual Health Service; 2 of these relate to ongoing issues with the service telephone line. Risk 1047 has added to the risk register and is being managed by the Business Unit.

Patient Experience Team

A complaint has been raised about the Patient Experience Team following a number of difficult conversations over the telephone and expectations being set with the complainant around zero tolerance to abuse. This is now being investigated by the Head of Clinical Governance.

The Patient Experience Team have received a subsequent interaction with another individual who wishes to pursue a complaint against the Leeds Sexual Health Service, the telephone contact has included abusive language and shouting from the individual directed towards the team. A management plan has been put in place with support from the Security Manager and this will be monitored. PET is reviewing how a Zero tolerance approach is communicated via the telephone line and website to prevent future instances of verbal abuse towards the team.

The graph below highlights the number of complaints that have been received by the Organisation over the last 12 months for comparison.



15 complaints were closed in May-June. Learning and actions identified from these complaints:

Dental service (Reginald Centre)- Complaint related to clinical judgement/treatment and concerns around poor treatment:

- This patient experienced a 6-week delay in his referral. The service will review their pathways and responsiveness; we agree that onward referrals should be included in this process and that referral letters are sent within a maximum of two weeks.
- The investigator will ask the team to be mindful of how they communicate when in consultation with patients specifically when treatments may not meet expectation. This will also include a plan to review communication for people with additional needs and neuro diversity.
- Aspects of the complaint will be taken forward as a point of reflection for future pathways on an individual and group level.
- Safeguarding posters have now been displayed in the dental waiting rooms.

Yeadon Neighbourhood Team- concerns related to the care provided and communication to/with the complainant's father. Several issues raised including provision of equipment, medication queries, visiting times and storage/disposal of PPE:

- A new process has been initiated within the Neighbourhood Team to track and monitor progress with all equipment requests moving forward.
- Staff have been reminded of the importance of recording all conversations in patient records.
- Additional training and guidance are being offered to staff working in our Neighbourhood Teams to improve communication and to support timely and effective referrals to this service.
- Further PPE training and an audit of compliance with the PPE policy is being implemented which will help us to gain assurance of improvement within this aspect of care.
- Staff have been reminded of the importance of establishing appropriate and clear lines for communication with both patients and carers.

- Training and support for the Neighbourhood Teams to specifically encourage improvements with creating personalised care will be implemented.
- We acknowledge that our communication around explaining how care is funded and provided to patients in the community could have been better and this will serve as a point of reflection for us when advising patients and families around the next stages of their care in the future.

There were 87 concerns received in May-June 2021.

15 of these concerns were received by the Leeds Sexual Health Service and the majority related to ongoing issues with accessing the service via the telephone system. The issue has been raised with the project team in May and a query raised as to whether installation of an improved system can be bought forward due to the ongoing impact on patient care and experience and the service are awaiting a response. Current plan for installation is late summer 2021.

The Podiatry service has received 8 concerns throughout May-June from patients and carers, and these have related to delays in treatment, service provision and access to information. All concerns have been resolved, but the increased contact has been highlighted to SBU Quality Lead through the Patient experience monthly workstream meetings. Podiatry have developed an Improvement Plan in response to this and to support learning from patient safety incidents.

There were no other themes identified on review.

Complaint Responses

In May, 3 complaints were not shared with the services within 3 working days. In all instances these were acknowledged with the complainant within 3 working days, but extra time was required to explore with the individuals whether they would like to pursue raising a concern or a complaint. In each case, once this was confirmed the complaint was shared immediately with the relevant services

3 complaints exceeded the internal target of 40 working days to receive a response. Extensions were agreed with the individuals due to the IG team requiring more time to complete a related investigation into an alleged data breach, a delay in receiving patient consent and a response being held by LCH at the complainant's request as they are awaiting the outcome of a Will reading.

Claims

There have been 0 clinical claims received. There have been 0 non-clinical claims received in May- June.

Covid-19

We have received 2 Covid-19 related complaints in June, and 5 Covid-19 related concerns between May-June.

The 2 complaints received in June are both multi-agency complaints with LCH taking the lead on a complaint received by Leeds Mental Wellbeing Service related to a delay in treatment. The second complaint is being led by LTHT and is related to the care provided at South Leeds Recovery Hub; both investigations are ongoing.

Covid-19 related concerns have included queries on service delivery post lockdown, appointment issues and difficulties in communicating with the service. The concerns have been resolved through supporting the individuals to be put in touch with the service directly or the correct information.

LCH Charity

The LCH Charity supported the Yorkshire Three Peaks Challenge which has raised £2,847.86 including Gift Aid so far.

The NHS Big Tea celebrated the 73rd birthday of the NHS and Frontline worker day; some teams across LCH took the opportunity to hold tea parties to celebrate, and the Morley Morrisons were raising money on the day for the LCH Charity- we are waiting to hear the sum raised.

Effective

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

Leeds Community Healthcare NHS Trust

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Responsible Director	Target - YTD	Forecast	Financial Year	Q1
Number of NICE guidelines with full compliance versus number of guidelines published in 2018/19 applicable to LCH	RB	100%*		2021/22	
				2020/21	85%
Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH	RB	No Target		2021/22	
				2020/21	54%
Clinical Outcome Measures - Percentage of services at stage 3; measures agreed and services have access to them	RB	75%*		2021/22	86%
				2020/21	-
Clinical Outcome Measures - Percentage of services at stage 6; using measures with some patients some of the time	RB	60%*		2021/22	48%
				2020/21	-
NCAPOP audits: number started year to date versus number applicable to LCH	RB	100%*		2021/22	100%
				2020/21	0%
Priority 2 audits: number completed year to date versus number expected to be completed in 2021/22	RB	100%*		2021/22	100%
				2020/21	7%
Total number of audits completed in quarter	RB	No Target		2021/22	100%
				2020/21	4%
Percentage of patients recruited into NIHR portfolio studies (CRN Target 700)	RB	100%*	●	2021/22	2%
				2020/21	-

* These are year-end targets; measures are not RAG rated by quarter. The forecast indicates whether we expect to achieve the target at year end.

NICE Guidance

NICE guidance is now reviewed by the Clinical Governance Team and the Head of Medicines.

As reported in quarter 4, the position of paused NICE Guidance from previous years, applicable to LCH is being assessed. The position statement due for the end of quarter one has not been achieved due to current pressures. There are 42 Guidance with partial/non-compliance from 2017/2018 to 2020/2021, 4 of those date back to 2017. Updates from services are pending completion to understand if this is an accurate position.

Since April 2021, 48 new Guidance have been reviewed and 13 distributed to a total of 23 services. Of the 13, 4 were shared to 5 teams for information only, and 9 were shared to the remaining 18 services for a baseline assessment of compliance.

Two teams report full compliance: ICAN for CG170 Autism Spectrum Disorder in under 19s: Support and Management, and Cardiac Team for NG196 Atrial Fibrillation: Diagnosis and Management. Virtual Frailty Ward assessed NG196 as non-applicable on their review. Of the remaining 15, 6 baseline assessments are over 1 month old and therefore overdue.

The overdue position statement from 2017-2021 and overdue guidance for 2020/2021 are escalated via the Quality Lead monthly Business Unit report to the Clinical Lead and via the quarterly Head of Clinical Governance report to Quality Assurance and Improvement Group.

Any risk associated with partial/non-compliance is being assessed as the updates on Guidance are being received.

Outcome Measures

Services have continued to refocus on using clinical outcome measures to help them navigate planning service delivery going forwards. Having established the use of some clinical outcome measures in some services, it has become more technically straightforward for the use of these measures to be shared into other relevant services. With this has come shared learning and building confidence in teams. It is becoming evident that considering the use of clinical outcome measures across pathways rather than in a service specific manner is likely to ensure the greatest shared learning, use of resources, and rigour of use.

Services are considering the use of clinical outcome measures alongside many other imminent priorities (such as reducing backlog); in addition to the challenges services have had prioritising this whilst services stopped or provided a much reduced offer during the pandemic, the speed of progress to the higher levels of the ten-step model has been slow.

Clinical Audit

The NHS Standard Contract requires relevant providers of NHS services to participate in the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

NHS Trusts are responsible for funding a proportion of the NCAPOP costs through a process known as Subscription Funding. Each financial year NHS England publishes a Gateway letter detailing the amount to be paid by NHS Trusts and NHS Foundation Trusts to the Healthcare Quality Improvement Partnership (HQIP) as part of this charge. NCAPOP projects provide a valuable quality assurance function, as well as information to support local and national quality improvement and quality planning. A range of outputs such as national benchmarked reports, case studies and other quality improvement tools are published, which supports the participation of clinical audits that are relevant to LCH service delivery. NCAPOP audits are classed a priority 1 (must do) audits. Audits that are included in the figure are: Sentinel Stroke National Audit Programme (SSNAP), Diabetic Footcare Audit, National Asthma and COPD programme and Epilepsy 12 audit for children and young people.

Research

Although appearing low the research accrual figures for Q1 remain within projected activity plans which do not anticipate even recruitment across the year.

The current performance metric of 700 accruals into NIHR portfolio studies, remains part of the local CRN funding formula, but has been stood down as a CRN HLO. The blunt nature of this metric as a performance measure has recently been acknowledged by the NIHR and seems likely to change over the forthcoming years as measures to better measure a broader range of research delivery experienced within organisations are defined. Research accrual figures suffer from lag each quarter because recruitment at study sites require sponsor validation. The figure including un-validated accruals is 84 – or 12% of target. Slow recruitment to one MSK study (E-Rehab) has caused a service waiting time issue however mitigation measures to speed up recruitment are under way. The recently launched national survey of AHP Research perceptions led by Dr Comer and sponsored by LCH is expected to significantly boost accrual numbers. LCH is currently involved in delivery of 10 studies as a recruiting site and 2 as a Patient Identification Centre (PIC). The R&D team are supporting PIC site activity in primary care for two studies. This is fewer studies overall than LCH is generally used to supporting and reflects the pause in activity and study closures that was required during the pandemic. Unpausing of paused studies is almost complete.

Work continues on CRN funded Strategic project to pilot research delivery and support, working within the Primary Care MoU. The work develops the primary care research delivery model and refines a feasible and innovative R&D “service offer” for Primary care.

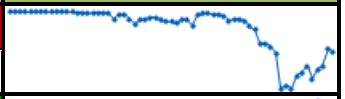
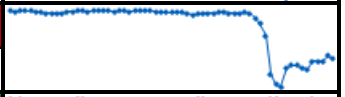
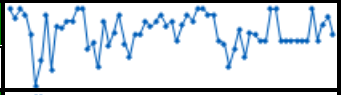
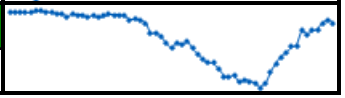
The Covid Rehab service is one of 18 partners (10 NHS and 8 HEI) in a successful University of Leeds led £3.4 million NIHR bid for a two-year research study about Long Covid. This is a high profile piece of work which should prove extremely beneficial for patients in the service and for the development of the service as a whole.

There are staff capacity pressures in R&D team and recruitment is ongoing. Work is continuing on out of hospital primary care support following further CRN strategic funding and work is required to rapidly set up participation within the recently announced, Leeds led NIHR multicentre Long Covid research study.

Responsive – June 2021

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

Leeds Community Healthcare NHS Trust

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Apr	May	Jun	Time Series
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	86.3%	●	2021/22	83.1%	88.5%	87.3%	
					2020/21	89.6%	90.1%	88.7%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	0	●	2021/22	0	0	0	
					2020/21	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	42.4%	●	2021/22	39.2%	44.0%	43.7%	
					2020/21	55.3%	35.2%	24.1%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	76.2%	●	2021/22	74.8%	77.5%	76.1%	
					2020/21	93.2%	86.7%	69.2%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	99.5%	●	2021/22	99.5%	99.7%	99.2%	
					2020/21	99.1%	99.3%	99.6%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	89.6%	●	2021/22	88.7%	91.6%	88.4%	
					2020/21	31.5%	35.6%	45.6%	

Consultant-Led Waiting Times

Performance against the 18-week referral to treatment standard is below expectations. There are 221 patients waiting more than 18 weeks. The majority of these (109) are waiting for Paediatric Neurodisability (PND) appointments. The service has secured a locum to support the reduction in the waits who will commence in August. A review of job plans has also identified further capacity to support PND.

There has been an improvement in the Consultant-led Paediatric Audiology waits with 98.9% of children now being seen within the 18-week standard. This improvement is also reflected in the 6-week diagnostic target for Audiology. Whilst there is still considerable progress to make 44% of children are now being seen within the standard compared to 28% in 2020/21. The waits accumulated during the first wave when the service was paused by national direction.

IAPT

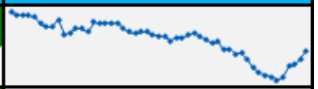
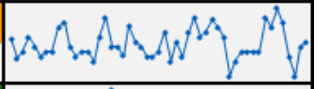
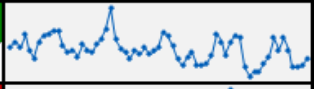
The Leeds Mental Wellbeing Service is commissioned to provide primary care liaison service, perinatal services and Improving Access to Psychological Therapies (IAPT) services. The national targets for the service relate specifically to IAPT. The service is performing well against both the 6-week and 18-week targets

The Business Committee considered a comprehensive paper on waiting lists at the July meeting

Well-Led – June 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.

Leeds Community Healthcare NHS Trust

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Responsible Director	Target - YTD	Forecast	Financial Year	Apr	May	Jun	Time Series
Staff Turnover	LS/JA	<=14.5%	●	2021/22	10.3%	10.9%	11.7%	
				2020/21	11.8%	11.9%	11.4%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	●	2021/22	16.5%	17.8%	18.8%	
				2020/21	18.6%	21.5%	21.6%	
Stability Index	LS/JA	>=85%	●	2021/22	87.0%	86.5%	85.8%	
				2020/21	88.4%	88.5%	88.6%	
Short term sickness absence rate (%)	LS/JA	<=2.2%	●	2021/22	1.7%	1.3%	1.4%	
				2020/21	2.1%	1.7%	1.0%	
Long term sickness absence rate (%)	LS/JA	<=3.6%	●	2021/22	3.0%	3.6%	3.7%	
				2020/21	3.8%	3.0%	3.3%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=5.8%	●	2021/22	4.7%	4.8%	5.1%	
				2020/21	6.1%	4.7%	4.3%	
AfC Staff Appraisal Rate	LS/JA	>=90%	●	2021/22	76.2%	75.0%	72.9%	
				2020/21	84.0%	81.4%	81.8%	
Statutory and Mandatory Training Compliance	LS/JA	>=90%	●	2021/22	89.9%	87.9%	89.2%	
				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	Forecast	Financial Year	Apr	May	Jun	Q1	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		2021/22	**0**	**2**	**0**	**2**	
				2020/21	0	1	1	2	
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%**	**11.3%**	**11.3%**	**11.3%**	
				2020/21	10.5%	10.9%	10.9%	10.9%	
Total agency cap (£k)	BM			2021/22	-	**382**	**308**	**690**	
				2020/21	294	242	213	2546	
Percentage Spend on Temporary Staff	BM	No Target		2021/22	-	**4.2%**	**5.6%**	**4.8%**	
				2020/21	5.4%	4.8%	4.6%	5.0%	

Retention

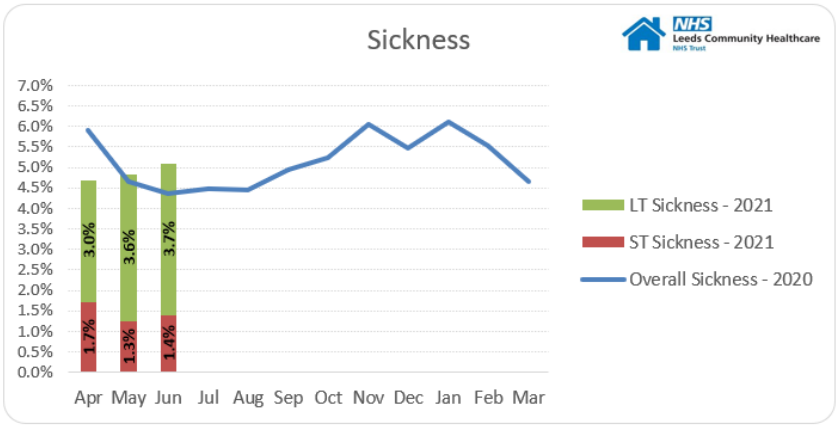
The overall trend continues to be relatively positive with turnover reporting at 11.7% which is below the 2020/21 outturn target of 14.5% but a slight increase on the May turnover figure of 10.9%. Further analysis indicates that turnover has increased in June in the Children's Business Unit (CBU) and which CBU management had anticipated in prior months given resignations received. Staff leaving within the first 12 months of employment has increased further this month to 18.8% but is below the target of 20%. This figure represents a total of 6.4 full time equivalents with half of these individuals leaving from across the CBU.

The most prevalent reason for leaving is promotion and in an increasingly tight labour market where many other Trusts and businesses seeking comparable skills are recruiting this is not unexpected. Nonetheless further work is underway to both understand exit trends as well as work with new starters on retaining their skills within LCH. Additionally, work to maintain workforce stability continues 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 is set out in **Appendix 2.**

Sickness Absence

	Target	Apr	May	Jun
Overall Sickness - 2020	(5.8%)	5.9%	4.6%	4.3%
Overall Sickness - 2021		4.7%	4.8%	5.1%
Adult Business unit - 2021		6.4%	6.6%	6.7%
Children's Business Unit - 2021		4.0%	3.8%	4.9%
Corporate Directorate - 2021		2.3%	1.8%	2.0%
Operations - 2021		3.9%	5.9%	4.7%
PCN Business Unit - 2021				
Specialist Business Unit - 2021		4.0%	4.3%	4.3%



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 continued across all Business Units and Corporate Teams through to April, however both May and June figures have shown a slight increase in sickness absence figures overall. The overall Sickness absence is 5.1% with 1.4% attributable to short term absence and 3.7% long term absence. 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 period. This increase correlates with an increased workload demand across teams (due to system pressures and clearing patient backlogs) as well as capacity challenges as increased numbers of staff catch COVID and / or are self-isolating due to family members' infection, being tracked and traced or school bubbles bursting.

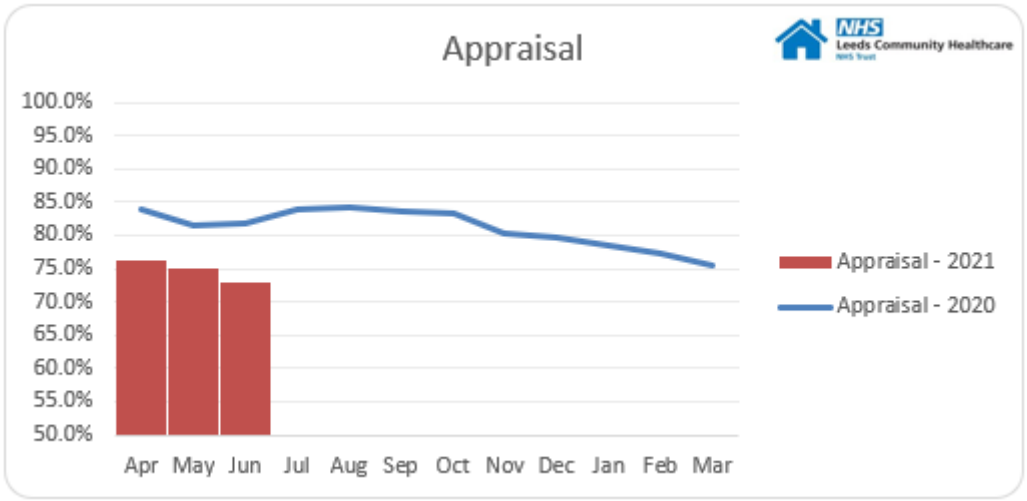
ABU continues to have comparatively higher sickness absence overall currently at 6.7% which we are continuing to monitor and provide support on – this figure has, however, remained largely static over the past number of months. Support is being provided to Operational Leads and their teams and absences are discussed and reviewed on a monthly basis with their HR Business Partner. It is notable this month that absence in CBU has risen by just over 1% to 4.9% with an even split of that rise between short term and long-term absence. Again, there is proactive support and management across the business unit and further analysis underway to understand this rise.

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. A recent report to the Board has outlined the full and comprehensive range of health and well-being interventions that the Trust has deployed throughout the pandemic period and beyond.

Appraisal

The Appraisal position has dropped by **3.3%** over the last two months to an overall compliance rate of **72.9%**

Overall Trust Wide Appraisal Rate – June 2021 data



	Target	Apr	May	Jun
Appraisal - 2020	90%	84.0%	81.4%	81.8%
Appraisal - 2021		76.2%	75.0%	72.9%
Adult Business unit - 2021		63.2%	61.5%	58.3%
Children's Business Unit - 2021		87.6%	86.4%	83.6%
Corporate Directorate - 2021		88.1%	90.0%	86.4%
Operations - 2021		89.1%	88.9%	88.5%
PCN Business Unit - 2021			100.0%	97.0%
Specialist Business Unit - 2021		75.3%	73.1%	72.9%

As of 9th July, we have 753 outstanding appraisals, 153 (22%) of these are new staff who appear not to have had an objective setting meeting recorded in ESR. This has been flagged through Leaders Network.

ABU has the largest number of outstanding appraisals (388) 90% of these are from Neighbourhood Teams which represent 47% of all outstanding appraisals. A meeting has been arranged by the ABU HR Business Partner for the 19th July where a recovery plan will be discussed.

Focusing on SBU (198 outstanding appraisals). Hotspots include - Podiatry and Dental (22%), Neurology and SLT (17%), Leeds Mental Wellbeing Service (12%) and Custody Services (12%). These services make up 62% of all outstanding appraisals in SBU. This analysis has been provided to the HR Business Partner for SBU.

In CBU (116 outstanding appraisals). Hotspots include CAMHS (40%), 0-19 (20%) and ICAN (20%). These services make up 80% of all outstanding appraisals in CBU. This analysis has been provided to the HR Business Partner for CBU.

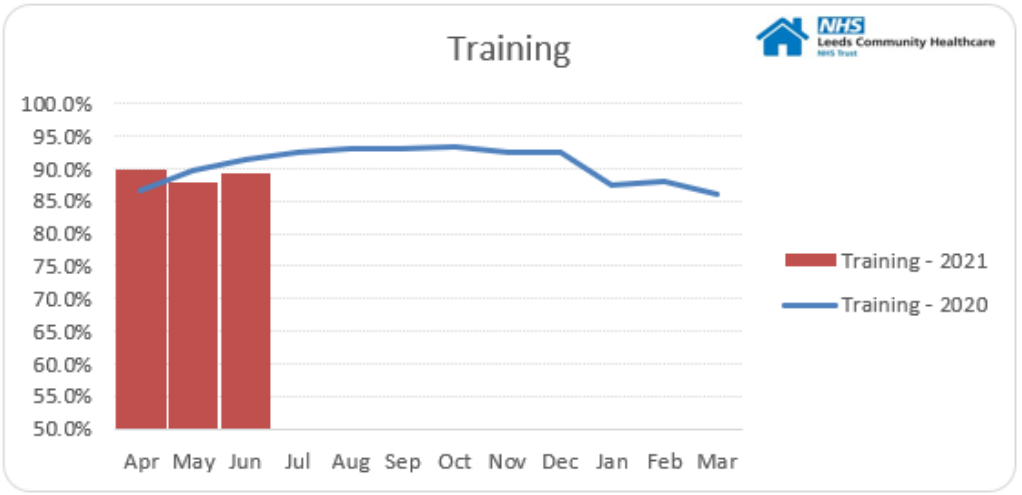
Corporate (32 outstanding appraisals) and Operations (19 outstanding appraisals). Targeted reporting has been provided to Corporate Managers.

Statutory and Mandatory Training

The overall Statutory and Mandatory position has increased by **+1.3%** from May to an overall compliance rate of **89.2%**

Overall Trust Wide Statutory & Mandatory Training Rate – June 2021 data

	Target	Apr	May	Jun
Training - 2020	90%	86.7%	89.7%	91.3%
Training - 2021		89.9%	87.9%	89.2%
Adult Business unit - 2021		84.2%	82.0%	83.5%
Children's Business Unit - 2021		92.1%	90.3%	91.3%
Corporate Directorate - 2021		93.5%	91.5%	93.0%
Operations - 2021		94.0%	93.5%	94.1%
PCN Business Unit - 2021			62.6%	70.1%
Specialist Business Unit - 2021		93.3%	92.0%	93.1%



We are now reporting on all the 13 MaST subjects as defined by the Trust.

We were successful in gaining Skills for Health accreditation across all Core Skills Training Framework (CSTF) subjects, meaning our training as a Trust is meeting the national learning outcomes as defined by CSTF.
Over the next quarter we are focusing on low performing subjects through targeted communication and reporting analysis in partnership with subject matter experts. These include:

- Dementia Tier 2 (current compliance 76%)
- Mental Capacity Act (75%)
- Resus (77%)
- Moving and Handling Level 2 (81%)
- Moving and Handling Inanimate Loads for Leeds Equipment Service (74%)
- Health, Safety and Welfare (85%)

We are also supporting the HR Business Partner for PCN to improve the overall MaST compliance rate for the PCN Business Unit. We anticipate this having a positive impact from August onwards.
We continue to monitor and maintain our high performing subjects all of which are in excess of our 90% target. These include:

- Safeguarding Children Level 1 & 2 (97%)
- Equality, Diversity and Human Rights (96%)
- Safeguarding Adults Level 1 & 2 (95%)

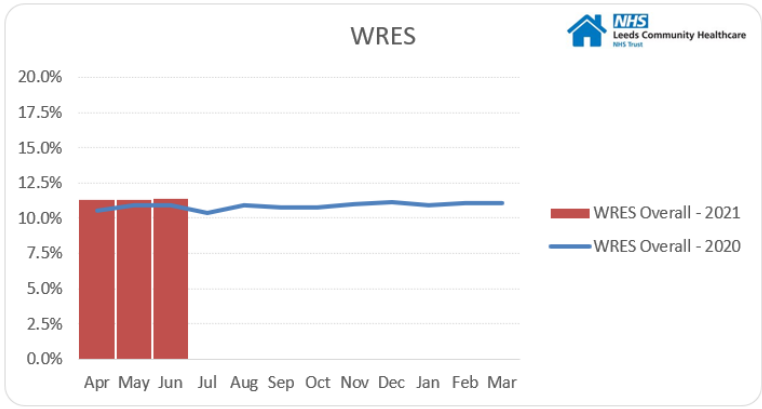
- Data Security Awareness (95%)
- Infection, Prevention and Control Level 1 & 2 (95%)
- Prevent Awareness and WRAP (97%)

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. Please note that figures are based on the 2011 Census data but once the 2020 Census data is published, we will adjust our targets to reflect this more up to date position.

The percentage of BME staff employed in the overall workforce at the end of June 2021 is 11.4% - this is virtually static as compared with April 2021.

	Apr	May	Jun
WRES Overall - 2020	10.5%	10.9%	10.9%
WRES Bands 8-9 - 2020	4.0%	4.0%	4.1%
WRES Overall - 2021	11.3%	11.3%	11.4%
WRES Bands 8-9 - 2021	5.1%	5.5%	5.5%



Work continues on the WRES agenda within the context of that goal that our workforce represents the communities we serve. For example, we are currently working with the WY&H ICS to overhaul the recruitment & promotion process to ensure fairness and equity for all applicants including those from a Black, Asian and minority ethnic background through the six priority actions:

1. Ensuring board executives own the agenda
2. A system of 'comply or explain' to ensure fairness during interviews
3. Talent panels
4. Enhance EDI support
5. Overhaul interview processes
6. Adopt resources, guides and tools have productive conversations about race

In July, the Director of Workforce will be attending the Race Equality Network meeting to present and discuss how the Workforce Strategy & specific WRES actions can improve recruitment and promotion rates in the areas identified using our equality analysis of 3 years of recruitment NHS Jobs data, and

subsequently by the NHSEI WRES teams recently shared disparity ratio data (the disparity ratio is the comparison between the progression ratios for white and BME staff).

Finance – June 2021

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

Leeds Community Healthcare NHS Trust

Finance	Responsible Director	Target - YTD	Forecast	Financial Year	Apr	May	Jun	Q1
Net surplus (-)/Deficit (+) (£m) - YTD	BM			2021/22	-	-1.0	-2.0	-2.0
Capital expenditure in comparison to plan (£k)	BM			2021/22	-	117	80	197
CIP delivery (£k)	BM			2021/22	-	88	44	132

NHS England has decided that the amended finance regime introduced in 2020/21 to support the NHS in dealing with the Covid-19 pandemic will continue through the first half of 2021/22 (H1). At the time of writing there are no further details as to what the funding regime will be for the latter half of the year. Under the current finance regime the Trust's Income and Expenditure revenue plan extends to the end of September 2021 (H1); it is expected a further planning round will be undertaken for H2. The capital and cash plans are for the full 12 months.

Income & Expenditure (I&E) Summary

The Income and Expenditure is planned to breakeven at the end of September (table 1). To the end of June **year to date** expenditure is £2m less than the income the Trust has received leading to a surplus of £2m. This is because the work to recover the backlog waiting lists is timed for later in the year. The **forecast outturn** at the end of September is breakeven.

The Trust continues the work commenced last year to actively collaborate with partners to ensure Leeds as a "Place" delivers its financial obligations for the year whilst managing activity pressures, Covid-19 and reset and recovery costs.

Included within the Income & Expenditure position is £0.3m of Covid-19 vaccination related additional costs; this is matched by additional funding from NHS England, in addition the Trust has £0.2m of additional costs related to Covid measures in place.

There were net 140 vacancies in June this is an increase on 66 on last month. Non-pay and reserves expenditure is £1.5m less than the plan for June; the pay and non-pay budgets includes resource for backlog work.

Income

The Trust is receiving nationally calculated block payments from NHS Leeds CCG, NHS Wakefield CCG (as host of the ICS) and NHS England commissioners. These do not reflect current contractual expectations but are based on historic values adjusted for the Trust's estimated expenditure for the first half of the year. The Trust is receiving £4.5m Covid income in H1.

At the end of June income is in line with planned levels and there is a small underachievement of other income expected by the end of September following updated information from Health Education England in respect of training income.

£336k for income due to the Trust for Covid Vaccination costs incurred has been included in income.

Pay and Non-pay Expenditure & Vacancies

Pay expenditure year to date and forecast is less than planned; this is driven by the levels of vacancies and includes slippage on plans to address back-logs.

There were a net 140 whole time equivalent (wte) vacancies for June.

These fall in the following areas:

Specialist Business Unit	-44 wte
Children's Business Unit	-31 wte
Adults' Business Unit	-51 wte
Operational Management	-1 wte
Corporate	-6 wte
Estates including front of house	-14 wte
Covid	+7 wte

In the main the increased number of vacancies arise from new service development posts and waiting list backlog funded posts being allocated to budget in advance of the posts being filled.

Agency staffing costs to the end of June were £690k of which £308k was incurred in month. There is no agency cap for H1.

Non-pay excluding reserves (table 3), is £268k underspent at the end of June. This is being driven by establishment expenses where there is underspending on planned costs for travel, training and meeting rooms hire; and premises for rent and other estates maintenance costs which are not evenly spread throughout the financial year. This underspending is partially offset by the overspending in the historic CIPs reported in other expenditure, where negative expenditure budgets have been created to reflect required savings, but no actual savings schemes have been identified. The Trust has deployed reserves to support agreed service and waiting list initiatives as these are implemented.

Delivery of Cost Improvement Plans

The national calculated income for the Trust assumes delivery of a 0.5% CIP for H1; this is £265k. The Trust has identified Estates savings to meet this requirement.

Capital Expenditure

The Trust plans to spend £3.7m on capital for 2021/22. This includes:

- £0.7m Estates maintenance and fire safety.
- £1.6m for redevelopment of Seacroft (scheme expected to complete in 2022/23) subject to further Board approval.
- £0.3m clinical equipment.
- £0.7m approved for IT equipment and cyber security.
- £0.3m for the completion of the EPR project.
- £53k to complete phase 1 of the WY e-job planning and e-rostering project.

The capital plan has been approved by the West Yorkshire Integrated Care System (ICS).

Year to date capex is £197k expenditure against a planned expenditure of £662k. The slippage is mostly in respect of IT related expenditure and is a matter of timing. The Trust will review its capital requirements as the year progresses as there is currently a forecast capital resource shortfall across the ICS. The Trust is currently forecasting to spend to its plan and does not expect to be able to have to reduce that to mitigate over-commitments in other organisations.

The capital expenditure is fully financed from depreciation and the Trust's cash reserves.

Cash

The Trust's cash position remains very strong with £44.9m in the bank at the end of the month.

Better Payment Practice Code

The Trust's cumulative Better Payment Practice Code performance has exceeded the 95% target for paying invoices within 30 days for all 4 the measures; the underperformance reported last month has been recovered. The finance team continue to take measures to ensure compliance is maintained.

Appendix 1 – June 2021

All recorded CAS Alerts for May and June 2021

Leeds Community Healthcare NHS Trust

Reference	Date Issued	Action type	CAS Title	Description	Status	Due date	Done date
MDR 015-05/21	17/05/2021	For Action	MHRA Class 2 Medicines Recall: AstraZeneca UK Limited, Bricanyl Injection, 0.5 mg/ml solution for injection or infusion (PL 17901/0112), EL (21)A/12	AstraZeneca UK Limited is recalling the above batch of Bricanyl 0.5mg/ml solution for injection or infusion as a precautionary measure due to out of specification results for a routinely tested known impurity during stability testing.	Reviewed by Medicines, not stocked or supplied by LCH, closed at panel.	24/05/2021	24/06/2021
2021/ 1218	06/05/2021	For Action	Becton Dickinson Venflon Pro Safety Needle Protected I.V. Cannula (ICN 1218)	Becton Dickinson (BD) has identified an issue with specific lots of BD Venflon Pro Safety (VPS) Needle Protected IV Cannulae after identifying an increase in reports of leakage from the injection port.	All actions completed	31/05/2021	07/06/2021
MDR 359-04/21	20/05/2021	For Action	MHRA Class 3 Medicines Recall: Advanz Pharma Carbimazole 10mg and Carbizamole 15mg tablets, EL (21)A/13	Advanz Pharma is recalling the above batches of carbimazole tablets as a precautionary measure, due to an out of specification observation for tablet appearance of samples during routine stability testing.	No action required, assessed by Medicines, closed at panel.	28/05/2021	24/06/2021

CEM/CMO/2021/012	09/06/2021	For Action	Personal Protective Equipment And Heat: Risk Of Heat Stress	Wearing personal protective equipment (PPE) in warm/hot environments increases the risk of heat stress.	Shared in Leaders Network.		
NatPSA/2021/003/NHSPS	16/06/2021	For Action	Eliminating the risk of inadvertent connection to medical air via a flowmeter	Due to the proximity of the	NatPSA/2021/003/NHSPS	16/06/2021	For Action
MMS-21-3999	24/05/2021	For Action	T34 TM Ambulatory Syringe Pumps	BD is issuing this field safety notice to advise of a software upgrade for certain serial numbers of 3rd Edition	Serial numbers assessed not held by LCH.	10/06/2021	28/05/2021
CEM/CMO/2021/013	14/06/2021	For Action	Updated Publication Of Remdesivir Guidance For Patients Hospitalised With Covid-19 (Adults And Children Aged 12 Years And Older)	Remdesivir has been available to UK clinicians treating hospitalised patients with COVID-19 since May 2020.	Assessed not releavnt	29/06/2021	29/06/2021
NatPSA/2021/002/NHSPS	19/05/2021	For Action	Urgent assessment/treatment following ingestion of 'super strong' magnets	Small powerful magnets, also known as neodymium or 'super strong' rare-earth magnets, are sold as toys, decorative items, and fake piercings and are becoming increasingly popular. Unlike traditional magnets, these 'super strong' magnets are small in volume but powerful in magnetism and easily swallowed.	Pathway developed, currently for stakeholder comments.		
SDA/2021/006	25/06/2021	For Information Only	Champix® (varenicline) 0.5mg and 1mg tablets – Supply Disruption	All Champix® (varenicline) products are unavailable until further notice.	For information only		

CEM/CMO/2021/014	29/06/2021	For Information Only	COVID-19 Therapeutic Alert - Palivizumab passive immunisation against respiratory syncytial virus (RSV) in at risk pre-term infants	Palivizumab, administered as an intramuscular injection, is used to provide protection against respiratory syncytial virus (RSV) in at-risk patients, and has been shown to decrease hospitalisation in this group.	For information only		
NatPSA/2021/005/MHRA	25/06/2021	For Information Only	Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds	Philips have issued 2 FSNs about selected ventilators and CPAP and BiPAP devices: See additional information section for affected models.			
PL 35507/0191	04/05/2021	For Information Only	MHRA - Class 4 Medicines Notification - Lupin Healthcare (UK) Limited Syonell 250mg Gastro-Resistant Tablets (PL 35507/0191), Syonell 500mg Gastro-Resistant Tablets (PL 35507/0192) - EL(21)A/11	Lupin Healthcare (UK) Limited has informed us of a discrepancy with the product packaging for several batches of Syonell 250mg Gastro-Resistant Tablets and Syonell 500mg Gastro-Resistant Tablets. This discrepancy relates to the incorrect amount of active pharmaceutical ingredient (valproate semisodium) printed on the outer packaging.	For information only		
MDR 050 - 10/20	18/06/2021	Not Applicable	Bristol Laboratories Limited, Brown & Burk UK Ltd, Teva UK Ltd, Irbesartan-containing and Losartan-containing products, EL (21)A/14	Bristol Laboratories Limited, Brown & Burk UK Ltd and Teva UK Ltd are recalling the above batches of products as a precautionary measure due to contamination with an impurity called 5-(4'-(azidomethyl)-[1,1'-biphenyl]-	Not applicable	MDR 050 - 10/20	18/06/2021

				2yl)-1H-tetrazole, which has mutagenic potential.			
SDA/2021 /007	25/06/2021	Not Applicable	Dexamethasone 0.1% (Maxidex®) 5ml eye drops	There are limited supplies of preserved dexamethasone (Maxidex®) 0.1% eye drops in a multi-dose container until early August 2021 due to a manufacturing issue. During this period stock will only be available to order directly from Novartis and subject to order limits.	Not applicable		SDA/2021 /007
NatPSA/202 1/004/MHRA	16/06/2021	Not Applicable	Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd due to precautionary risk of causing overdose	Zentiva Pharma UK Limited have notified the MHRA of an issue related to the homogeneity of a batch of Co-codamol 30/500 Effervescent Tablets that could result in a potential underdose and lack of efficacy or an overdose.	Not applicable		

Appendix 2 – June 2021

Retention background data

In June 2021 there were 30 leavers (28.9 WTE's) across the Trust.

Detailed breakdown of leavers with reasons is set out below:

By Organisation Hierarchy

Staff Group	(All)
Leaving Reason	(All)

Sum of FTE				Less than 12 Months		
Month	Business Unit	Servic	Team	More than12Months	Less than 12 Months	Grand Total
2021 / 06	833 Adult Business unit			4.9	1.0	5.9
	833 Children's Business Unit			4.4	3.4	7.8
	833 Corporate Directorate			4.6	2.0	6.6
	833 Operations			2.0		2.0
	833 Specialist Business Unit			4.9		4.9
	833 PCN Business Unit			1.6		1.6
2021 / 06 Total				22.5	6.4	28.9
Grand Total				22.5	6.4	28.9

By Staff Group	
Business Unit	(All)
Service	(All)
Team	(All)

Sum of FTE		Less than 12 Months		
Month	Staff Group	More than12Months	Less than 12 Months	Grand Total
2021 / 06	Add Prof Scientific and Technic	2.6		2.6
	Additional Clinical Services	1.0	1.0	2.0
	Administrative and Clerical	7.2	3.0	10.2
	Allied Health Professionals	2.1		2.1
	Medical and Dental	0.4		0.4
	Nursing and Midwifery Registered	9.2	2.4	11.6
2021 / 06 Total		**22.5**	**6.4**	**28.9**
Grand Total		**22.5**	**6.4**	**28.9**

By Leaving Reason	
Business Unit	(All)
Service	(All)
Team	(All)

Sum of FTE		Less than 12 Months		
Month	Leaving Reason	More than12Months	Less than 12 Months	Grand Total
2021 / 06	Retirement Age	1.6		1.6
	Voluntary Resignation - Child Dependants	0.6		0.6
	Voluntary Resignation - Health	1.6		1.6
	Voluntary Resignation - Lack of Opportunities	0.6		0.6
	Voluntary Resignation - Other/Not Known	4.9	2.0	6.9
	Voluntary Resignation - Promotion	7.2	1.6	8.8
	Voluntary Resignation - Relocation	2.0	1.0	3.0
	Voluntary Resignation - To undertake further education or training	1.0		1.0
	Voluntary Resignation - Work Life Balance	3.0	1.8	4.8
2021 / 06 Total		**22.5**	**6.4**	**28.9**
Grand Total		**22.5**	**6.4**	**28.9**

Appendix 3 – June 2021

Detailed Financial Data Tables

Leeds Community Healthcare NHS Trust

Table 1 Income & Expenditure Summary	June Plan WTE	June Actual Contract WTE	YTD Plan £m	YTD Actual £m	YTD Variance £m	H1 Plan £m	H1 Forecast Outturn £m	This Month Forecast Variance £m	Forecast Variance Last Month £m
Income									
Contract Income			(45.1)	(45.1)	0.0	(89.9)	(89.9)	0.0	(0.0)
Other Income			(3.4)	(3.4)	0.1	(6.5)	(6.2)	0.2	(0.2)
Total Income			***(48.5)***	***(48.5)***	***0.1***	***(96.4)***	***(96.2)***	***0.2***	***(0.2)***
Expenditure									
Pay	3,035.3	2,894.9	32.3	31.8	(0.5)	65.4	64.5	(1.0)	0.4
Non pay including reserves & non recurrrent			15.5	14.0	(1.5)	29.4	30.3	0.9	(0.1)
Total Expenditure	***3,035.3***	***2,894.9***	***47.8***	***45.8***	(2.0)	***94.9***	***94.8***	***(0.1)***	***0.3***
EBITDA	**3,035.3**	**2,894.9**	**(0.7)**	**(2.7)**	**(2.0)**	**(1.5)**	**(1.4)**	**0.1**	**0.1**
Depreciation			0.5	0.5	(0.1)	1.1	1.0	(0.1)	(0.1)
Public Dividend Capital			0.2	0.2	0.0	0.4	0.4	0.0	0.0
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Payable			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Retained Net Surplus	**3,035.3**	**2,894.9**	**0.0**	**(2.0)**	**(2.0)**	**(0.0)**	**0.0**	**0.0**	**0.0**
	Variance =	**(140.4)**							

Table 2 Month on Month Pay Costs by Category	April £k	May £k	June £k	YTD Actuals £k
Directly employed staff	9,829	9,978	9,620	29,427
Seconded staff costs	263	283	283	828
Bank staff	330	227	276	833
Agency staff	155	227	308	690
Total Pay Costs	**10,577**	**10,715**	**10,486**	**31,778**

Table 3 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k
Drugs	203	232	29	21
Clinical Supplies & Services	4,986	4,988	2	(1)
General Supplies & Services	1,224	1,254	30	43
Establishment Expenses	1,793	1,551	(242)	(90)
Premises	3,583	3,278	(305)	(127)
Other non pay	356	575	218	202
Total Non Pay Costs	**12,144**	**11,877**	**(268)**	**49**

Table 4 Savings Schemes M01-M06	2021/22 YTD Plan £k	2021/22 YTD Actual £k	2021/22 YTD Variance £k	2021/22 H1 Plan £k	2021/22 Forecast H1 Outturn £k	2021/22 Forecast Variance £k	2021/22 YTD Variance %
Estates savings	133	133	0	265	265	0	0%
Total Efficiency Savings Delivery	**133**	**133**	**0**	**265**	**265**	**0**	**0%**

Table 5 Capital Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.2	0.1	(0.1)	0.7	0.7	0.0
Seacroft Estates	0.0	0.0	0.0	1.6	1.6	0.0
Clinical Equipment	0.1	0.0	(0.0)	0.3	0.3	0.0
IT Equipment	0.3	0.0	(0.3)	0.7	0.7	0.0
Electronic Patient Records	0.1	0.1	(0.0)	0.4	0.4	0.0
e Rostering & e Jobs	0.0	0.0	0.0	0.1	0.1	0.0
Totals	**0.7**	**0.2**	**(0.5)**	**3.7**	**3.7**	**0.0**

Table 6 Statement of Financial Position	Plan 30/06/21 £m	Actual 30/06/21 £m	Variance 30/06/21 £m	*Opening 01/04/21 £m*	Planned Outturn 31/03/22 £m	Forecast Outturn 31/03/22 £m	Forecast Variance 31/03/22 £m
Property, Plant and Equipment	31.1	30.7	(0.4)	*31.0*	32.6	32.6	0.0
Intangible Assets	0.2	0.2	(0.0)	*0.2*	0.2	0.2	0.0
Total Non Current Assets	**31.4**	**30.9**	**(0.4)**	*31.2*	**32.8**	**32.8**	**0.0**
Current Assets							
Trade and Other Receivables	8.1	7.5	(0.6)	*5.6*	8.1	8.1	0.0
Cash and Cash Equivalents	38.7	44.9	6.2	*39.6*	35.0	35.0	0.0
Total Current Assets	**46.8**	**52.4**	**5.6**	**45.2**	**43.1**	**43.1**	**0.0**
TOTAL ASSETS	**78.2**	**83.3**	**5.1**	*76.4*	**75.9**	**75.9**	**0.0**
Current Liabilities							
Trade and Other Payables	(17.9)	(19.9)	(2.1)	*(15.0)*	(15.6)	(15.6)	0.0
Provisions	(0.7)	(1.8)	(1.0)	*(1.8)*	(0.7)	(0.7)	0.0
Total Current Liabilities	**(18.6)**	**(21.7)**	**(3.1)**	*(16.8)*	**(16.3)**	(16.3)	**0.0**
Net Current Assets/(Liabilities)	**28.2**	**30.7**	**2.5**	*28.4*	**26.7**	26.7	**0.0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**59.6**	**61.6**	**2.0**	*59.6*	**59.6**	59.6	**0.0**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	*0.0*	**0.0**	0.0	**0.0**
TOTAL ASSETS LESS LIABILITIES	**59.6**	**61.6**	**2.0**	*59.6*	**59.6**	**59.6**	**0.0**
TAXPAYERS EQUITY							
Public Dividend Capital	0.8	0.8	(0.0)	*0.8*	0.8	0.8	0.0
Retained Earnings Reserve	26.1	28.1	2.0	*26.1*	26.1	26.1	0.0
General Fund	18.5	18.5	0.0	*18.5*	18.5	18.5	0.0
Revaluation Reserve	14.2	14.2	(0.0)	*14.2*	14.2	14.2	0.0
TOTAL EQUITY	**59.6**	**61.6**	**2.0**	*59.6*	**59.6**	**59.6**	**0.0**

Table 7 BPPC Measure	Performance YTD	Target	RAG
NHS Invoices			
By Number	97%	95%	G
By Value	100%	95%	G
Non NHS Invoices			
By Number	98%	95%	G
By Value	95%	95%	G

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2020-21(41)

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

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Category of paper: for assurance
History: Senior Management Team 21 July 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 at Appendix A 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 remains staff capacity, the second strongest theme is the functionality of Digital / Information Technology (IT) systems.

There are no extreme risks scoring 16 (extreme) currently on the risk register

There are 15 risks scoring 12 (very high). Two of these are newly identified risks and have been added to the risk register:

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

- Increased **v**olume of callers using the Leeds Sexual Health appointment line due to no walk-in service

One risk has recently been escalated to a score of 12 (very high)

- Increase in referals for the Adult Speech and Language Therapy Service

Recommendations

The Board is recommended to**:**

- Note the new and escalated risks, which have been scrutinised by Quality and Business Committee

- Seek additional assurance against Board Assurance Framework (BAF) strategic risks that are linked to the strong themes identified in this report

1. Introduction

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.

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).

The report provides a description of risk movement since the last register report was received by the Board (May 2021), including any new risks, risks with increased or decreased scores and newly closed risks.

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

2. Background

This paper has previously been considered by the Senior Management Team (SMT) at its meeting on 21 July 2021.

3. Board Assurance Framework Summary

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)

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.

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

Levels of assurance have been provided for fifteen out of the 20 strategic (BAF) risks during May and June and Audit Committee in July 2021, with reasonable assurance given to all fifteen. Details of the committees commentary about specific risks is as follows (please also refer to the Chairs' assurance reports):

The Business Committee concluded in May 2021 that there was reasonable assurance for BAF risk 3.6 'Maintaining business continuity in the face of significant disruption' having considered the Covid update, Reset and Recovery information and the Neighbourhood Teams transformation report. However the Committee recognised the increasingly likely risk of pressures to the Leeds health system materialising as we move into autumn/winter.

BAF risk 1.3 achieved reasonable assurance overall in both May and June 2021 Quality Committee meetings as the risk is being managed well however limited assurance was provided in relation to the Adult SALT pathway.

Audit Committee has agreed to adopt the same method of evaluating the assurance level for the strategic risk assigned to it. This is BAF risk 2.4 'maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security'. At its meeting on 23 July 2021 the Audit Committee agreed that the Data Security and Protection Toolkit (part 2), the Information Governance update and the Information Group minutes collectively provided reasonable assurance.

4. Risks by theme

For this report, the 62 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.

Themes within the current risk register are as follows:

The strongest theme across the whole risk register remains to be 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
- inefficient or changes in processes leading to decreased staff capacity

Specifically:
Thirteen[1] risks are related to staff capacity due to an increase in service demand;
Eight[2] risks concern vacancies, including difficulties recruiting staff to posts.
Five[3] risks are related to services being paused in response to COVID 19, resulting in an increased workload and increased waiting times.

Three[4] risks are concerned with processes

The second strongest theme continues to be Digital / 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[5]
- Helpdesk Support Capacity [6]

[1] Risks: 980,979,994,957,956,954,913,1047,987,904,877,1048,1049
[2] Risks: 950,903,980,979,877,836,772,1049
[3] Risks: 1036,1039,1021,1015,984
[4] Risks: 1034,1043,982
[5] Risks: 1040
[6] Risks: 992,1025

- Increase in potential cyber-attacks due to unsupported software[7]
- The functionality of software[8] used within the Trust, specifically:
    - 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
    - OrderComms not working at bespoke sites
    - PCIMS (patient information system)

*Business Committee explored this risk theme in depth at its June 2021 meeting.

The third strongest theme is patient safety risks 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
- Vision screening for children
- Hearing tests for children
- School immunisations programme

There is a theme related to the provision of the CAMHS service. The risks within this service include:

- Compliance with documenting ligature risk assessments
- Increase in demand for secure CAMHS beds
- Lack of bed availability
- Increased waiting times for follow-up appointments
- Changes in the process impacting on staff capacity within the CAMHS Transition Team

There is also a theme of staff safety risks due to COVID, transporting oxygen cylinders, working environment (Leeds Community Equipment Service), lone working and violence and aggression (WYOI), and uncoordinated response in the event of an incident (fire or security) at health centres.

4.1 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%)

[7] Risk 1050
[8] Risks: 1041,1017,963,1020,961,974

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.

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

4.2 **Risk theme alignment with Board Assurance Framework**

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: Digital / 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: provision of the CAMHS service
BAF Risk 1.3 maintaining and continuing to improve service quality
BAF Risk 2.1 Insufficient resource to deliver major change programmes
BAF Risk 2.2 delivering contractual requirements
BAF Risk 3.1 having suitable and sufficient staff capacity and capability and reduced levels of sickness

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

New or escalated risks (scoring 15+)

No new risks scoring 15+ have been added to the risk register since May 2021:

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

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

No risks have been deescalated below 15 since May 2021

5.2 Summary of risks scoring 12 (high)

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.

Table 1. Details of 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
957	Increase in referrals for the Adult Speech and Language Therapy Service	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
1025	Information Technology (IT) Helpdesk Support Capacity	12
1033	Delayed transfer of children/young people from WYOI who require medium secure CAMHS hospital beds.	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 Police Custody service	12
1041	**NEW:** PCMIS (patient information system) used by LMWS does not have the functionality to run a system capture of all safeguarding cases	12
1047	**NEW:** Increased volume of callers using the Leeds Sexual Health Appointment Line due to no walk-in service	12

5.3 **New or escalated risks (scoring 12)**

Two new risks scoring 12 have been added to the risk register since May 2021, and details of these risks (controls and actions) have been provided to the Quality and Business Committees for scrutiny:

Risk 1041 PCMIS (patient information system) used by LMWS does not have the functionality to run a system capture of all safeguarding cases

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

Description: PCMIS (the patient information system) used by LMWS does not have the functionality to run a system capture of all safeguarding cases, nor does it have dedicated space within individual records for the storing of safeguarding related information and updates.

For individual cases, relevant safeguarding information is difficult to find and there is a risk that it may be missed by clinicians which could result in clinicians not acting to prevent harm to vulnerable individuals.

There is also a risk that the service is unable to run reports to capture the number of clients where safeguarding issues have been identified, subsequently the service are unable to audit, implement learning or provide information for CQC which could result in a fine and/or reputational damage

Date to reach target: 30/09/2021
Risk Owner: Clinical Lead, Leeds Mental Welfare Services
Lead Director: Executive Director of Nursing and Allied Health Professionals

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Risk 1047 Increased **v**olume of callers using the Leeds Sexual Health appointment line due to no walk-in service

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

Description:
Due to a change in service delivery during the pandemic, the Leeds Sexual Health appointment line is now the point of access for service users. This has resulted in an increasing volume of calls being received. There is a risk that the service will be unable to manage the number of calls, which could result in service users not being able to gain access to advice or obtain appointments. This could ultimately result in a delay in treatment and potential worsening of symptoms.

Date to reach target: 02/08/2021
Risk Owner: General Manager, Specialist Service
Lead Director: Executive Director of Operations

One risk has been escalated to a score of 12 (high) and as a result has had further scrutiny at Quality Committee in June 2021:

Risk 957 Increase in referrals for the Adult Speech and Language Therapy Service.

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

Due to an increase in referrals to the Speech and Language Therapy Service, there is a risk that the current staff capacity may not be able to meet the 18 week waiting time for routine referrals. As a result, a patient's condition could deteriorate and this may impact on hospital admissions and GP attendance. It could also impact on staff morale, potentially resulting in increased sickness and/or increased staff turnover.

Further actions required to address the risk include:
Long waiter profiling pilot commenced.
Long waiter triage and re-assessment will be triggered at 18 weeks plus.
Staff are working additional hours and a recruitment campaign is underway.

Date to reach target: not yet determined
Risk Owner: Clinical Head of Service, Neurology and Adult SLT
Lead Director: Executive Director of Operations

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6. Risk profile - all risks

There are 15 open clinical risks on the Trust's risk register and 47 open non-clinical risks. The total number of risks on the risk register is currently 62. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk:

Table 2. 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	3	1	0	5
3 - Moderate	1	13	17	12	0	43
2 - Minor	0	3	6	2	2	13
1 - Negligible	0	0	1	0	0	1
Total	1	18	27	14	2	62

7. Impact:

7.1 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.

7.2 Resources

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

8. Recommendations

The Board is recommended to**:**

- Note the new and escalated risks, which have been scrutinised by Quality and Business Committee
- Seek additional assurance against Board Assurance Framework (BAF) strategic risks that are linked to the strong themes identified in this report

Appendix A. Board Assurance Framework levels of assurance

Details of strategic risks (description, ownership, scores)								Level of Assurance				
Risk		Risk ownership		Risk score				Committee agreed level of assurance				
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Additional Information
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	SL	QC	3	4	**12**				✓		Overall reasonable assurance. Safeguarding strategy update in May 2021 provided a continued level of substantial assurance
	Risk 1.2 If there are insufficient clinical governance arrangements put in place as new care models develop and evolve, the impact will be on patient safety and quality of care provided.	RB	QC	3	3	**9**				✓		
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm	SL	QC	2	4	**8**				✓		Majority of items scrutinised in May and June 2021 collectively provided reasonable assurance. Limited assurance was provided in relation to the Adult SALT pathway
	RISK 1.4 If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve.	SL	QC	4	3	**12**				✓		
	RISK 1.5 If, as a result of the Trust's altered capacity due to the Covid-19 pandemic, the Trust cannot deliver services in a timely and equitable manner, then the impact will be further increases to waiting lists, sub-optimal outcomes for patients and complaints to the Trust.	RB	QC	4	3	**12**				✓		0-19 service spotlight provided significant assurance in May 2021 of how quality has been maintained throughout the pandemic, for our most vulnerable families.
	RISK 1.6 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, there will be a negative impact on patient outcomes, the Trust's resources and reputation	RB	TB	4	3	**12**						
Provide sustainable services	**RISK 2.1** If there is insufficient resource across the Trust to deliver major change programmes and their associated projects, then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	3	3	**9**				✓		
	RISK 2.2 If the Trust does not deliver contractual requirements, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	2	3	**6**				✓		
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	BM	BC	3	3	**9**						
	Risk 2.4 If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage.	BM	AC	3	4	**12**				✓		Data Security and Protection Toolkit (part 2), the Information Governance update and the Information Group minutes collectively provided reasonable assurance
	RISK 2.5 If the Trust does not deliver key financial targets agreed with NHS England through the ICS financial framework then it will cause reputational damage and raise questions of organisational governance	BM	BC	2	3	**6**				✓		
	RISK 2.6 If the Trust does not invest and create the capacity and capability to respond to the increasing dependency on digital solutions then systems may be unreliable, under developed, under used, lack integrity or not procured. The impact will be on the delivery of patient care and on staff resources and wellbeing	BM	BC	4	3	**12**				✓		Measures to improve IT support services, which is a challenging and pressured area, are being worked on and are providing mitigation for this risk

Recruit, develop and retain the staff we need now and for the future	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development , and a low level of sickness absence) then it may not maintain quality and transform services.	JA/LS	BC	4	3	**12**							
	RISK 3.2 If the Trust does not create and embed a culture of equality and inclusion, then it will fail in its duty to attract and retain a diverse workforce that is representative of the communities it serves, and will not reap the benefits of diverse thinking and representation.	JA/LS	TB	3	3	**9**							
	RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services.	TS	BC	3	3	**9**							
	RISK 3.4 If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing.	JA/LS	BC	3	3	**9**							
	Risk 3.5 If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention.	BM	BC	4	3	**12**							Some concerns about the gaps in evidence in the Premises Assurance Model but there was reasonably assured overall that the Trust's Health and Safety management system was improving.
	Risk 3.6 If the Trust is unable to maintain business continuity in the event of significant disruption, there is a risk that essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss	SP	BC	3	4	**12**							Overall reasonable. The Committee recognised the increasingly likely risk of pressures to the Leeds health system materialising as we move into autumn/winter.
Work in partnership to deliver integrated care and care closer to home	**RISK 4.1** If the Trust does not play an active part in the collaboration across the health and care system (ICS and ICP), then the system may not achieve better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.	TS	TB	2	4	**8**							
	RISK 4.2 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationship.	BM	BC	3	3	**9**							CAMHS Collaborative Business Case and Partnership Traded Contract Performance 2021/21 provided reasonable assurance at the May 2021 Business Committee meeting.

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (42)

Title: Freedom To Speak Up Guardian Annual Report 2020/2021

Category of paper: for assurance

Responsible director: Chief Executive
Report author: Freedom To Speak Up Guardian

Executive summary (Purpose and main points)

This annual report covers the period of August 2020 to July 2021. It records the work of the speaking up at Leeds Community Healthcare NHS Trust and across the wider system.

36 concerns were raised formally by LCH staff members during this reporting period. These figures do not include staff in informal work with the Freedom To Speak Up Guardian (FTSUG). 6 staff colleagues who formally raised concerns are from Black, Asian and minority ethnic communities and 4 of these concerns were related to issues of race.

The trust this year won the HSJ Award for Speaking Up Organisation of the Year. Several NHS trusts and national NHS bodies have had consultations and conversations with LCH about our work and approach to speaking up.

The work has continued to develop over the last year to ensure the voices of our staff are fully heard and understood. Staff report that the experience of contacting the FTSUG and champions is a positive one.

Recommendations

The Board is recommended to note the report and continue to enable the embedding of this work across the trust.

1 Introduction

This paper provides an overview of the work of the Freedom To Speak Up Guardian, basic activity data and recommendations on the role and its development and covers the period from August 2020 to July 2021.

2 Background

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

CQC guidance published in March 2016, in response to the Francis recommendations, indicated that trusts should identify or appoint a Freedom to Speak Up Guardian in 2016/17. The NHS contract for 2016/17, accelerated this process and trusts were required to have made an appointment by October 2016.

Following a competitive recruitment process, the trust appointed its Freedom To Speak Up Guardian in November 2016 and the appointee took up post on 1 December 2016.

3 Current position

The FTSUG receives strong ongoing support from the Chief Executive, Directors, the Chair, NEDS and the wider Trust.

A clear form of work has been established and is operating well. The work has three forms. The first is individual staff approaching the FTSUG and the Race Equality Network champions to discuss and formally raise concerns. The second is managers inviting the FTSUG to work in their teams so staff can be heard to enable better team cultures. The third is the invite to be part of change projects in the organisation as an additional source of support to staff and managers.

Work with the Race Equality Network continues. A new speaking up champion to support staff with domestic abuse / domestic violence issues has been appointed and is working with our Safeguarding Team.

The FTSUG works at local, regional and national levels. The local work at LCH continues to develop. The FTSUG works regionally through the Freedom To Speak Up Regional Network for Yorkshire and the Humber. The FTSUG works with the National Guardian Office in developing speaking up in General Practice and other individual projects.

The Trust this year won the HSJ Award for Speaking Up Organisation of the Year. Several NHS trusts and national NHS bodies have had consultations and conversations with LCH about our work and approach to speaking up.

The FTSUG has been invited to join and has joined the NHS Confederation Race and Health Observatory Stakeholder Engagement Group and the NHS Employers Staff Experience Steering Group. There are invites to present at the national Patient

Safety Congress later this year and deliver talks at Cambridge and Peterborough NHS Trust and Manchester University Foundation Trust Hospital about our work. Articles on the work have appeared on the NHS Providers website, the HPMA newsletter, the Journal of Practice Nursing. A YouTube video on Black History Month and Speaking Up Month last October featured a conversation with the FTSUG, Chair of the Race Equality Network and a colleague from NHS England / Improvement

We ran two sessions on 'Leadership and Speaking Up' for managers at LCH in July this year supported by Speaking Up Champions from the Race Equality Network. This has been supported by the Chief Executive writing an article on leadership and speaking up for the National Guardian Office newsletter.

The two year Vanguard work supporting Freedom To Speak Up Guardian in General Practice in Leeds has now been completed. A national report on the learning across the country has been produced.

The work supporting Freedom To Speak Up Guardians at Leeds City Council continues and is taking positive shape.

In the recent national Freedom To Speak Up Index which measures speaking up culture based on the Staff Survey results LCH rates joint 8th .

4 Activity data

The table below details speaking up concerns formally raised and shows the volume and type of activity with which the FTSUG has been engaged between August 2020 and July 2021. The table also indicates the nature of the issues raised with the FTSUG.

Business Unit	Numbers of concerns formally raised	Issues
Adult Business Unit	8	Culture, leadership, time for staff meetings and support
Children and Families Business Unit	11	Caseloads, patient care, staff dynamics, need of reflective spaces
Corporate Services	8	Process, interviews
Specialist Business Unit	9	Culture, behaviours, development opportunities, rota issues, staff health and welllbeing

36 concerns were raised formally by LCH staff members. These figures do not include informal work with staff. Staff report that the speaking up service is fast,

supportive and helpful. They also share that the experience feels safe and that it helps them think through what they need to do.

6 staff colleagues who formally raised concerns are from Black, Asian and minority ethnic communities and 4 of these concerns were related to issues of race.

5 Themes

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

- Colleagues from Black, Asian and other ethnic communities are raising concerns around themes of race, inclusion and equity, which is to be welcomed.

- Leadership and behaviours in teams are key factors.

- Process is a factor that staff raise in terms of time taken and response.

- Staff health and wellbeing features in concerns.

6 Assurances and Future Work

The assurances with the role are three fold – national engagement, organisational spread and local comparison.

We are reporting quarterly to the National Guardian Office. We work positively with the National Guardian Office and we are asked regularly to support new Guardians. Secondly, the FTSUG is meeting staff from across the Trust and at different roles / levels. The FTSUG has worked with staff in this period from all the business units and corporate services. Third, in terms of local comparison with neighbouring NHS trusts, we evaluate well in terms of staff seen.

The following are future work and plans.

- Discussion Work on Gap Analysis is proceeding. This is where a trust evaluates its practice against the public reviews carried out by the National Guardian Office where issues affecting speaking up have been reported in different trusts. The FTSUG along with the FTSUG at Leeds Teaching Hospitals Trust has created a basic Gap Analysis tool to carry out this work.

- At the Trust the work with the Race Equality Speaking Up Champions and the champion who works with domestic abuse / violence is ongoing and quality work has ensued. Discussion with both as the new national guidance on Speaking Up Champions (which limits champion work to awareness raising and signposting only) is ongoing to decide next steps. We will also continue to focus on and develop work with Trust managers and leaders about how to work best when concerns are raised.

- The Speaking Up Strategy is being written and will be located in the new Workforce Strategy as it links fundamentally to culture, change, staff and wellbeing.

7 Conclusions

The FTSUG work continues to receive positive support from the Trust and its leadership. LCH staff welcome the work and the forms we use.

The FTSUG role allows staff voices to be heard in the Trust. The role continues to illustrate the importance of workplace culture and leadership. It also has a strong focus on psychological and emotional support for staff.

The FTSUG work supports our reset work in building new ways of working and our commitment to inclusion, diversity, health and wellbeing, excellent clinical care and compassionate culture.

Our aspiration as a Trust to embody and live out our vision, values and behaviours in all our centres and services is supported and enabled by the speaking up work.

8 Recommendations

The Board is recommended to accept the report and continue its support to embed our speaking up work.

Leeds Community Healthcare NHS Trust

Guardian of Safe Working Hours
Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (43)

Title: Quarter 1 Report 21.22 of the Guardian of Safe Working Hours

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Category of paper: For assurance

History: Nil

Responsible director: Executive Medical Director

Report author: Guardian of Safe Working Hours

Executive summary (Purpose and main points)

Purpose of the report
To provide assurance that doctors and dentists in training within LCH NHS Trust are safely rostered and that their working hours are consistent with the Junior Doctors Contract 2016 Terms & Conditions of Service (TCS).

To report on any identified issues affecting trainee doctors and dentists in Leeds Community Healthcare NHS Trust, including morale, training and working hours.

Main issues for consideration

- The progress made with ensuring compliance of CAMHS ST rota pattern and internal locum cover.

- Improved engagement with Junior Doctor in the Junior Doctor Forum (JDF) and work that has been started to exploring and supporting paediatric Junior Doctor training opportunities.

Recommendations

Board is recommended to:

- Receive this assurance regarding Junior Doctor rotas and working conditions within the Trust

- Support GSWH with the on-going work to ensure CAMHS ST rota gaps and locum cover arrangements are compliant with the Junior Doctor terms and conditions.

- Support GSWH and JDF with regards to spending Fatigue and Facilities funds on ideas and suggestions as agreed by JDF.

Quarterly Report of the Guardian of Safe Working Hours

1.0 Purpose of this report

1.1 To provide the Board with assurance that trainee doctors and dentists within LCH NHS Trust are working safely and in a manner complaint with the 2016 Terms & Conditions of Service (TCS).

1.2 To identify risks affecting trainee doctors and dentists such as working hours, quality of training and advising board on the required response.

2.0 Background

2.1 The role of Guardian of Safe Working Hours (GSWH) was introduced as part of the 2016 Junior Doctor's contract. The role of the GSWH is to independently assure the confidence of junior doctors that their concerns will be addressed and require improvements in working hours and rotas.

3.0 Quarterly report of guardian of safe working hours

There are currently 18 Junior Doctors employed throughout the Trust (in different specialities) as detailed in the table below. This includes Junior doctors employed directly by LCH and on honorary contracts.

Department	No.	Grade	Status
Adults	0		LCH contract
CAMHS	4	ST	LCH contract
	4	CT	Honorary contract
Community Paediatrics	3	ST Level 1	Honorary contract
	2	ST Level 2/ Grid trainee	LCH contract
Sexual Health	1	ST	LCH contract
GP	3	GPSTR	LCH contract
Obstetrics	1		Honorary contract
Dental Services	0		Honorary contract

QUARTERLY OVERVIEW

Vacancies		There are two vacancies in CAMHS Specialty Trainee (ST) establishment.					
Rota Gaps (number of night shifts needing cover)		June 2021		July 2021		August 2021	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	21	n/a	10	n/a	19
	Internal Cover	n/a	16	n/a	5	n/a	11
	External cover	n/a	5	n/a	5	n/a	8
	Unfilled	n/a	0	n/a	0	n/a	0
Exception reports (ER)		0	0	0	0	0	0
Fines		None					
Patient Safety Issues		None					
Junior Doctor Forum		Due 29th July 2021					

3.1 **Rota gaps**

The CAMHS ST rota currently has vacancies related to maternity leave and gap in the rota (unfilled post).

GSWH has worked with Medical director, CAMHS medical lead, HR and BMA to address the concern that was raised in April 2021 by another Trust regarding whether the CAMHS Junior Doctors on-call rota is complaint with Junior Doctor contract T&Cs.

Immediate measures have been put in place to ensure compliance with internal locum cover. These include CAMHS medical lead and DME checking the rota on a monthly basis and Junior doctors involved have been reminded about the JD terms and conditions that apply in relation to picking up internal locum shifts.

Work is underway to ensure a long term solution is in place to ensure the rota is compliant with current JD terms and conditions including the relevant rota checking software.

3.2 **Exception reports**

No exception reports submitted.

3.3 **Fines**

No fines levied by the GSWH.

3.4 **Feedback from trainees**

The next Junior Doctors Forum (JDF) is due on 29/07/21. The date was selected as an outcome from doodle poll based on the date and time with maximum number of trainee's availability.

3.5 **Update from the BMA**

No new updates from BMA since last Quarterly meeting.

4.0 Impact

4.1 ***Quality***

4.1.1 This report has been informed by discussions with trainees, supervisors, CAMHS Medical Lead and Paediatric College tutor in Leeds Community Trust, along with information from human resources and guidance received from NHS employers and Health Education England.

4.1.2 Work continues to explore further ways to help with engagement of junior doctors in the JDF meetings. Doodle poll idea and flexibility in choice of virtual and face to face meeting has been explored. This has been well received by Junior Doctors.

4.2 **Challenges with Community Paediatric Training**

There continues to be absence in reporting from paediatric trainees in relation to impact of on-call rota on training and educational opportunities.

Discussions regarding the impact of on-call rota on training time and missed educational opportunities have been started and specific meetings are being planned to engage Junior doctors to gather this data without the reliance of exception reporting.

4.3 **Fatigue and facilities fund**

Ideas for using the remaining money from the fatigue and facilities funding as decided by junior doctors at the last JDF meeting had been put forward to SMT for approval. There continues to be challenges around using these funds for improvement of estates and suggestions (as suggested by Junior doctors at last JDF) including well-being courses, Gym membership vouchers are explored. GSWH has consulted the BMA throughout the process.

5.0 Recommendations

Board is recommended to:

- Receive this assurance regarding Junior Doctor rotas and working conditions within the Trust

- Support GSWH with the on-going work to ensure CAMHS ST rota gaps and locum cover arrangements are compliant with the Junior Doctor terms and conditions.

- Support GSWH and JDF with regards to spending Fatigue and Facilities funds on ideas and suggestions as agreed by JDF.

Trust Board Meeting held in public: 6 August 2021.

Agenda item number: 2021-22 (44)

Title: Professional registration: Nursing and Allied Health Professions

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Category of paper: For information
History: N/A

Responsible director: Executive Director of Nursing and Allied Health Professionals
Report author: Assistant Director of AHPs

Executive summary (Purpose and main points)

Purpose of the report

This report provides an update on nursing and AHP registration. The paper describes the current context for regulation for both nurses and AHPs and an overview the current situation within the organisation.

Main points

Staff that are required to be registered with statutory regulators Nursing and Midwifery Council (NMC) and The Health and Care Professions Council (HCPC) are appropriately registered.

Plans are in place to ensure that the organisation can meet the request of NHS England to regulate psychological well-being practitioners.

The organisation is aware of referrals to regulators and clear processes for this have been embedded in the revised policy

Recommendations

The Board is recommended to:
Note the positive position of nursing and AHP registration.

Professional Registration

1 Introduction

1.1 Professional registration exists to protect the public. For some professions this is statutory and it is illegal to be employed in certain roles without the appropriate registration. This includes professions overseen by the NMC and HCPC who collectively cover the majority of clinical staff in LCH. Medics are regulated by the General Medical Council (GMC) and compliance with this is included in the medical directors update. Dentists and dental nurses are regulated by the General Dental Council (GDC), pharmacists are regulated by the General Pharmaceutical Council (GPhC) and social workers have their own regulator Social Work England (SWE) since 2019.

1.2 Some roles within the psychological services do not currently fall within statutory registration. NHS England are leading work to revise this. The organisations revised registration policy has acknowledged this and has made clear the need for voluntary registration with an accredited register. This paper summaries nursing and AHP registration compliance for the year July 2020 to June 2021.

2 Background

2.1 Nurses are regulated by the NMC. They are required to pay an annual subscription to remain registered annually and revalidate every 3 years. The process of revalidation is clearly set out and includes confirmation from the individual's line manager that they have met all parts of the revalidation requirements. Staff will receive an email from the NMC and from the Electronic Staff Register (ESR) 3 months prior to their revalidation date. From 2019 NMC have also regulated nursing associates.

2.2 AHPs are regulated by the HCPC. HCPC protect the titles that AHPs work to meaning that it is an offence to practice under any of the titles unless you are on the register. Registrants are required to pay an annual fee and re-register every 2 years. They are required to maintain a portfolio of continuing professional development (CPD) which they may be asked to submit at the time of re registering. Staff will receive a notification from ESR 4 months prior to re-registration and a letter from HCPC 2 months prior. LCH employ 7 of the 14 professions regulated by the HCPC. (Podiatrist, Dietitians, Occupational Therapists, Paramedics, Physiotherapists, Practitioner Psychologists and Speech and Language Therapists). During the last year, dietitians, podiatrists and practitioner psychologists have undergone re registration. Paramedics, speech and language therapist and occupational therapists are currently in the process of re registration completing in August, September and October respectively.

3 Current position

3.1 LCH employ 1190 staff in the staff group “nursing and midwifery” on ESR indicating that they require NMC registration for that post. 1143 are on the NMC register with current registration.

3.2 Twenty seven (27) have an expired registration date. On checking the register, 8 of these staff do have current registration and their records need updating. Fifteen (15) of these are staff that have retired and returned to just deliver vaccinations. They are not required to be registered to do this as vaccinations can be delivered by unregistered staff under supervision. Three (3) are employed as psychological well-being practitioners and will fall under the emerging guidance form NHS England. Their role and staff group need to be updated on ESR. One (1) is a social worker on the Social Work England register and practicing as a triage co-ordinator which is appropriate.

3.3 Twenty (20) staff in the staff group “nursing and midwifery” are showing as having Health and Care Professions Council registration all of which is current. They are employed in clinical roles whose title includes nurse but the functions of which can be delivered by any register professional.

3.4 The Trust employs 7 Nursing Associates who are also required to register with NMC and all have appropriate registration. There are additional staff employed within the organisation who hold NMC registration even though it is not a requirement of the role and their registration is current.

3.5 LCH employ 510 staff in the staff group "Allied Health Professional" requiring registration with HCPC. 505 are on the HCPC register with current registration. There are additional staff employed within the organisation who hold HCPC registration even though it is not a requirement of the role and their registration is current.

3.6 Of the five staff in the Allied Health Professional group who would be expected to have HCPC registration: two (2) have current registration and ESR needs to be updated; one (1) is on the Social Work England register with current registration and this is appropriate for the post; two (2) are employed in audiology where it is not necessary to have statutory registration although voluntary registration is best practice. Conversations will take place with the audiology line manager to clarify the definitions and expectations in the revised policy.

3.7 There have been a total of seven referrals to the NMC by members of the public relating to our staff. Four of these related directly to a complaint that we also dealt with. The NMC have not placed any restrictions or interim orders on the staff members practice whilst they investigate. We have no concerns about the staff members practice and they are continuing to be employed within the organisation. The remaining 3 are unrelated. Again the NMC have not placed any restriction or interim orders on the staff members practice and we do not have any concerns about them. They continue to practice as normal within the organisation. One of these three referrals occurred over 2 years ago and is linked to an inquest at that time. The delay in reaching a conclusion for the staff member has been escalated to the NMC by the Executive Director of Nursing and AHP because of the ongoing impact on the individual’s health and well-being.

3.8 The trust has made 3 referrals to the NMC in the last year. One has now proceeded to a formal hearing and the Trust will have a witness attending the hearing. The referred staff member no longer works for LCH. Both of the other staff members have been through formal HR processes within LCH which have resulted in dismissal or staff leaving.

3.9 There have been 2 referrals by members of the public to HCPC with regards to members of our staff over the last year. One is a physiotherapist in MSK and the other an Occupational therapist in ICAN. Both of these cases are still within the HCPC Fitness to practice process. HCPC have not placed any restrictions or interim orders on the individuals while they investigate. Both cases have been risk assessed internally and both are still in the employment of the organisation without restriction.

3.10 There have been 2 referrals by LCH to HCPC. One related to a physiotherapist form the Neighbourhood Teams (NTs). The staff member no longer workers in LCH. The second related to a physiotherapist in the MSK service and is still being investigated by HCPC. This individual has been through and internal disciplinary process and continues to be employed by the organisation having received a formal written warning.

3.11 The professional registration policy has been reviewed in the last year as identified in the paper to Board in August 2020. The review has addressed the issues identified last year and has been approved by SMT and staff side. The revised policy is clear that any staff who have responsibility for assessment, treatment or intervention formulation and review and discharge, need to be on a professional regulation register. This is in line with the work NHS England are undertaking to ensure that all psychological practitioners are regulated in some way. .

3.12 Two services in LCH, CAMHs and LMWS, will be impacted by the changes that NHS England are making to professional registration for psychological well-being practitioners. The lead for LMWS has provided assurance that all staff are currently appropriately regulated meaning that the changes will have minimum impact. Within CAMHs we have identified 6 individuals who may struggle to meet the criteria. Individual plans are in place to support staff in gaining regulatory registration and a business case is being developed to support any training required to achieve this.

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4. Conclusion

4.1 Staff that are required to be registered with statutory regulators NMC and HCPC are appropriately registered.

4.2 Plans are in place to ensure that the organisation can meet the request of NHS England to regulate psychological well-being practitioners.

4.3 The organisation is aware of referrals to regulators and clear processes for this have been embedded in the revised policy

5.0 Recommendations

5.1 The Board is recommended to note the above position

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (45i)

Title: Draft LCH Workforce Strategy 2021-25

Responsible director: Director of Workforce
Report author: Director of Workforce

Executive summary (Purpose and main points)

The Draft Workforce Strategy 2021-25 is presented here for SMT discussion prior to its submission at Trust Board on 6 August 2021.

Discussion and stakeholder engagement has been sought with a wide variety of forums over the past 8 weeks, with key feedback from stakeholders summarised below and reflected in this draft:

Resourcing, wellbeing, inclusion and organisational design are seen as the most critical features

Organisational Design and Resourcing elements in particular to be amplified, ensuring balance between cultural / development aspects and structural / "hard" aspects of Workforce remit

Balance in tone between service need and individual preference must be struck

Golden thread of **attracting, developing and keeping the right people to deliver excellent care** recognised

Accessibility of the strategy is important: aim to be meaningful for all who interact with it. "I/My" statements welcomed.

The Strategy is deliberately designed to be succinct, with its main body currently 12 ½ pages. Feedback is particularly welcomed on style, tone and alignment with overall LCH strategy and priorities.

Drafting notes are retained throughout the document in red text.

Following its presentation to the Board on 6 August 2021, the Draft Workforce Strategy will be shared for further iteration and comment with key stakeholders during August and September.

Trust Board is due to receive a final draft of the Workforce Strategy 2021-25 on 1 October 2021.

Recommendations

The Board is recommended to note the progress in development of the Draft Workforce Strategy 2021-25; and to provide views its content; also including its style, tone and alignment with overall LCH strategy and priorities.

Draft LCH Workforce Strategy 2021-25 (V0.1) NEEDS COLOURFUL COVER & CONTENTS PAGE W PHOTOS

Hello

We are pleased to share the LCH Workforce Strategy (2021-25) with you. It describes our LCH workforce and organisational development ambitions and objectives for the next 3 years.

Many people and services from across LCH have contributed to the Strategy's development. This has helped shape it to meet your needs, and we thank each one of you.

People and their wellbeing are the essence of LCH – without you this organisation cannot deliver excellent services to our communities. Everything this Workforce Strategy describes is therefore designed to help LCH to **attract, develop and keep the right people** in order to deliver outstanding care. This is what we call our **"Golden Thread"**.

We are always keen to hear feedback; you can reach us at jennyallen.laurasmith@nhs.net . Thanks for reading.

Jenny & Laura

PHOTO

Where have we been?

Much progress was made during the lifespan of the last Workforce Strategy (2019-21). We want to build on its successes, and learn from the things that didn't quite achieve the results we expected. A few examples are below.

Examples of 2019-21 Strategy ambitions achieved

- **People are more likely to be well and work** — Capacity increased and sickness absence rates reduced between March 2019 and March 2021
- **People are more likely to stay at LCH** — Turnover dropped from 13.6% per year in 2018/19 to 10.5% per year in 2020/21
- **LCH people work in a more integrated way with partner organisations** — >40 people now work in PCNs on a daily basis; >200 people have worked in the Leeds Vaccination Programme

Examples of where we must go further than we did in 2019-21

- **LCH is more representative of our diverse Leeds communities** — but there is a long way to go to ensure better representation and eliminate unequal experiences at work
- **Our excellent Leadership Programmes have supported more LCH leaders than ever** — but to achieve consistent excellence, we want all new & middle managers to receive specific leadership support
- **More LCH vacancies are filled, meaning better capacity for services** — but we want to be increasingly sophisticated in our workforce planning and service offer

By the end of the lifespan of this new Workforce Strategy, we want to have made further progress towards the things that matter most to us as a workforce and as an organisation.

Covid-19 Pandemic Impact

The majority of the previous Workforce Strategy's lifespan was during the Covid-19 pandemic, which inevitably impacted on the pace of progress of some elements.

For example, work on Talent Management slowed in line with Business Continuity requirements; whilst work on Health & Wellbeing accelerated, with some transformative work implemented on psychological wellbeing and remote working.

INSERT PHOTOGRAPHY / CASE STUDIES

What is important now?

Lots of factors both internal and external to LCH have been taken into account during the development of this Strategy. We have summarised them in the diagram below, using the well-regarded Harvard and Warwick models of HR Management to identify the different types of factor. If you would like more detail about any of factors mentioned here, or about the Harvard and Warwick models, please see **Appendix 1. (to be added) (- or "click in the online version)**

What do we want to achieve next?

There are seven Themes in this Strategy: **Organisation Design**; **Resourcing**; **Inclusion**; **Wellbeing**; **Leadership**; **System Partner** and **Foundations**.

These are underpinned by three Enablers, which contribute to every Theme: Employee Voice; Data & Evidence; and Digital & Technology. The importance of these three Enablers is summarised below:

Employee Voice

Employee Voice permeates every element of our work. Employee engagement and speaking up are critical ingredients of LCH's cultural identity as we seek to listen, learn and grow as an Employer of Choice to attract and keep the right staff. This is perhaps most important when people are telling us about where and how things can improve. Alongside LCH's wide range of formal and informal listening and feedback channels, and our strong partnership working arrangements with Trade Union colleagues; our Freedom to Speak Up Guardian, Champions and approach are vital here, and our LCH ***Speaking Up Strategy*** *can be found at* ***Appendix 2 (to be added)***

Digital & technology

*How we work is changing. Service efficiency and quality will be increasingly enhanced by technological capability to better meet patient needs. Hybrid working, accelerated during the Covid-19 pandemic, is going to stay, or become, the norm for many. In the long term, over 30% of workplace tasks have the opportunity to be digitised*insert MB reference. This Strategy anticipates and expects to support & enable the changes to working practices, skills and organisational design that will underpin an increasingly digitally enabled organisation, aligned with the Digital Strategy and associated funding streams.*

Data & evidence

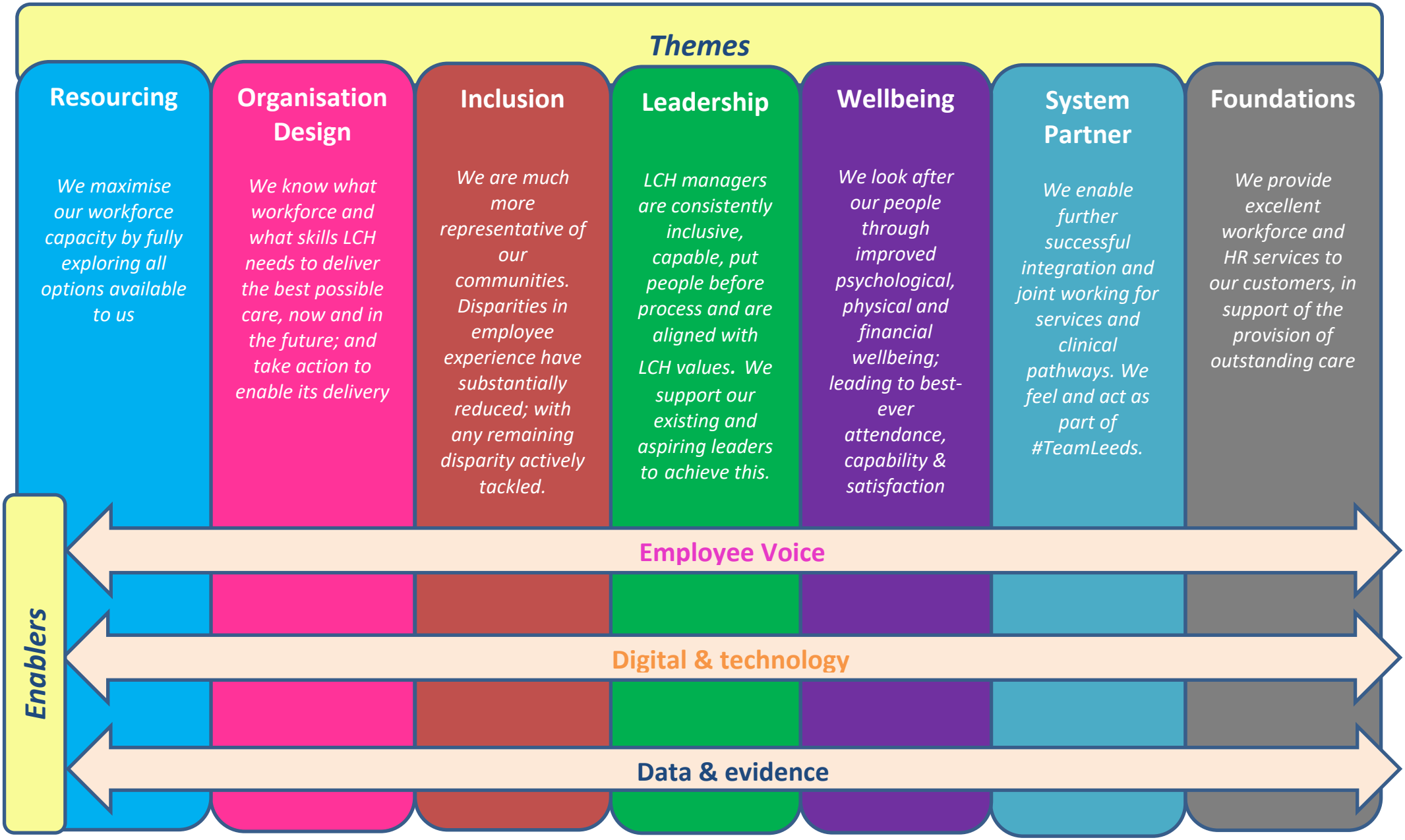
Understanding the case for, and the impact of, interventions is vital, to ensure efficacy and minimise waste. Our commitment with this Workforce Strategy is to base the interventions we prioritise and implement on evidence gleaned from data and / or research; and to monitor the efficacy of interventions using quantitative and qualitative measures. This will enable us to focus our capacity on the things that we expect to have the best impact in achieving our Ambitions; and to avoid or remove focus and capacity from those things which are comparatively of limited or no value to our Ambitions.

The following page summarises what we aim each of these Themes and Enablers will have achieved by 31 March 2025.

In determining each Theme, Enabler and Aim, we have asked ourselves our **Golden Thread** question: Will this help us to **attract, develop and keep the right people**, in order to deliver outstanding care?

Themes , Enablers and Ambitions

The Ambition for each Theme is shown in italics in the Workforce Strategy infographic below. Each Ambition describes what we want to have achieved by 31 March 2025.



What will this mean for LCH people? **Staff photos down side of this page**

By achieving the Ambitions described on the previous page, here is what we hope to achieve for all of us who work at LCH:

Resourcing

I am able to target the widest possible pool of suitable prospective applicants when I recruit to a vacancy ***TOO WORDY***

I want to stay at LCH and develop my career here (is this too parochial given #TeamLeeds ambitions?)

PHOTO

Organisation Design

I anticipate and plan for my team's long term and short term skills requirements

I use technology and remote working practices to enhance both my working life and the service I deliver

PHOTO

Inclusion

As a leader, I take action to identify and address inequalities

@LCH I Can Be ME : I bring my authentic self to work

Leadership

I have the training and support I need to lead at LCH

I am supported to balance my commitment to deliver outstanding services with my outside-work commitments

PHOTO

Wellbeing

I sensitively discuss individual health & wellbeing needs with my team members

I am heard, supported and can flourish at LCH

System Partnership

My team and I are part of #TeamLeeds

I work with people from other health & care organisations

PHOTO

Foundations

It is easy for me to access high quality, professional Workforce services and information

I use the People before Process approach to effectively support and manage my service

How will we achieve our Ambitions?

Within each Theme, there are between five and seven objectives. We believe that delivering these objectives will enable LCH to achieve the Ambition for each Theme.

Many of our objectives contribute to multiple Themes; for example our objective to improve our recruitment & selection processes will contribute to our Resourcing Ambition as well as to our Inclusion Ambition.

Changes external or internal to LCH might influence the objectives during the course of this Strategy, causing them to be adjusted or added to, so we can make sure the Strategy remains relevant throughout its lifespan.

Our objectives are described in the big boxes below and on the next three pages:

Resourcing

We maximise our workforce capacity by fully exploring all options available to us

1. *We will increase the breadth and quality of our attraction and marketing techniques and better "sell" LCH as an employer of choice; particularly in hard-to-recruit and high volume recruitment exercises, to widen and diversify our prospective applicant pool*
2. *We will specify and mobilise a new temporary staffing model to improve flexibility and resilience in staffing capacity*
3. *We will enhance our internal Bank capacity and increase fill rates by introducing flexible payment options, a clear reward structure and simple, technology-enabled shift booking capability*
4. *We will adapt our approach to internal "mutual aid" to ensure that employees are well-supported before, during and after; and to embed improved workforce agility into our organisational culture*
5. *We will attract and retain more staff by enabling a range of flexible working options that meet individual and service needs*
6. *We will develop our existing Appraisal processes to introduce an inclusive talent management approach that improves retention, staff development and succession planning*

Organisation Design

We know what workforce and what skills LCH needs to deliver the best possible care, now and in the future; and take action to enable its delivery

1. *We embed tactical, operational and strategic workforce planning principles alongside Business Units to deliver a mature workforce planning cycle and a clear understanding of required and future organisational workforce needs*
2. *We work alongside services and clinical leaders to specify and diversify career pathways, enabling development, progression and retention in the LCH workforce as well as creating enhanced opportunities for prospective employees*
3. *We work alongside services and in line with the LCH Digital Strategy to support and enable improved organisational productivity and the release of more time to care through implementation of new technology and approaches, including eRostering capability*
4. *We develop and implement a new Hybrid Working approach that better meets organisational and employee requirements*
5. *We engage with external partners to jointly address shared current and anticipated skills shortages*

Inclusion

We are much more representative of our communities. Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.

1. *We will identify the Leeds communities most under-represented in our workforce and work alongside them to understand and reduce barriers to working at LCH, particularly in leadership roles, through improvements to our recruitment and selection processes*
2. *As an anti-racist organisation, we will consider how we use appraisal processes, to emphasise the personal responsibility each of us has for calling out and reporting racist or discriminatory behaviours*
3. *We will identify and tackle areas of the organisation with most disparity in employee experience between those with and without protected characteristics, working with those areas to develop targeted action plans that reduce those disparities*
4. *We will work with all of our Staff Networks to better understand and incorporate their lived experience and diverse employee needs into our organisational approaches and policies*
5. *We will build on the success of the Allyship and Reverse Mentoring Programmes to continue our journey towards a compassionate and inclusive organisational culture, enabling every employee to feel that **#@LCHICanBeME***

Leadership

LCH leaders are consistently inclusive, capable, put people before process and are aligned with LCH values. We support our existing and aspiring leaders to achieve this.

1. *We will deliver a leadership development provision that adapts and responds to the organisation, the wider system needs and in the context of hybrid working*
2. *We understand the development needs of our aspiring, new and middle managers; and monitor uptake of leadership development courses to identify and close gaps in support or coverage*
3. *All leaders will be offered development to improve their skills and confidence in undertaking kind and curious conversations with staff, particularly regarding diversity, inclusion and wellbeing*
4. *Areas of the organisation experiencing detriment associated with leadership behaviours or capability are identified and action plans agreed in partnership with affected services*
5. *A new mentoring scheme is implemented, enabling experienced and skilled leaders to support and develop others*

Wellbeing

We look after our people through improved psychological, physical and financial wellbeing; leading to best-ever attendance, capability & satisfaction

1. *Employee wellbeing is of equivalent importance to the Trust Board as clinical performance, with scrutiny spearheaded by a Non Executive Wellbeing Guardian (is this congruent?)*
2. *The Health & Wellbeing offer is expanded to incorporate financial and lifestyle wellbeing support*
3. *The LCH psychological support offer demonstrably enables more people to remain well and at work*
4. *Fewer people report feeling pressure to attend work when not well enough to do so*
5. *Leaders and staff feel safe, comfortable and confident to engage in "wellbeing conversations", leading to improved understanding and support*
6. *Employees with lived experience of health conditions and/or disabilities are empowered to coproduce new LCH health & wellbeing approaches and initiatives to better meet their needs*

System Partner

We enable further successful integration and joint working for services and clinical pathways. We feel and act as part of #TeamLeeds.

1. *We develop and share a #TeamLeeds talent pipeline with health & social care city partners, prioritising collaboration on recruitment exercises and rotational post opportunities that meet LCH workforce needs*
2. *We lead on the full establishment of new protocols that enable working across organisational boundaries, supporting an increase in rotational posts and enabling inter-organisation teams to become increasingly Business As Usual*
3. *We are instrumental in the delivery of Leeds One Workforce objectives, including System Leadership and Talent Management, working closely with the Leeds Health & Care Academy and supporting the participation of LCH people*
4. *We collaborate with city partners to achieve economies of scale and success together in response to specialist needs and/or shared challenges*
5. *We enable the GP Confederation to become a mature employer with established policies, controls, terms and conditions*
6. *We develop the LCH ARRS offer to Primary Care into a self-sustaining model providing clearly-specified and valued services*

Foundations

We provide excellent workforce and HR services to our customers, in support of the provision of outstanding care

1. *Workforce services are benchmarked, consistent, stable, professionally led and with core KPIs visible to customers*
2. *"We Move Together": Workforce teams integrate and prioritise their work to deliver the initiatives and change which will deliver the most impact for the organisation.*
3. *We have a resourcing service for substantive and temporary roles that is customer focused and technology-enabled*
4. *HR Business Partners are embedded in Business Units, commissioning interventions and services from Workforce colleagues aligned to the Workforce strategy.*
5. *A strengthened analytics function, incorporating automation of core tasks, enables increased use of data to drive evidence-based decision making*
6. *The People before Process approach is fully embedded, embracing Just Culture and Speaking Up principles*
7. *Organisational Training and Development offer and approach is designed and delivered in partnership with QPD* ***INCLUSION SUBJECT TO DISCUSSION WITH DoN***

How will we know we've achieved our Ambitions?

In line with our Data & Evidence Enabler, we will be monitoring progress towards and achievement of our Ambitions using a dashboard of target quantitative and qualitative measures, which are summarised below. Our focus is on measuring outcomes more than inputs.

Resourcing *We maximise our workforce capacity by fully exploring and exhausting all options available to us*	• Bank fill rates increase by 10% and active Bank capacity increases by 20% • Turnover is below 12%, with stretch target of 10-10.5% • Vacancy fill rates achieve 90%, with more applicants for hard-to-recruit roles than in 2020/21
Organisation Design *We know what workforce and what skills LCH needs to deliver the best possible care, now and in the future; and take action to enable its delivery*	• Resourcing plans are in place for each Business Unit and refreshed annually • eRostering is fully implemented, enabling systematic skills and capacity planning by services • Hybrid Working is fully embedded, and Flexible Working options taken up by >50% of LCH staff
Inclusion *We are much more representative of our communities. Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.*	• X% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% • Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents, with aspirations towards complete closure of the gap • 100% of new starters and middle managers have been offered training in LCH's approach to inclusion
Leadership *LCH leaders are consistently inclusive, capable, put people before process and are aligned with LCH values. We support our existing and aspiring leaders to achieve this.*	• Quarterly and National Staff Survey results evidence overall improvement of at least 5 percentage points in staff experience of their leaders [Q nos], with areas identified as providing poorer leadership experiences for staff show improvement of at least 10 percentage pts • Appraisal rates achieve and sustain 90% compliance target post-pandemic, with quality assured through systematic monitoring
Wellbeing *We look after our people through improved psychological, physical and financial wellbeing; leading to best-ever attendance, capability & satisfaction*	• Absence due to stress / anxiety / depression is below X%, with overall annual sickness below 5% • Indicators from new Model Hospital Psychological Safety & Healthy Working Environments sections • Staff reporting that LCH takes positive action on HWB rises by X%
System Partner *We enable further successful integration and joint working for services and clinical pathways. We feel and act as part of #TeamLeeds.*	• A minimum of 4 recruitment or training exercises per year are delivered collaboratively with ICP partners • The GP Confederation has a full suite of pay, terms & conditions protocols
Foundations *We provide excellent workforce and HR services to our customers, in support of the provision of outstanding care*	• Service specification with KPIs is in place for Resourcing, Workforce Information and HR • TBC – based on KPIs eg time to recruit; average length of formal ER case

Scrutiny of progress towards the Ambitions is important, and we aim to provide this with transparency and accountability.

To achieve this, we will provide a 6-monthly progress report to the Senior Management Team, employee relations forums and to Trust Board. We will also publish this report via MyLCH and the LCH Midday Briefing to enable everyone in the LCH workforce to view it.

Further scrutiny of particular objectives within Ambitions will be carried out by other formal groups and Committees including the Business Committee through the Quarterly Workforce Report and the new Inclusion Forum through its biannual session.

Risks to delivery

As with every Strategy, it is important to recognise from the outset where risks to delivery may occur. Principle areas of risk are set out below. These will be taken into consideration in each of the 6-monthly updates provided to LCH on the Strategy's progress towards achievement of its objectives. [and will be added to the LCH risk log upon approval of the Strategy by Trust Board? Or appended as a table to this Strategy?]

1. **Changes to LCH or NHS priorities:** where changes in organisational direction or priorities are required, changes to the Ambitions and their objectives may follow
2. **Capacity constraints:** in the event of reduction in the financial or human resources available, delivery of objectives may be affected
3. **Capability constraints:** where scarce skills required for delivery are not available, delivery of objectives may be affected
4. **Continuation or repetition of Covid-19 pandemic:** associated Business Continuity measure and other pandemic-related work requirements might require reassessment of objectives and trimescales

What happens next?

Following approval of the Workforce Strategy we embark upon the matter of delivering its Ambitions against the seven Themes.

Monitoring, reporting and scrutiny of progress will help us to ensure we remain on track. Our course of action and objectives would be adjusted as necessary in response to the realisation of any risks or other significant changes and opportunities.

With every review of the Strategy's progress, we will keep in mind the **Golden Thread** that is so important – enabling LCH to **attract, develop and keep the right people**, in order to deliver outstanding care.

Thank you for reading this document and sharing in our LCH Workforce Strategy Ambitions for our current and future workforce, our patients and communities.

As we said in our Foreword, we are always keen to hear feedback; you can reach us at jennyallen.laurasmith@nhs.net .

Best wishes

Jenny & Laura

Appendix 1: Internal and external context slide / hexagons content

Appendix 2: Freedom to Speak Up Strategy

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (46)

Title: Health Equity Strategy update

Category of paper: For noting
History: none

Responsible director: Medical Director
Report author: Health Equity Lead

Executive summary (Purpose and main points)

Our Health Equity Strategy is LCH's response to how we address unfair and avoidable differences in the health of different groups and communities, by working with communities and partners to create equitable care and pathways.

This paper provides an update on work to deliver this since the strategy was approved in May 2021, as well as planned activity to December 2021.

Drawing on learning from national and local evidence, and engagement with services and partners, cross-cutting themes and priorities have been identified around:

- Commonalities in approach at national, regional and local level to focus on access, experience and outcomes, with the additional focus on unwarranted variation in treatment options and safety implications of that
- Leadership and governance to ensure consistency of commitment and to turn intention to action
- Mutually supportive activity around addressing inequity for patients and the diversity and cultural competency of the workforce
- Estates and the impact of accessing multiple services
- Air quality, climate change and sustainability

All of these require us to break from working in silos, whether that be between services, strategies and programmes, organisations, at place or ICS level. A shared purpose of improving health equity can support practical application of working across those boundaries.

Recommendations

Board is recommended to:

- Receive the report and progress update (Appendix 1) and note activity to be updated in next progress report in December 2021.
- Note the cross-cutting themes and support further joint working within Board members' own assurance routes to facilitate further discussion and progress.
- Consider the ICS focus on leadership in improving health equity and the ways this can be reflected in LCH's own leadership and governance, as well as the way we contribute to system leadership and governance at place and ICS levels.

Health Equity Strategy update (July 2021)

1. Background

Since the strategy was approved (May 2021), much of the focus has been on continuing conversations with staff and partners that were started in the development of the strategy:

- Reiterating focus on equitable access, excellent experience and optimal outcomes for all, reflecting the language now being used nationally, for example by Dr Bola Owolabi, Director of Health Inequalities, NHSE.
- Raising awareness of the health-care specific causes and impacts on the health of vulnerable and marginalised communities, both in the inadvertent ways health systems and services can add to existing inequity as well as the ways we can contribute to improving equity through the provision of services to our diverse communities.
- Exploratory conversations with services, programmes and workstreams about what they already know about any inequity in their delivery and identification of any support needs or resources to better understand the current position, identify and implement solutions.

2. Sharing and celebrating our change stories

- The University of Leeds and LCH have been awarded £3.4m funding from NIHR to lead national research into treatment for Long-Covid, which includes addressing health inequalities as one of its key deliverables. By informing policy, practice and research approaches to reducing inequality, the research will enable long-Covid care to be accessed by those from disadvantaged groups. The research is co-designed by a patient and public advisory group that includes diverse groups and communities to ensure issues of health inequalities and inequities will be taken into account. The qualitative research will be undertaken with a range of disadvantaged and intersecting social groups (women, minority ethnic, deprived, disabled, homeless and Traveller communities). Best practice that is co-designed in this way, with people from a range of communities, is likely to have an impact on practice from the early stages of the project, improving access, experience and outcomes for diverse groups experiencing Long-Covid.

- The updated Communications template went live on 19 July, with additional focus on a range of communication needs as well as digital inclusion. This template is mandated on SystmOne and with the associated communications in the lead up to the launch and detailed information and guides now available on new intranet pages dedicated to patient information and accessibility, is expected to have a significant improvement on both completion and data quality regarding patient communication requirements. In turn, this will have a positive impact on access, experience and outcomes in services.

- CAMHS have developed a set of easy-read guides to help people understand what to expect before and during neurodevelopmental and autism assessments. Not only will these improve equity in access and experience for people with communication difficulties or learning disabilities, they also respond to frequent feedback over the years about the sort of information people want about accessing our health centres and services generally. “You said… we did”.

- A new partnership has been established between the Long-Covid Service and our Giving Voice Choir, for people with neurological conditions and their carers, building on learning from a national pilot about singing for breathing and the benefits of this in recovery from respiratory and mental health impacts of long-Covid..

- The Estates team are undertaking a health needs analysis project that aims to compare community disease/ health data with referral patterns and service delivery to ensure that we are targeting the right communities – not just the ones that have the best referral rates. This project will ensure that where we have sites in areas of high deprivation that they are used effectively by our services.

- CAMHS identified that while Leeds College has 50% Black, Asian and minority ethnic young people in attendance, this was not reflected in the young people accessing the mental health offer in college. They have therefore started a pilot in-reach programme including drop-ins that do not require a referral through the college and can provide wellbeing plans or resources where this is all that is required, or engagement with young people onto other sources of support.

- LCH and partners have been shortlisted for the Nursing Times Awards 2021 Team of the Year for their work to widen access to palliative and end of life care for homeless and vulnerably housed people in Leeds.

3. Cross-cutting themes

A number of cross-cutting themes have been identified through engagement to date. These will continue to be worked through in the delivery of the strategy and linking with other appropriate workstreams.

3.1 Diverse and inclusive workforce

As described in the Health Equity strategy and other associated documents ('Our equity and inclusion lens - the different ways we impact on health equity'), while our health equity strategy focusses on equity in care and pathways, there are other ways as an organisation we also impact on equity. One of these is through our workforce, in terms of our workforce being representative of the communities we serve, cultural competency of staff at all levels and supporting the health and wellbeing of our diverse staff groups and communities. These are addressed in the development of the new workforce strategy (due October 2021). Supporting this, work is starting with the Organisational Learning and Improvement team about how we raise expectations around diversity and inclusion and are more explicit about these, for example within 'how we work' (our behaviours). Improving cultural competency and action on inequity for patients will improve this for diverse staff groups, and vice versa. With this in mind, CAMHS are developing some work with the Race Equality Network to consider how a joined up approach to diversity in workforce and equity in the population they serve could be mutually supportive and raise the impact and profile of both, rather than seeing this as two distinct pieces of work.

LCH is working in collaboration with partners across the city as part of the Leeds One Workforce Narrowing Inequalities Programme, whose purpose is to attract, recruit and develop a healthcare workforce from local communities in Leeds. Currently, the programme is focussed on Armley and the surrounding areas and the Red Kite View recruitment campaign. LCH has taken part in the virtual community engagement events promoting our entry level roles in the Administrative profession including Front of House and our domestic roles. We will engage with and navigate candidates through a modified recruitment and selection process during this first phase with the future aim to increase our impact through expanding opportunities and adapting pathways and support.

3.2 Estates

The impact of poverty and deprivation on health and inequity includes the cost and time of travel, the complexity of journeys when using public transport and that people are more likely to be in jobs where it is harder to take time off for health appointments, either for themselves or for children or other people they have caring responsibilities for. Our use of estates can be a key enabler in ensuring not only that we do not inadvertently exacerbate existing inequity, but also that we are proactive in taking action to address it. This has been raised particularly by children's services, where children with additional needs often require multiple services and it is therefore beneficial to them and their families to be able to provide multiple appointments in the same place and for that place to be straight-forward and cheap to get to for our most deprived communities. We will also explore the impact of accessing multiple services in other areas, particularly relating to the impact of having multiple long-term conditions, where there is evidence that people living in poverty are more likely to have multiple long-term conditions, as a well as a correlation between multiple long-term

conditions and poor mental health and with insecurity in housing (evictions). Joint work with estates will enable us to consider how, as a whole organisation rather than individual services in silos, we can best address the impact of accessing multiple services.

3.3 Climate change

Leeds City Council's new air quality strategy is explicit about the need to support those living in those communities most exposed to dirty air. These are often also the communities who are experiencing compounding inequities for other reasons too – areas of high deprivation, poor living and work conditions, greater prevalence of respiratory and other long-term conditions and the associated intersectionality between deprivation and minority ethnic groups. Work to address our impact on air quality will support improvements in the health of those communities and address inequity.

4. Learning from partnerships

Partnership continues to be an important way of working in the development and delivery of our health equity strategy. Building on the update provided in Appendix 1, commonalities, shared priorities and mutually supportive future connections can be seen in:

4.1 **West Yorkshire and Harrogate Integrated Care System** 10 big ambitions and work to reduce health inequalities. LCH connects directly into this work through the WYH Health Inequalities Group, other workstreams relating to specific communities' experience of inequity such as Learning Disabilities, the Communities of Practice, Health Inequalities Academy and most recently the Leadership Health Inequalities system training with the Kings Fund. All are focussing on a movement to action and system-wide learning from existing good practice, recognising that we are not starting from scratch and that this enhanced focus on addressing inequity builds on what is already happening. The ICS leadership session called for 'step-change in governance' to ensure that addressing inequity in health is part of everything we do. It discussed the role of leaders: how we make it easy for our staff to work with communities to address inequity and the importance to governance of consistently asking the question 'what impact does this have on health inequalities'. There was a recognition of the implied or explicit permission required to not know the answer to that question at the time, but that it came with a responsibility to find it out. This is reflected in previous discussions with Board, Quality Committee and Business Committee about our equity and inclusion lens and how we ensure consistency in commitment and action on this agenda. Proactive awareness-raising and the addition of equity in reporting requirements work together to achieve this, along with consideration from Boards, committees, their sub-groups and programme boards of whether they have assurance that we are neither inadvertently increasing inequity nor missing opportunities to improve health equity. The EDS2 outcome relating to the identification in papers that come before the Board of equality-related impacts including risks (Board paper, March 2021) can support this.

4.2 Citywide **Tackling Health Inequalities Group** (THIG) concerns itself with the role of health and care in addressing inequity, while the recent Joint Strategic Assessment (formerly JSNA) is broadly focussed on wider determinants. While there are links with work to address wider social determinants, THIG's focus reflects our own, that our strategy is focussed on what we can do as a health provider – understanding how we as a health provider contribute to or exacerbate inequity, as well as the role of our services in meeting the health needs of vulnerable and marginalised communities. THIG's journey in influencing citywide and emerging ICP structures in addressing inequity reflects our own commitment to moving from understanding inequity to taking action to address it.

4.3 **LTHT** recent work on inequity has identified some key lines of enquiry around differences in access (demand, referrals, planned and unplanned care, waiting times), treatment options and outcomes based on demographic and socio-economic status. This is broadly reflective of our own focus on access, experience and outcomes, with the addition of a specified focus on variation in treatment options. This focus has also been identified within work on inequity and patient safety (National

Patient Safety Strategy and Yorkshire Quality and Safety Research Group). LCH and citywide work to reduce unwarranted variation will address the impact of individual practitioner bias in treatment options, but further work will be required system-wide to understand and address inequity in the safety and effectiveness of treatment and devices across diverse patient groups.

5. Capacity

The strategy implementation plan identified a risk that "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". To mitigate this, the secondment of the Health Equity Lead has been extended to July 2022, which will provide leadership capacity for the first full year of implementation. The Public Health Registrar supporting this work is moving onto his next placement at the beginning of August. There will be a gap before the newly appointed public health consultant working across the three provider trusts commences in post, but public health input will continue to be available through the citywide Tackling Health Inequalities Group.

6. Governance

Following Board discussion (May 2021) about reporting for the health equity strategy, the following annual process has been put in place:

- Strategy update report to March, August, December Board meetings each year, starting from August 2021
- Board workshop – January each year, starting from January 2022.
- 'Deep dive' with Business Committee in October 2021 and Quality Committee in April 2022 (repeated for following years).

The existing internal LCH health equity group is being expanded to include Business Unit representation, third sector representation and exploration of the best way to include other partners such as LCPs. This group is testing out a more 'action learning' approach to influencing change, acting as 'critical friends' to each other to maintain the scale, pace and accountability to each other and our communities in how action is taken across LCH to improve health equity.

7. Next steps

Delivery of the strategy will continue in line with the activity given in Appendix 1, building on the learning and priorities shared within this paper, through discussion with Board and ongoing engagement with services, corporate teams, partners and communities.

8. Recommendations

Board is recommended to:

- Receive the report and progress update (Appendix 1) and note activity to be updated in next progress report in December 2021.
- Note the cross-cutting themes and support further joint working within Board members' own assurance routes to facilitate further discussion and progress.
- Consider the ICS focus on leadership in improving health equity and the ways this can be reflected in LCH's own leadership and governance as well as the way we contribute to system leadership and governance at place and ICS levels.

Appendix 1: Progress update on strategy delivery

Objectives	Year 1 focus	Update (July 2021)	Planned work to December 2021
Increase understanding of health equity in our services	We will improve the recording of diversity and inclusion data, starting with ethnicity, postcode and communication requirements. We will then review the data that tells us about the access, experience and outcomes of Communities of Interest, starting with ethnicity and deprivation. We will increase the meetings and reports where health equity is considered and use our analysis to plan year 2 priorities.	• By the end of August 2021, Business Intelligence will have prepared a draft equity data report available on PIP for services using SystmOne, which will show by ethnicity and deprivation: - Access – referrals and first contacts - Experience – completion of communication template - Outcomes – improvements, no change and worse outcomes for those services that have outcome measures available. As more outcome measures are developed, equity reporting will be part of this. • Patient Engagement Champions session has been held on how services get feedback on access, experience and outcomes for all and understanding differences in this for diverse groups and communities with further work planned to review these additional sources of qualitative health equity data. • Learning from evidence and experience in LCH, a guide to analysing equity data is being drafted.	• Review the draft equity data report with services and Business Intelligence Team to sense-check both the data provided and the newly-developed guide to analysing equity data • Once analysis of the completion of the communication has been undertaken, this can then be compared to the use of translation services to understand implementation • Further work with LMWS and CMHS who use a different clinical system but have bespoke reporting and analyst capacity to understand their equity data
Work in partnerships	Delivering our 3rd sector strategy, including health equity priorities. Supporting delivery of LCPs health equity projects and Synergi mental health projects. Engagement with THIG and WYH health equity programmes and communities of practice. Taking part in the EDS2 partner review and achievement of Sanctuary	• 3rd sector strategy workshops and discussion at Strategy Steering group about health equity impact and potential activity in each workstream. • Synergi has reviewed the mental health needs assessment for children and young people with connections to both mental health and 0-19 services. • THIG – development of a citywide toolkit, engaging in the new ICP structures to consider their impact on and role in addressing inequity, supporting the new Solidarity Network programme funded by Kings Fund https://mikechitty.blog/1410-2/	• Continued engagement for learning and influence in existing partnerships • Recruitment of 3rd sector reps to LCH health equity group • Development of action plan for a coordinated city-wide approach to addressing inequity in the health of vulnerable migrants. Connections with migrant health board and work to achieve health streams of sanctuary.

	Health award with provider partners.	• Engagement with WYH (health inequalities and LD groups and communities of practice) and system-wide planning session with Kings Fund	
Develop tools and resources	In year 1, our tools and resources to support leaders, staff, partners and communities to work together to identify and address inequity will include: Equity and Quality Impact Assessment process, Review Panel and EIA information sessions; Health Equity MS Team channel and intranet pages; document outlining principles and minimum standards for understanding and using data; Communities of Interest insight documents.	• Health equity group continues to meet monthly supporting identification and prioritising joint work and resource / information requirements • Delivery of 3 EQIA and 3 equity-specific information sessions and engagement in first EQIA review panel held as part of the new process • Team discussions to raise awareness of health equity, impact on marginalised communities – Children's Management Team, ABU leadership, Virtual Ward (Frailty), Health Case Management, CAMHS, Long-Covid • Guide to support analysis and understanding of health equity data under development	• Explore and test out different methodologies for LCH's health equity group to inform and influence change. This will support understanding of implementing change without a formal change programme approach. • Review of EQIA and EIA information sessions to inform future delivery • MS Teams channel for health equity • Health equity intranet pages go live • AHP health equity change stories, based on new AHP framework to support AHP day in October
Focus on equity in quality and safety	Analysis by ethnicity and deprivation to understand and act on inequity in mortality, pressure ulcers and other incidents, complaints and concerns. Consider equity in our proactive approaches to quality, including research, evidence-based guidance and outcomes. Develop an equity assessment process in the development of	• Mortality data has been reviewed by overall mortality, mortality in the over-70s, age at time of death and by ethnicity. Interpretation at this early stage is challenging, with further analysis alongside additional data sets required. • Connection to Yorkshire Quality and Safety Research Group work on how the risk of harm from healthcare varies between different groups of patients, the mechanisms driving these differences, and what possible solutions may be able to reduce this inequity	• Use learning from the successful NIHR long-Covid research bid and its approach to the inclusion of equity as a key deliverable and diversity within patient participation to inform future research • Further development of plans to understand potential inequity in safety in LCH, informed by the new National Patient Safety Strategy

	clinical policies and protocols.		
Address inequity through person-centred care	Support 100% Digital inclusion projects and share learning within LCH service delivery Support delivery of self-management activity that improves health equity Develop awareness and identify actions to address inequity through shared decision-making, health literacy and personalised care planning and support.	• Digital inclusion is now part of the communications template (launched July) • The development of self-management materials are linked to new resources and information on the intranet about creating accessible content which will improve access and outcomes in self-management	Continued support of100% digital inclusion projects, and charitable funds provision of tablets to carers, linking to services who identify digital needs through the communications template. As further work is undertaken to understand service need around health equity, this will be aligned to activity around shared-decision making, health literacy and personalised care planning and support.

Test different ways of working	Identify and implement solutions to inequity in long-Covid, mental health and frailty. Review learning from delivery to plan broader testing in year 2.	• Mental health
		  ○ Engagement with Leeds Mental Health Strategy and transformation of community mental health including transition from children's to adult services and improving inequity in access through earlier engagement and support for mental health (reducing proportion of people accessing crisis services when not known to other mental health services)
		• Long-Covid
		  ○ New partnership with Giving Voice Choir, building on learning from national pilot about singing for breathing to engage with local community choirs.
		• Frailty
		  ○ First areas of focus agreed as length of stay by gender and postcode
			• Testing new approach to mental health including Making Every Contact Count (mental health) and roll-out of #Askmehowlam campaign around mental health and long-term conditions
			• Learning from evidence-base developed through Long-Covid research
			• Understanding impact of accessing multiple services and impact of this on estates requirements
			• Increased understanding of inequity in length of stay in Virtual Ward (Frailty) informing action in both VW and NT transformation

Share successes and progress	1st edition of LCH change stories shared with services and partners to prompt further engagement, with additional change stories shared through Midday Briefing and Health Equity intranet and further editions of LCH Change Stories collated, analysed and shared in Board reports. Other opportunities to share progress including Quality Account and Thank You event.	For specific examples, please see section 2 of the Board paper: sharing and celebrating our change stories. Success and progress have been shared in engagement with services, through partnerships, on social media and My LCH Awards and Thank Yous Hub	Ongoing sharing and learning across networks, plus specific opportunities including: • EDS2 review with partners • Thank You Event nominations
Understand 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. 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.	• Social Value workshop and further engagement in LCH to understand how we take this forward, including connections with Anchor Institutions work • Scoping additional models • Ongoing discussions to understand the relative merits of an organisation framework with the potential to specify LCH's impact, and system thinking that organisational boundaries in understanding and evaluating impact are artificial and unnecessary.	• Supporting the development of system-wide approaches to understanding impact • Testing models of understanding in LCH, for example Ford et al (2021) "Framework for unpacking health inequalities" and Chris Bentley "implementation decay" model.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (47i)

Title: Research and Development Strategy Update

Category of paper: for assurance

History: Quality Committee 26 July 2021

Responsible director: Executive Medical Director

Report author: Head of Research and Development

Executive summary

This report provides an update to the Trust Board on the implementation of the Research and Development Strategy 2020-2025.

Implementation of the strategy has been impacted by the COVID-19 pandemic as the focus and priorities for key staff have been diverted to support the Trusts response and frontline services. However, progress has been made on aspects of the strategy albeit at a slower pace than planned.

Notable achievements over the past six months include:

- The contribution of over 700 hours of staff time made by LCH to the delivery of COVID-19 vaccine studies
- The delivery of the integrated community research project across LCH and the Leeds GP Confederation, resulting in GP practices recruiting research participants.
- Supporting the Leeds Long COVID Rehab Service as part of a collaboration who have been awarded grant funding to explore and compare gold standard care

Recommendations

The Trust Board is recommended to:

- **receive** this report and note the work undertaken to date

1 Background

The Research and Development (R&D) Strategy 2020-25 was approved by the Trust Board in February 2020, and shortly after this, services were impacted by the COVID-19 pandemic. Therefore, regrettably the implementation of the strategy has been impeded due to the need to refocus and reprioritise resources, to support delivery of frontline clinical services and the vaccination campaign.

Despite this progress has been made and a number of initiatives are underway that will support the delivery of the R&D Strategy.

2 Strategy Implementation

The R&D Strategy lists 4 workstreams: Workforce Culture; Patients and Communities; Partnerships and Sustainability. A summary of progress in each of these areas is shown below.

2.1 Workforce Culture

A successful bid to the Clinical Research Network for “Greenshoots” funding by the MSK Service, support by the R&D team, enabled two physiotherapists to make applications to the National Institute of Health Research (NIHR) for pre-clinical academic fellowships; one applicant was successful. The fellowship will enable the service to develop their own research, supporting the strategic ambition of bottom-up service-initiated research.

The evaluation of the “Greenshoots” bid has enabled the development of a Clinical Research Adviser role who will contribute to and develop a grassroots/service level inspired research workforce.

Work is underway with the Workforce Directorate and a range of corporate workstreams (including clinical outcome measures, audit and service evaluation), to explore how appraisal conversations and job planning can be used to develop improvements in clinical care, for example by developing and supporting research active practitioners.

2.2 Patients and Communities

This aspect of the strategy has proved challenging to implement given the COVID restrictions and shift to virtual/digital delivery of clinical care. It is anticipated that the progression of the Patient Experience Survey can be re-launched as research activity refocuses from survey-based studies to clinical intervention type studies.

2.3 Partnerships

In summer 2020, the Trust received funds from the NIHR Clinical Research Network to undertake a scoping project to determine the feasibility of an integrated research governance, management and delivery system in Leeds which would support research in the community. Additional funding was secured to further develop the work over the course of 2021/22, with LCH acting as the regional vanguard for

identifying and overcoming barriers to research outside of traditional hospital settings.

LCH is currently recruiting patients via GP practices across the city for two studies, ALABAMA[1] and BASIL[2]. The work with Primary Care was originally planned for the later years of the strategy (2023/24 onwards), however, this has been brought forward and the results are already being reaped; a pan-Leeds research partnership is developing with the support of the Leeds Academic Health Partnership.

The team have made a significant contribution to the COVID vaccine research undertaken in the city, contributing over 700 hours of LCH research staff time to the NOVAVAX[3] and COV-Boost[4] studies.

The Leeds COVID Rehab Service, led by LCH, will be one of ten clinics and eight Higher Education Institutions (HEIs) taking part in a new £3.4million study led by University of Leeds clinical academic Dr Manoj Sivan. The place of LCH in leading the set up and delivery of the clinic in which the Chief Investigator is based has placed us in a key position to lead and influence the clinical input and interventions required for Long COVID so far. The study will introduce a 'gold standard' for care that can be shared within England and the rest of the UK that will take account of both accessibility and cost effectiveness.

2.4 Sustainability

The team successfully generated income from an agreement with Wakefield-based Spectrum Community Health CIC to support their research governance and management and delivery.

3 Key milestones in the next six months

Work over the next six months will focus on:

- Successful completion of the integrated community research project (due to complete by March 2022)
- Exploring with city-wide partners the Leeds-place based research and development collaborative, ensuring a strong community-primary care voice is heard and respected
- Recruitment of up to two Clinical Research Advisers to progress the work at a Service and Business Unit level to engage the workforce in developing their own research ideas
- Agreeing a model for research to be "everyone's business" through better appraisal conversations and clinical development
- Supporting our CAMHS Clinical Academic to submit an application for an NIHR clinical doctorate, which will create opportunities for involvement in future CAMHs funding bids, service development, improved patient care and future publications attributed to LCH

[1] ALlergy AntiBiotics And Microbial resistAnce (ALABAMA): a study to find out if people with a penicillin-allergy label in their GP health records really do have an allergy
[2] Behavioural Activation in Social IsoLation (BASIL): a study aiming to prevent or mitigate depression and loneliness among older adults with multiple health conditions
[3] NOVAVAX: a COVID-19 vaccine study (now closed to recruitment). Leeds was the top recruiting site nationally
[4] COV-Boost: a study to evaluate different COVID-19 vaccines given as a third dose, to inform UK immunisation policy

- Recruitment of patients to the Long COVID study, providing real-time education to other healthcare staff and patients.

4 Strategy Review and Oversight

The R&D strategy is reflected in the R&D corporate team work plan and as such is discussed at the bi-monthly Research Governance Group. Discussions provide assurance of progress, with escalations being made via the quarterly reporting to the Quality Improvement and Assurance Group.

5 Recommendations

The Trust Board is recommended to:

- **Receive** this report and note the work undertaken to date.

Research & Development Strategy

July 2021 update

Leeds Community Healthcare NHS Trust

	Short (April 2021 to March 2022)	Medium (April 2022 to March 2024)	Long (April 2024+)
Workforce culture	☑ Development of structured research offer for retirees and part-time staff thorough CLASS ■ Implementation of Clinical Research Adviser posts	■ Launch of formal research offer as part of retirement planning package ■ Scoping of how research can be included in appraisal and job planning ■ Evaluation of Clinical Research Adviser posts ■ Development of research mentoring programme	■ Embedding of research into appraisal and job planning ■ Research career opportunities promoted as positive reason to join LCH through recruitment routes
Patients and communities	■ Refinement of the Patient Experience Survey (PRES)	■ Increased participation in PRES from all research active services	■ Friends and Family test to incorporate a question about participation in research
Partnerships	■ Scoping of additional academic clinical posts	☑ Scoping of existing primary care research infrastructure and opportunities for development ■ Appointment of additional Clinical Academic posts	☑ Development of joint LCH/Leeds GP Confederation Research team ■ Establishment of research partnership with social care ■ Evaluation of Clinical Academic posts
Sustainability	☑ Identification of potential non-NHS partners to offer research management studies to ☑ Evaluation of 'Green Shoots' physio pilot with MSK Service & scoping of further areas for 'Green Shoots' funding	■ Development of research management service offer	■ Implementation of research management service offer

Leeds Community Healthcare NHS Trust

Trust Board meeting held in pubic: 6 August 2021

Agenda item number: 2021-22 (48i)

Title: Medical Directors Annual Report (including Statement of Compliance)

Category of paper: Assurance
History: Quality Committee: 26 July 2021

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

Executive summary (Purpose and main points)

Purpose of the Report:

To provide Trust Board with an update and overview regarding our responsibilities as an employer of Medical and Dental staff within the Trust, including:

- Appraisal and medical revalidation
- Managing concerns
- Pre-employment checks.

It fulfils the requirements set by NHS England in relation to:

- Annual Organisational Audit
- Designated Body Annual Board Report
- Statement of Compliance

This Executive Medical Director's report covers the period 01/04/20 to 31/03/21 and includes information and activity relating to the Trust responsibilities regarding employment of medical and dental staff; based on the four key principles identified in the handbook and guidance regarding "Effective Clinical Governance for the Medical Profession"[1] published by the GMC in 2018. It is accompanied by the recommended template for the Statement of Compliance for 20/21, encompasses elements previous included in both the Statement of Compliance and the Annual Organisational Audit (AOG). Whilst this template formally refers to our employment of medical professionals, for the purpose of the Board report it also references our employment of dentists, unless specifically noted otherwise.

The report details key areas of progress and further identified work against each of the four key principles identified in the GMC document of 2018 as those that underpin effective clinical governance in this context. These are:

- Principle 1: Organisations create an environment which delivers effective clinical governance for doctors
- Principle 2: Clinical governance processes for doctors are managed and monitored with a view to continuous improvement
- Principle 3: Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination
- Principle 4: Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice

Despite the ongoing pressures resulting from the Covid19 pandemic the Trust has continued to provide high quality appraisal, supported and developed doctors and dentists in regards to both appraisal and their general wellbeing, improved engagement with medical and dental staff and continued to further improve our systems to better support our medical and dental staff.

Leeds Community Healthcare NHS Trust has a robust system in place for ensuring appraisal and revalidation of doctors employed by the Trust, for the appraisal of dentists and ensuring appropriate fitness to practice and fitness for role of other medical staff who work for the Trust. 34 doctors and 8 dentists have had an annual

[1] Effective Clinical Governance for the Medical Profession

appraisal for the year April 2020 and March 2021. 5 doctors have been successfully revalidated.

Work identified in the 19/20 Medical Directors report to further strengthen our systems and processes in regard to effective clinical governance of the medical profession has continued, and further steps are identified for progress during 20/21.

Key areas of progress during 20/21 and identified areas for further work during 21/22 are detailed underneath each of the four key principles. Full detail is encompassed within the Statement of Compliance attached to this report.

Recommendations

Board is recommended to:

- Note the contents of the 2020/21 Annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the statement of compliance and submission to NHS England

1 Introduction

Leeds Community Healthcare NHS Trust is a Designated Body responsible for the appraisals of all doctors employed by the Trust. Regulations require that all Designated Bodies must nominate or appoint a Responsible Officer, who must be a licensed doctor. This post is held in LCH by the Executive Medical Director and is therefore represented on the Board.

The Responsible Officer is supported by a Deputy Medical Director (Professional Standards) and a Head of Medical Education and Revalidation. The Deputy Medical Director post has been held by an individual holding consultant status since Sept 2019. This individual has undergone NHSE approved Responsible Officer training.

This report covers the period of 01/04/20 - 31/03/21. During this period LCH had a prescribed connection with 40 doctors, and responsibilities to 10 dentists who undergo annual appraisal but whose regulatory body the General Dental Council (GDC) does not currently have a revalidation process. The Trust also has responsibilities to doctors working in LCH who are self-employed or work via an agency but conduct regular work for the Trust. LCH does not currently provide appraisal and revalidation services for this group of doctors but supports them to ensure they have appropriate alternative arrangements for appraisal and Responsible Officer alignment.

In the last financial year LCH has appointed 3 consultants: two paediatricians and a CAMHS consultant.

LCH had had one doctor in a remediation or MHPS process during 20/21. This investigation has been undertaken by a doctor appropriately trained outside LCH. The Trust Board have been regularly updated in private session.

2 Position statement for 20/21

Principle 1: Organisations create and environment which delivers effective clinical governance for doctors

The four Trust policies related specifically to the employment of medical and dental staff were reviewed and renewed during 20/21:

- Appraisal and Revalidation Policy
- Medical and Dental Job Planning Policy
- Remediation, Reskilling and Rehabilitation Policy
- Maintaining High Professional Standards (MHPS) Policy

The Trust has robust processes in place to ensure appropriate checks are undertaken to confirm all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role. This has been further strengthened during 20/21 for doctors and dentists employed as agency or bank locums by the inclusion of fitness for role checks by the Medical or Dental Lead (or nominated deputy) and the inclusion of additional pre-employment checks for bank and agency staff including details of their Responsible Officer.

During 20/21 the participation of medical and dental staff in Leaders Network has been significantly increased, due to the ability to access these remotely. Appraisal

forums, medical and dental drop-in sessions and Medical Director attendance at consultant meetings have also taken place remotely. Medical and dental staff have reported that they have felt supported and better connected and engaged to the Trust strategic direction, priorities and values than they have done previously as a result of this.

Priorities for 21/22 include:

- Review of our recruitment processes for medical and dental staff, including consistency and quality of interview questions, patient involvement and AAC panel organisation
- Review and re-procurement of the electronic appraisal system in use within the Trust prior to the current 5 year contract with our current provider (PREP) coming to an end
- Changes to the Dental aspects of the Appraisal and Revalidation policy have been proposed in conjunction with the new Dental lead. These proposed amendments will require the policy to be reapproved by JNC and the Trust during 2021.

Principle 2: Clinical governance processes for doctors are managed and monitored with a view to continuous improvement

LCH has a combination of individual service and central mechanisms which hold information pertinent to effective clinical governance for medical and dental staff. Each service is responsible for meetings and discussions regarding these, and medical and dental staff of all employment status are encouraged to participate and actively contribute.

During 20/21 work was started with the Medical & Dental Leads, QPD and Workforce Directorate to align the service level and central systems and processes that sit behind this, where appropriate, in order to provide central assurance regarding the quality and validity of data underpinning it.

Work is underway to embed meaningful objectives into medical and dental job plans, and to incorporate elements of Trust appraisal into the Job Planning process. This is anticipated to further strengthen the engagement of medical and dental staff to service and Trust objectives, priorities and values.

Revalidation Panels were carried out as required during 20/21, linking with Trust systems to ensure that appropriate submission and reflection on incidents and complaints is included in the relevant appraisals.

Priorities for 21/22:

- Ongoing work in conjunction with the Trust Quality & Performance Panels and the Quality Assurance & Improvement Group (QAIG) subcommittee workstreams is planned to progress the opportunities for individual clinicians and services to routinely access data in a way that permits them to benchmark against their peers, both in service and nationally.
- A review of the feasibility of conducting an annual cross-verification of the Trust systems for recording incidents and patient feedback to ascertain whether it is feasible to conduct this annually. It is currently conducted every 5 years ahead of revalidation. This is consistent with an anticipated move to

Trust responsibility to provide this data for individual clinician appraisal from 21/22.

Principle 3: Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination

Revalidation Panels ensure that all revalidation recommendations are supported by a thorough consideration of all aspects of the five years of appraisal preceding the recommendation. Introduction of these panels during 18/19 has strengthened the Trust process and reduces the possibility of bias or discrimination. Our current processes have been reviewed by the Trust Equality, Diversity & Inclusion lead and identified as good practice.

In 19/20 it was noted that medical and dental staff did not appear to utilise the opportunities available through the Freedom to Speak Up Guardian (FTSUG). During 20/21 the role of the FTSUG was highlighted through engagement meetings with medical and dental staff, their leadership teams and the JNC. This year there have been two specific concerns raised by medical and dental staff out of a total of 84 cases, representing 2.4% of concerns raised via this route during 20/21. This is to be noted as an improvement in the ability of medical and dental staff to feel safe and able to raise concerns within the Trust.

Junior medical staff can also raise issue or concern via the Guardian of Safe Working Hours (GSWH) , and whilst no formal exception reports have been received, concerns have been raised via the GSWH to JNC for the Trust to hear and act upon.

During 20/21 there have been no grievances raised by any doctor or dentist employed by LCH.

Priorities for 20/21:

- Work is planned to benchmark our revalidation panel process against those from neighbouring Trusts to seek areas for learning and improvement, and particularly consider how we might appropriately include patient representation.
- Plans to make Unconscious Bias training available for all appraisers during 20/21 were not feasible due to the ongoing constraints of the Covid19 pandemic and this is now planned for 21/22.

Principle 4: Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice

LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard.

During 19/20 a quality assurance exercise was conducted utilising the NHSE approved "Appraisal Summary and PDP Audit Tool" (ASPAT) for the 18/19 cycle. No significant issues were identified although areas for learning and improvement identified by the audit were fed back to both appraiser and appraisees.

LCH adopted the recommended model of appraisal for 2020 and supported the implementation through regular Appraiser forums to which appraisees were also

invited. Submission of relevant information in regards to fitness to practice was maintained, but the focus of appraisal during the 19/20 cycle was on the doctors health and wellbeing and verbal reflection during the appraisal meeting as advised, rather than on a requirement to upload evidence in advance. Our appraisers and appraisees have fed back positively in regard to the approach taken.

During 20/21 regular Appraiser forums have continued to be facilitated quarterly via MS Teams. These are an opportunity for the appraisers in the Trust and the RO to discuss any new guidance or conduct development work to improve the quality of appraisals within the Trust. They also provide an opportunity for supported peer discussion regarding challenges and uncertainties. During 20/21, topics included:

- Wellbeing of our appraisers and their appraisees during the ongoing challenges of the Covid19 pandemic
- Introduction of the MAG 2020 appraisal form with an emphasis on wellbeing of doctors
- Challenges of appraisal via MS Teams and lessons learnt
- Feedback updates from NHS England revalidation team
- Peer support

Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a “Scope of Work” letter provided by their Medical or Dental lead, detailing their work within the Trust. LCH provides appraisal and revalidation support for all doctors with a designated connection to the organisation. During 20/21 we have noted the Trust employs a small number of doctors working via bank, where the situation regarding their Responsible Officer is unclear.

Priorities for 21/22:

- Due to the ongoing impact of the Covid19 pandemic it is not clear if peer review will be appropriate during 21/22 but if the opportunity is presented the Trust will actively participate.
- Clarify and establish the required support for doctors working for LCH on bank who have no other regular employment.
- Review the appraisal model in conjunction with guidance from NHSE and the GMC, continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.
- A further quality assurance exercise is planned for 20/21 adapting to the current guidance from NHSE on the focus of appraisal.

3 Recommendations

Board is recommended to:

- Note the contents of the 2020/21 Annual Executive Medical Director’s Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the statement of compliance and submission to NHS England

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Leeds Community Healthcare NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Dr Ruth Burnett, Executive Medical Director has held the post of Responsible Officer since 1st August 2018 Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Nil Comments: The Deputy Medical Director (Professional Standards) holds the post of Deputy Responsible Officer and has undergone appropriate training. The RO and Deputy RO are supported by a Medical Education and Revalidation Manager. The Trust has supported appropriate attendance for these three individuals at Responsible Officer and Medical Education meetings provided by NHSE, and the report contains evidence of reflection and learning from this attendance. Action for next year: Continue ongoing support with attendance at relevant meetings and education opportunities. Support with reprocurement of the online appraisal system provided for doctors as the current contract is due to expire during 21/22.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None

Comments: Accurate records of all licenced medication practitioners with a prescribed connection to LCH are maintained via PREP, which is a designated electronic system supporting appraisal.

Action for next year: Reprocurement required for a new electronic appraisal system ahead of the current contract ending

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Review and reapproval of Appraisal and Revalidation policy

Comments: The Medical Appraisal and Revalidation policy was reviewed and approved in September 2020.

The three additional Medical & Dental policies were also reviewed and reapproved during 20/21:

- Job Planning
- Remediation, Re-skilling and Rehabilitation for Doctors and Dentists
- Maintaining High Professional Standards (MHPS)

Action for next year: Changes to the Dental aspects of the Appraisal and Revalidation policy have been proposed in conjunction with the new Dental lead. These proposed amendments will require the policy to be reapproved by JNC and the Trust during 2021.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: to undertake a peer review with an assigned organisation

Comments: The Trust was not assigned a peer Trust with which to undertake a peer review during 20/21 due to the impact of the Covid19 pandemic. The Revalidation Team continue to engage with regional events run by NHSE.

Action for next year: Due to the ongoing impact of the Covid19 pandemic it is not clear if peer review will be appropriate during 21/22 but if the opportunity is presented the Trust will actively participate.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None

Comments: All doctors, regardless of employment status, are involved in governance processes relating to incidents and complaints. The Trust encourages them to be actively involved in any issues raised by patients, will ensure they have access to the relevant clinical record and will provide copies of documentation relating to these incidents for the purposes of appraisal.

Training and development opportunities are available and will be supported as appropriate for all doctors regardless of employment status. Every member of LCH staff has access to regular support from their clinical and operational line managers, including discussion regarding development needs and opportunities, clinical supervision and encouragement, and opportunities to be involved in local governance and service improvement processes.

LCH provides appraisal and revalidation support for all doctors with a designated connection to the organisation. During 20/21 we have gained a small number of doctors working for the Trust via bank, where the situation in regards to their Responsible Officer is unclear.

Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a "Scope of Work" letter provided by their Medical Lead, detailing their work within the Trust.

Action for next year: Clarify and establish the required support for doctors working for LCH on bank who have no other regular employment.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

   Action from last year: None

   Comments: LCH adopted the Appraisal 2020 model, and supported the implementation through regular Appraiser forums to which appraisees were also invited. Submission of relevant information in regards to fitness to practice was maintained, but the focus of appraisal during the 19/20 cycle was on the doctors health and wellbeing and verbal reflection during the appraisal meeting as advised, rather than on a requirement to upload evidence in advance. Our appraisers and appraisees have fed back positively in regards to the approach taken.

   Action for next year: Review the appraisal model in conjunction with guidance from NHSE and the GMC, continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

   Action from last year: None

   Comments: Yes, any doctors who have not had an appraisal have had an understandable reason for this and submitted plans to complete this within an approved timeframe.

   Action for next year: None

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Medical appraisal policy due for review and reapproval Comments: The Medical Appraisal & Revalidation policy was reviewed and approved in September 2020. Action for next year: Changes to the Dental aspects of the Appraisal and Revalidation policy have been proposed in conjunction with the new Dental lead. These proposed amendments will require the policy to be reapproved by JNC and the Trust during 2021

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None Comments: The Trust has a ration of one appraiser to five appraisees, ensuring that no individual is required to conduct an excess of appraisals, but all have sufficient experience to maintain competency and confidence. This ration is in line with NHSE guidance. Action for next year: Review number of appraisers and the potential to recruit and train more

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: None Comments: Appraisers are all supported to attend appraisal network/development attempts and are provided with both individual feedback and anonymised Trust feedback from the quality assurance process. LCH has continued to provide quarterly Appraiser Forums during 20/21, utilising MSTeams to enable this to continue despite the pandemic. Focus during this year has included support for appraisers and appraisees, cascading of new guidance and information, implementation of the Appraisal 2020 format and ongoing work to ensure appraisal covers the full scope of a

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

doctor’s practice. It also provides an opportunity for supported peer discussion and development in the context of appraisal.

Appraisees have been reminded about the need to have a whole of practice appraisal, including leadership or education roles in addition to work in other settings. LCH has developed examples and template letters that can be sought or provided to support appraisal of full scope of practice, and this has been highlighted to peer organisation as gold standard via the Responsible Officer network meetings.

Action for next year: Review feedback from appraisees once current round of appraisals has been completed. This will be fed back individually to appraisers and in a generalised manner with any relevant education required via the Appraiser Forums.

During 21/22 it is planned to review and widen the opportunity for supported learning, quality improvement and peer support in light of the increased opportunities for remote attendance provided during the Covid19 pandemic.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Ensure appropriate feedback in the form of scores and comments from the 18/19 cycle is provided individually to appraisers and aggregated information with key themes discussed in the first Appraiser Forum of 20/21. This was completed.

Comments: During 19/20 the Deputy Medical Director and RO Manager conducted a quality assurance exercise utilising the NHSE approved "Appraisal Summary and PDP Audit Tool" (ASPAT) for the 18/19 cycle. No significant issues were identified but areas for improvement and learning were fed back to appraisers.

Changes to the nature of appraisal mean that the appraisal tool previously used is no longer suitable. An alternative tool has not been proposed by NHSE and use of the previous tool would not be appropriate. During 19/20 there has been no complaints or appeals, and appraisers all received positive feedback.

Assurance is provided to Quality Committee and Board via the annual Medical Directors report, and regular monitoring of compliance with appraisal figures through the Trust Performance Brief.

Action for next year: A further quality assurance exercise is planned for 20/21 adapting to the current guidance from NHSE on the focus of appraisal.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	39
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	34
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	5
Total number of agreed exceptions	5

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None Comments: No recommendations have been made to the GMC during 20/21 regarding the fitness to practice of any doctors with a prescribed connection to LCH as a Designated Body. Regular meetings are held with the GMC ELA and any potential concerns are discussed here and appropriately recorded. Action for next year: Continue to engage with the GMC appropriately

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None Comments: The Responsible Officer made 5 positive recommendations to the GMC during the period covered by the report, all in a timely manner and supported by a Revalidation Panel. This covers all doctors for who recommendations were due during this period. Action for next year: Consider implementation of a formalised process for the results of the revalidation panels to be communicated directly to the doctors in question

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To further review these and implement learning from the

Comments: LCH has a mixture of individual service and central mechanisms which hold information pertinent to effective clinical governance for doctors. Each service is responsible for meetings and discussions regarding this, and doctors of all employment status are encouraged to participate and actively contribute.

During 20/21 work was started with the Medical & Dental Leads, the Quality team and the Workforce Directorate to standardise the systems and processes that sit behind this where appropriate, in order to provide central assurance regarding the quality and validity of data underpinning it. It has been identified that there is a lack of consistency regarding which data is available, discussed, where it is stored and whether it is benchmarked.

Work was undertaken in 20/21 to develop our appraisers in regards to Quality Improvement activities that could be undertaken as part of their annual appraisal cycle, aiming to improve the quality of submission but also the embedding of these activities within service quality improvement mechanisms.

Action for next year: During 21/22 and integrated in the Reset & Recovery work post pandemic we plan to conduct further work regarding this, and improving the access to data that enables an individual clinician to benchmark their clinical practice.

It is also planned to continue work with the Quality and Research teams to ensure that quality improvement work undertaken by doctors and dentists is embedded within service and Trust work regarding research, audit, quality improvement and clinical outcomes.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Implement process to ensure cross-verification of appraisal information submitted with Trust systems takes place in a more timely manner.

Comments: Revalidation processes include cross-verification of information submitted on Workforce and Trust systems to ensure any incidents and complaints are appropriately submitted and reflected on during a revalidation cycle. Existing routine systems to monitor the fitness to practice of all doctors include:

- Mortality reviews
- Clinical governance forums and meetings in service
- Quality improvement activity
- Freedom to speak up activity
- Never events

Action for next year: The process planned for implementation during 20/21 was further consulted on and reviewed, and has been subject to appropriate challenge from some appraisees despite this being a voluntary addition to the appraisal submission. It is now proposed to explore an organisational regular cross-verification of this data with Trust systems as is currently in place for revalidation panels. This proposal has been supported and welcomed by Medical & Dental leads, and in the Appraiser forum.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: The Maintaining High Professional Standards (MHPS) policy and the Remediation, Reskilling and Rehabilitation policy have all been reviewed and reapproved during 20/21.

Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Actions from last year: Review the options in regards to implementing a quality assurance process in regards to responding to concerns about doctors and dentists in the Trust, and present the findings to Board and/or Quality Committee.

Comments: High level information is collected in regards to the management of incidents, concerns, complaints and significant events across the Trust. At present it is not possible to separate this out regarding doctors and dentists.

Information is collected about the management of significant concerns regarding doctors including type, number and outcomes of concern. This report is discussed between the RO and Director of Workforce and is subject to the EDI monitoring systems in place within the Trust and the

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

numbers are so low within the Trust that it would not be possible to quality assure these other than the monitoring that currently takes place.

Action for next year: Explore whether it is possible to better identify medical and dental staff within the Trust systems regarding concerns, complaints and incidents in order to be able to appropriately analyse all concerns.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: None

Comments: The Trust is able to respond promptly to any request, this is signed off by the Responsible Officer prior to the transfer of information.

Work is ongoing to improve knowledge regarding the role and duties of the Responsible Officer outwith the Medical Directorate such that the duties and responsibilities for both doctors and the Trust are fully understood. It is important this includes the requirement to inform the RO regarding concerns and the need for information to be stored appropriately and readily available such that it can be provided on request to other Responsible Officers and regulatory bodies.

LCH has robust processes for requesting appropriate information from partner organisations on transfer to the Trust of new Designated Body doctors, and for providing it when doctors transfer out.

Action for next year: It is planned during 21/22 to develop a key information source for operational, clinical and workforce colleagues containing the key aspects of the responsibilities of the Trust and the Responsible Officer, accompanied by additional education opportunities and support on request. This has been identified as particularly important for services who employ doctors but do not have a designated Medical Lead in the service.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: None

Comments: All processes are managed according to the Trust's Maintaining High Professional Standards (MHPS) policy, which was reviewed and reapproved during 20/21. This policy was discussed with the JNC prior to implementation. The policy includes the requirement to discuss any such cases with the Practitioner Performance Advice (PPA, formerly NCAS) at regular intervals.

The Trust has a designated Non-Executive Director to support processes for responding to concerns and ensure that these are fair and free from bias and discrimination.

Issues around potential bias and conflicts of interest are discussed prior to commencement of any formal process by the senior team.

All doctors and dentists have access to the Trust Freedom to Speak Up Guardian and awareness has been raised during 20/21 to ensure all doctors and dentists are aware of this role within the Trust and how to access it.

Action for next year: None.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Review the process for employment of doctors and dentists via agency and bank.

Comments: The Trust has robust processes in place to ensure that appropriate checks are undertaken to confirm that all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role. These processes are in line with NHS mandatory pre-employment checks.

Work has been undertaken during 20/21 with the Workforce Directorate to ensure that the processes undertaken in regards to bank and agency doctors and dentists is similarly robust. These applications are now reviewed by the Medical or Dental lead (or appropriate deputy) for fitness for role prior to any employment commencing and a new form has been developed that ensures additional checks are incorporated in line with best practice (e.g. Confirmation of Responsible Officer).

Action for next year: Review and improve our recruitment processes for consultant medical staff, including development of a bank of appropriate questions, review and renewal of the interview paperwork and streamlining of the AAC panel organisation process.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Leeds Community Healthcare NHS Trust has a robust system in place for ensuring appraisal and revalidation of doctors employed by the Trust, for the appraisal of dentists and ensuring appropriate fitness to practice and fitness for role of other medical staff who work for the Trust. 34 doctors and 8 dentists have had an annual appraisal for the year April 2020 and March 2021. 5 doctors have been successfully revalidated.

The completion of the self-assessment template in regards to "Effective Clinical Governance for the Medical Profession" (GMC 2018) during 20/21 has been a valuable exercise to identify key priority areas to focus on during 21/22. This work will further strengthen our Trust assurance and quality improvement processes further in regards to our responsibilities as an employer of medical and dental staff.

Overall conclusion:

Despite the ongoing pressures resulting from the Covid19 pandemic the Trust has continued to provide high quality appraisal, supported and developed doctors and dentists in regards to both appraisal and their general wellbeing, improved engagement with medical and dental staff and continued to further improve our systems to better support our medical and dental staff.

The work undertaken during 20/21 will ensure that the work to embed these processes strengthens and supports Trust and service reset and recovery priorities. Clarity and improvement is also anticipated to ensure Trust processes better support the requirements for medical and dental staff processes, and the quality improvement and benchmarking required by medical and dental staff is better incorporated to the benefit of services and the Trust.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (49i)

Title: Combined Safeguarding Annual Report

Category of paper: For Approval
History: Quality Committee 26/07/2021

Responsible director: **Executive Director of Nursing and Allied Health Professionals**
Report author: Head of Service, Safeguarding

Executive summary (Purpose and main points)

This document forms the Safeguarding Annual Report for Leeds Community Healthcare NHS Trust (LCH) 2021-2022.

The purpose of the Safeguarding Annual Report is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2020 – 2021 and outline key ambitions for 2021-22.

The report covers the period 2020-2022 and provides information on:

- Safeguarding Adults
- Prevent
- Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood (SUDIC)
- Children Looked After and Care Leavers

Main issues for consideration

- Continue to evaluate and develop LCH safeguarding services, continuing to be proactive and responsive and keep safeguarding a priority within LCH.
- Work with partners to deliver the citywide strategic plan for safeguarding adults and children
- Raise awareness of safeguarding supervision and develop a training package to deliver to LCH managers as per LCH safeguarding strategy
- Implementation of MCA amendment bill of Liberty Protection Safeguards (LPS) legislation (depending on government guidance release date).
- Work with partners to establish an overarching guidance regarding capturing the “Voice of the Child” and provide evidence of how LCH services meet the requirements of that guidance
- Continue to work with the LTHT and deliver Children’s Medical Protection Service from an appropriate venue
- Engage with psychological support for staff
- In conjunction with SUDIC Strategic Reference Group partners organise a West Yorkshire wide SUDIC conference
- To explore along with other geographical areas the best model of health care for Looked After children and Care Leavers and seek to ensure we have the best possible services we can for this extremely vulnerable group.

Recommendations

LCH Board is recommended to note the contents of this report and approve its publication.

Leeds Community Healthcare NHS Trust

Safeguarding Annual Report 2020/21 Draft v3

Authors:
Head of Service, Safeguarding Adults, Children, Children Looked After (CLA) and Care Leavers – Lynne Chambers
Safeguarding Adults – Grace Stewart-Hanson
Prevent – Sharon Thomas
Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia – Kulvant Sandhu
Safeguarding Children – Wendy Brown
Specialist Child Protection Medical Services – Dr Anna Gregory
Sudden Unexpected Death in Infancy and Childhood (SUDIC) – Shelagh Davenport
Children Looked After and Care Leavers – Angela Dillon

Contents Page:

Introduction and Executive Summary

Leeds Community Healthcare NHS Trust (LCH) places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The Safeguarding Team ensure LCH meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005.

The purpose of this suite of reports is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2020 – 2021 and outline key ambitions for 2021-22.

Team Structure
The Safeguarding Team based at Stockdale House provides both corporate and operational functions and sits within the Quality and Professional Development directorate providing safeguarding advice, guidance, support, supervision and training for all LCH employees.

The team consists of Named and Designated Professionals, Lead Professionals, Safeguarding Advisors and Specialist Practitioners with responsibility for:

- Safeguarding Adults
- Mental Capacity, Deprivation of Liberty Safeguards and Dementia
- Prevent
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood
- Children Looked After and Care Leavers

The focus for 2020/21 has been to ensure Safeguarding has remained a priority during the COVID19 pandemic, which has required us to review, develop and change the way we offer our service to keep our patients safe and free from abuse wherever possible. The team have continued to ensure high quality training,support and advice has been provided to staff and managers when required. Importantly, this has all been underpinned by ensuring the teams emotional and well-being needs have been met during this period of increased safeguarding activity where the team have been remote working and therefore have had less face to face peer support

Alongside the global pandemic another motivator for change was to ensure we remain fit for purpose as we enter a time of significant change locally and nationally in response to the NHS Long Term Plan. The LCH Safeguarding Team will need to be agile in response as we move toward Integrated Care Systems (ICS) which will impact on how we organise and respond to safeguarding issues both within the Leeds health economy and across the West Yorkshire and Harrogate footprint; and as we work in ever closer alliance with the Leeds GP Confederation.

Partnership Working
The team works closely with the designated and named professionals within community paediatrics, the Clinical Commissioning Group (CCG) and across other health care providers as well as colleagues in Social Care to ensure our work force have the skills and support they need to safeguard all those in our care.

Governance Arrangements
Safeguarding reports are submitted on a twice a year to the Quality Committee and the committee receives the minutes of the safeguarding committee after each meeting. In addition outcomes from the safeguarding committee are shared with Leeds Clinical Commissioning Group (CCG) through the Children's and Adults Advisory groups and with Leeds Safeguarding Children Partnership (LSCP) and Leeds Safeguarding Adults Board (LSAB) through the relevant sub-groups.

Safeguarding priorities are set down in an annual work plan which is reviewed bi-monthly and updated through the Safeguarding Committee. Our safeguarding strategy up-dates are heard at Quality Committee twice yearly.

The Safeguarding Team is continually learning, improving and disseminating best practice. Through our contributions to LSCP practice audits, the continuous cycle of preparation for Ofsted Joint Targeted Area Inspection (JTAI) and CQC, as well as through collaboration with agencies in the Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Stronger Communities (previously known

as Safer Leeds), we have scrutinised, analysed and identified practice learning points as we strive to ensure the people of Leeds receive the best possible care.

Commitment
LCH has a responsibility to prevent and stop all forms of abuse or neglect happening wherever possible and to keep vulnerable adults safe, meeting statutory obligations and our duty of care.

LCH safeguarding team focuses on creating an environment where abuse is not tolerated, and safeguarding is everybody's business.

The safeguarding team offer guidance, support, and training to all staff in LCH to develop a workforce with the confidence and capability to meet our duty to safeguard; we work particularly with front line staff to ensure our patients can live free from abuse within their own homes. This level of support and guidance for staff and managers has been maintained throughout the COVID-19 pandemic.

It is acknowledged that some people require more support than others to make choices and manage risks; therefore, strong communication skills and quality mental capacity assessments remain key to ensuring a shared understanding of risk and action in the best interests of vulnerable adults.

Key achievements in 2020 – 21 are set out at the head of each report

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Safeguarding Adults

Key achievements 2020-2021:

- Maintained a full safeguarding service during COVID 19 (Remotely) Prior to COVID the team provided telephone advice and support which hasn't changed. We also provided face to face training which is now accessed via MSTeams, the numbers of staff members accessing training via this method has actually increased and feedback is good.
- Proactively continued to raise awareness of the principles of "Talk to Me, Hear My Voice" and "Think Family Work Family".
- Self -Neglect Policy published following Partnership working with LSAB.
- Worked in partnership with Safer Leeds to facilitate Routine Enquiry and Coercive Control, Risk and MARAC training.
- Creation and facilitation of Level 3 Safeguarding Training currently maintaining an upward trajectory projecting full compliance by August 2021.
- Successful online campaign implemented for Safeguarding Week Leeds-June 2020.
- Successful online campaign for White Ribbon Day, 16 days of action November 2020.
- Developed and delivered an online LCH Modern Slavery/Human Trafficking training package including flow chart and one-minute guide.

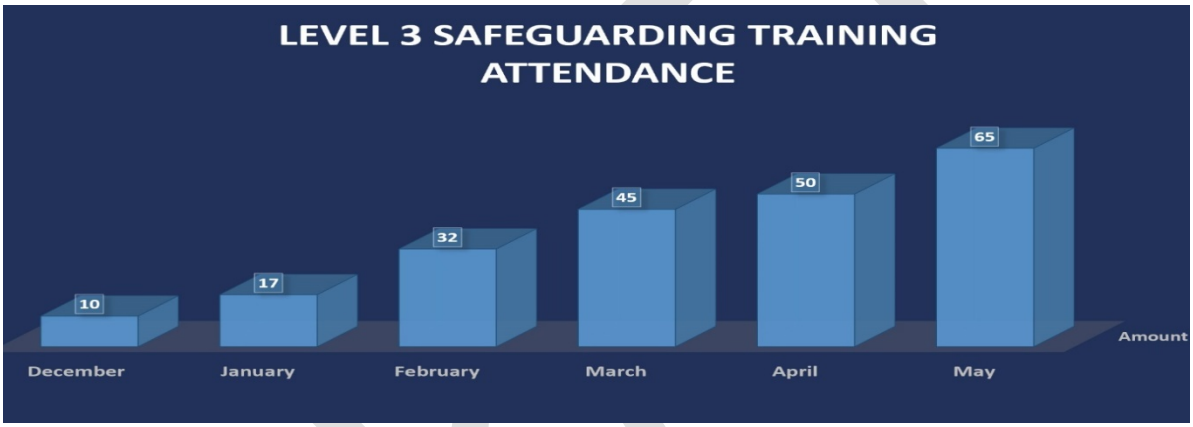
Key ambitions 2021-2022:

- Work in partnership with LSAB and partners to raise awareness of the city-wide Self-Neglect policy.
- Work in partnership with the LSAB to develop and embed an exceptional risk forum for Self-Neglect (SN) which will add another layer of support for staff working with SN as well as another layer of protection for the citiznes of Leeds
- Work in partnership with LSAB and our Health Economy partners to participate in the Citizen Practice Audit.
- Work in partnership with our Health Economy partners to raise awareness of the Domestic Abuse Bill April 2021
- Raise awareness of Safeguarding Supervision, its link to the Care Act and value within Adult Safeguarding, and its value to our practitioners.
- Launch of LCH Domestic Violence/Abuse Policy and Guidance on Supporting Affected Employees.
- Joint working within the Safeguarding Team and Safer Stronger Communities (previously known as Safer Leeds.) to obtain the Domestic Abuse Quality Mark (above policy is one aspect of the quality mark).

- Launch of Domestic Abuse Champion role within LCH (another aspect of the DV quality mark).
- Achieve compliance with safeguarding adults Level 3 Training of 85% or above.
- Work with a member of the CLA team to develop a video marking her experience of the loss of her sister due to domestic homicide. Video to be shared widely with partners.

A key priority for LCH is to raise awareness and empower staff to recognise the signs and symptoms of abuse. The Team want all staff to feel informed and confident to access the team for support and advice. The Safeguarding Adult Team does this by continuing to provide advice, training, and support to staff, in line with our statutory duties. We recognise that there are many different platforms for learning and always incorporate different techniques to help facilitate learning. Examples of social media campaigns and screensavers used for Safeguarding Week 21 (appendix 1)

Training
The team prioritised and worked hard to create and facilitate the introduction of Level 3 Safeguarding Training as per the Safeguarding Adults Intercollegiate Document, Adults Safeguarding: Roles and Competencies for HealthCare Staff (2018). This involved at times facilitating up to 3 sessions each week. The graph below shows the upward trajectory to date. The aim is to reach 85% compliance by the end of August 2021 At the time of this report we are on target to achieve this goal.



Safeguarding Adults Level 3 training feedback

'Thank you again for the session this morning Grace, It was really useful, informative and engaging. You are clearly very knowledgeable and passionate about this topic and we are so lucky to have you.'

Assistant director of AHPs, patient experience and engagement

Multi-agency working is a crucial element of safeguarding and the safeguarding team works closely with colleagues in other provider organisations, Leeds CCG, Adult Social Care, West Yorkshire Police, and voluntary and private sector organisations to safeguard and protect the people of Leeds.

Inter-agency Policy and Procedure
In response to the findings from a Safeguarding Adults Reviews, the Leeds Safeguarding Adults Board undertook a full review of inter-agency safeguarding policy and procedures; LCH as an LSAB partner was fully in engaged in the development of the new Leeds approach – "Talk to Me, Hear My Voice" a 'Citizen Led Approach'.

In 2021-22, LCH, in partnership with the LSAB will continue to embed the new Citizen–Led multi-agency policy and procedures. This has been somewhat delayed due to Covid restrictions. LCH were involved in the design of the leaflets used for advertising which ensured they reflected our patients and service users of the City in which we live.

Building on Making Safeguarding Personal (MSP) these procedures centre on the principles of citizen-led safeguarding, focussing on client perspectives, involving them, and listening to the person's wishes and views on prospective outcomes. Adhering to the 'Talk to Me Here My Voice' principles set out by LSAB.

Learning from Reviews

The Domestic Violence/Abuse agenda continues to be a priority area for Safeguarding and the Trust. The team have and continue to work hard to fulfil the requirements needed not only to educate staff, but to achieve the Domestic Violence Quality Mark awarded by Safer Stronger Communities.

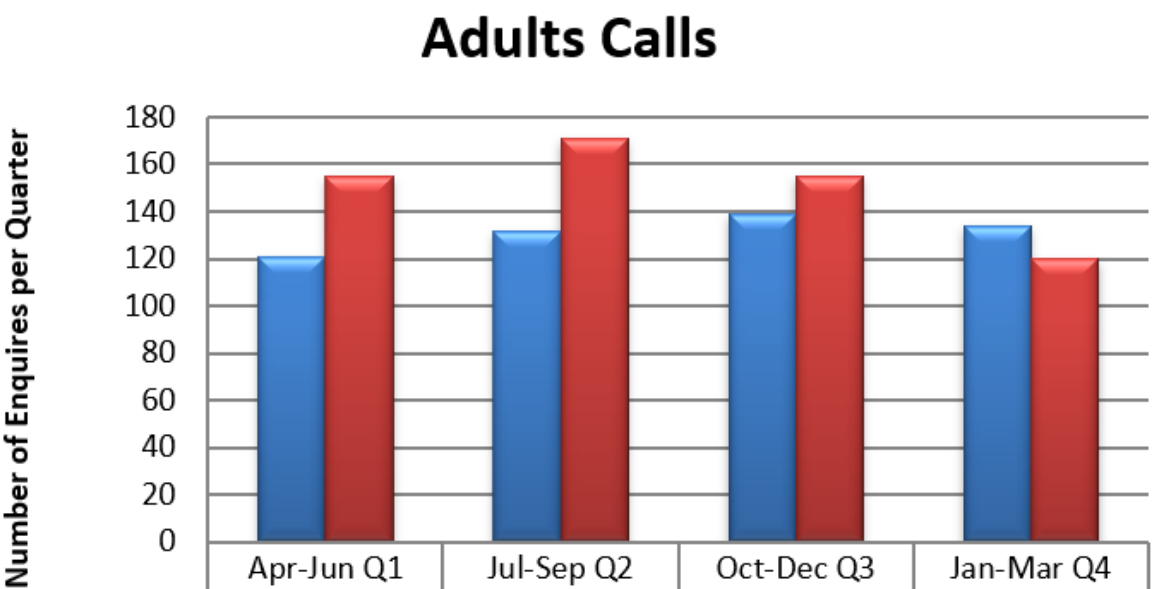
LCH continues to be an open and reflective contributor to Domestic Homicide Reviews (DHR) and Safeguarding Adults Reviews (SAR) where required. Both processes allow for analysis of findings from investigations carried out by individual agencies involved in the case, to make recommendations for improving future practice where this is necessary.

Previously DHR's highlighted the need for more knowledge and training around routine enquiry and SARs, and the need for more knowledge of self-neglect. LCH safeguarding team responded in partnership with Safer Leeds by providing training which has been tailored to address specific needs arising from DHRs and non-statutory Learning Lessons Reviews. Training continues to be delivered in partnership with Safer Stronger Communities (as above). It is also included within the Level 3 training package.

Safeguarding Activity

From March to December 2020 we saw an increase in calls for safeguarding advice and support. LCH safeguarding team provide advice and support to LCH staff on all aspects of safeguarding, as part of that process we audit the number of calls so we can collect themes and trends and ensure training and support is reflective of the needs of the community. Set below are graphs depicting the numbers of safeguarding advice and support calls, and referrals to Adult Social Care. Most months have seen a significant increase in calls to the team, with a decrease in calls from Jan – March this year. It is difficult to analyse the reasonbehind a reduction in calls but the team will continue to monitor.

Calls for safeguarding support and advice in total for 2019-20 and 2020-21

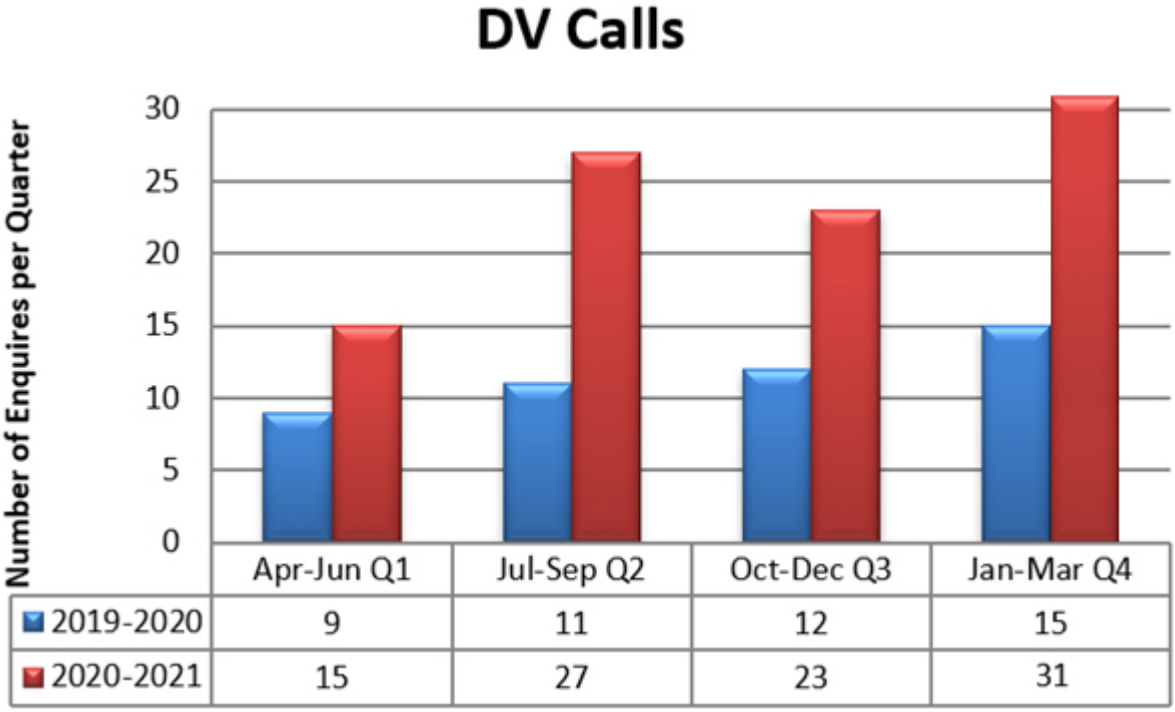


	Apr-Jun Q1	Jul-Sep Q2	Oct-Dec Q3	Jan-Mar Q4
2019-2020	121	132	139	134
2020-2021	155	171	155	120

There has been an increase in calls to the team for safeguarding support and advice during the pandemic with the exception of Q4 where there was a slight decrease. The team continue to keep safeguarding on

the radar by regular updates in the daily brief, continued training and bespoke drop in sessions on differing safeguarding topics.

Graph showing the number of calls relating to Domestic Violence/Abuse for 2019-20 and 2020-21.

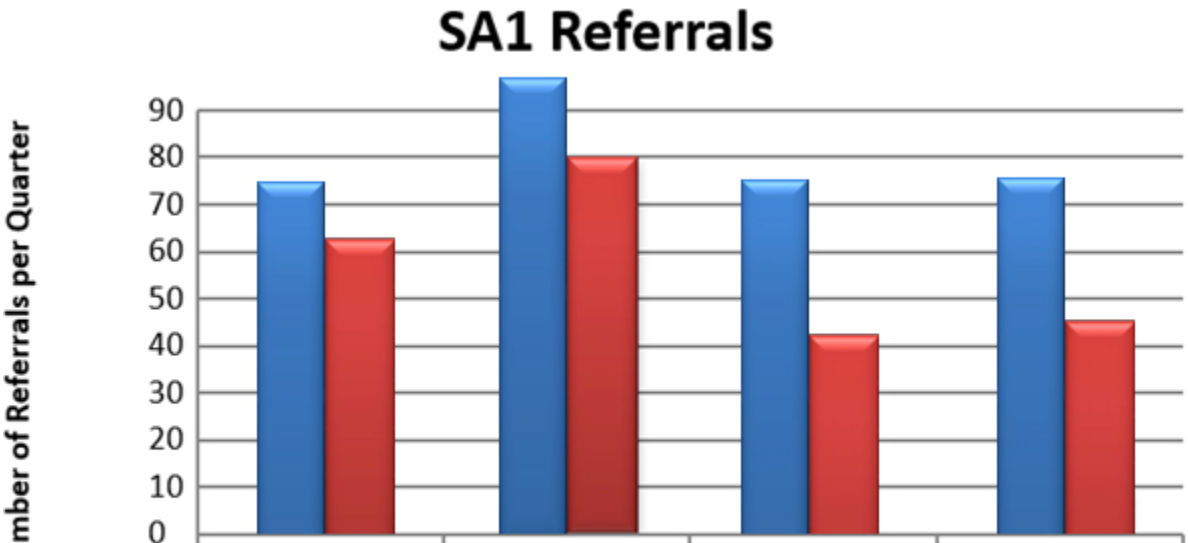


	Apr-Jun Q1	Jul-Sep Q2	Oct-Dec Q3	Jan-Mar Q4
2019-2020	9	11	12	15
2020-2021	15	27	23	31

Domestic Abuse and Routine Enquiry

Continuing from the themes published within the learning from reviews the Safeguarding team has reinforced the systems for staff to identify and respond to abuse. The use of Routine Enquiry is actively encouraged following appropriate training with the aid of a domestic abuse flowchart (below) to guide staff. We are not likely to see the full impact of COVID_19 on domestic abuse in Leeds until lockdown restrictions are fully lifted. It is imperative we are prepared to spot the signs of domestic abuse in our own relationships as well as our patients, are equipped to ask the right questions at the right time and have the knowledge to refer to appropriate services. Domestic abuse is included in Adult and Childrens safeguarding training and staff have accessed bespoke routine enquiry training. May 2018 – June 2020 134 trained, June 2020 – June 2021 194. These figures consist of mainly adult practitioners as routine enquiry is well established with childrens practitioners. Training and raising awareness will continue throughout 2021/22.

Safeguarding referrals to Adult Social Care 2019-20 and 2020-21



	Apr-Jun Q1	Jul-Sep Q2	Oct-Dec Q3	Jan-Mar Q4
2019-2020	74	98	75	76
2020-2021	62	60	42	46

There has been a noteable reduction in safeguarding referrals to adult social care over the past year, this could be due to a reduction in face to face visits, also people may have been referred to safeguarding from other sources (LTHT, family members, carers etc). As shown in the first graph we have seen an increase in calls for safeguarding support and advice in most months to which the team have been very responsive. We will continue to monitor the number of referrals throughout this year.

Safeguarding Champions

The Safeguarding team continues to engage virtually with LCH Adult Safeguarding Champions; this is set to reach a wider audience supporting staff to learn by sharing identified cases, receiving bespoke training, and developing their knowledge and understanding of the wider safeguarding strategy and agenda. We currently have 45 champions across the organisation, not all are able to attend the meetings every time over the past year an average of 15 have attended each meeting. Champions feedback included that they value the meetings, gain a greater understanding of safeguarding issues, themes and trends and feel more confident sharing learning to colleagues in their own teams. Our aim for the next year is to get representation from more services within LCH to attend the meetings.

Safeguarding champions act as ambassadors for safeguarding in LCH, imparting their enhanced safeguarding knowledge to their teams, ensuring safeguarding is on the agenda at team meetings, managing a safeguarding information board, and encouraging staff to maintain alertness to safeguarding in all that we do. It is hoped that this will become a joint plan over the next twelve months alongside the children's practitioners which will help facilitate some joint learning.

Domestic Violence/Abuse Champions

The Role of Domestic Violence/Abuse Champion is a new role that will be introduced alongside the Safeguarding Adults Champion's role. It is not specific to the Adult Business Unit, instead incorporating representation from CBU, SBU and Corporate Services. The role is like that above but will focus solely on Domestic Violence/Abuse. The recent Domestic Violence Bill of April 2021 and the changes that will bring with it highlight the ever-increasing need for our practitioners to share knowledge and expertise to their colleagues which will be increased from undertaking this role. Domestic Violence/Abuse champions working within the trust will increase the level of advice and support to staff, assist with raising awareness of the signs of abuse and help to keep it a high priority. 2021 – 22 will see the setting up of this group, creating terms of reference and outlining the main aims. By March 2022 champions will be fully functioning within LCH.

PREVENT

Key achievements 2020-21:

- Maintained a full service during COVID-19 (Remotely)
- Maintained involvement in local and regional forums to ensure LCH is informed of and engaged in continual practice development. Successful transition from a local e-learning to the national e-learning package Maintenance of training compliance more than the NHS England target

Key ambition 2021-22:

- Develop a webpage on My LCH to support staff in fulfilling their Prevent duty.
- Maintain services throughout the ongoing Pandemic.
- Maintain safe adapted services.
- Continue to raise the profile of Prevent across the organisation.

Prevent is one strand of the Government's counter terrorism strategy known as CONTEST. The Prevent strategy aims to stop people becoming terrorists or supporting terrorism. Prevent addresses all forms of terrorism but prioritises those according to the threat they pose to our national security. Prevent is delivered in partnership by a wide range of organisations including Health. Together we recognise that the best long-term solution to preventing terrorism is to stop people been drawn into terrorist behaviour in the first place.

The objectives of the Government's Prevent strategy are to:

- Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
- Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.
- Enable those who have already engaged in terrorism to disengage and rehabilitate.

Safeguarding vulnerable people who may be at risk of being drawn into terrorism is an essential part of the Prevent Strategy. Terrorism is a real and serious threat to us all because terrorists actively seek to harm us, to damage community relations and to undermine the values we share. Throughout the country there is a requirement for Prevent local action plans, to be in place to support vulnerable individuals –hence the necessity for a robust training package.

Health has a key role to play. Partnership involvement ensures that those at risk have access to a wide range of support, from mainstream services, through to specialist mentoring or faith guidance and wider diversionary activities.

A joined-up approach, motivation, and commitment to drive standards forward have resulted in achieving our training compliance expectations and maintain, what has been, an improving figure.

This has been achieved even during winter pressure periods and a global pandemic, which is a testimony to staff /team's resilience and commitment.

We acknowledged that face-face training generates a conversation and would be the gold-standard in an ideal world. However, within the current climate and risks around extremism, we felt we needed to reach out to all staff, regardless of roles and responsibilities.The e-learning resource is now available for all staff members; it meets the WRAP (Workshop to Raise Awareness of Prevent) training requirement for level three practitioners and counts toward the intercollegiate safeguarding competence / training requirements.

Regular meetings continue to take place across the Health Economy, where a shared learning approach and response has been adopted. This ensures continuity and reassurance around matters such as advice, consent, confidentiality, and documentation as well as support around each other's organisational practice.

The aim for LCH is to have a dedicated Prevent page with access links to training, information, resources, and contact details for concerns. Due to recent events, this is still ongoing and will be incorporated within

the new LCH media platform by the end of June 2021. Resources are shared across the Health Economy to be used for staff dissemination.

It is also important to note that Prevent, remains a legal duty and all NHS Trusts continue to be contractually obliged to collate and provide performance data-this is reviewed regionally before scrutiny by the National Safeguarding Steering Group.

Local Overview

The COVID-19 Pandemic has meant the UK has been on restricted lockdown measures. The changes to daily life have resulted in increasing community tensions, fake news and online usage by many.

In response to this a new national safeguarding website www.actearly.uk has been launched. The website is aimed at family and friends to encourage them to act early, share concerns and seek help if they are worried that someone they know is being radicalised. The website includes case studies, signs to spot, FAQs and details of a new national advice line staffed by trained Prevent officers.

The site also provides toolkits for staff and partners to access a range of support materials, from templates to posters to business cards and tweets. https://www.counterterrorism.police.uk/actearlypartners/

iThroughout the Pandemic, prevent concerns have continued to be addressed, regular monthly Channel Panels have continued via MSTeams and the Prevent team/police/chair and vice-chair continue to work effectively to address any concerns across the city.

National support for Channel and Prevent has come through the launch of the new Channel Duty guidance (Nov 2020). This provides a robust framework for building on much of the good work we know is already being delivered, whilst strengthening the quality and consistency of panels and the practice of panel members across England and Wales. This will enable us all to manage the vulnerability of individuals at risk of being drawn into terrorism more effectively.

Leeds 2021 Prevent Referrals

Referrals into the Prevent local authority and Police team come from many areas, schools, colleges, universities, healthcare professionals, social care members of the public, family members, the police themselves.

LCH staff continue to demonstrate professional curiosity and vigilance when assessing concerns. Contact with the Safeguarding Team continues for discussions pertaining to potential Prevent issues. Staff continue to work within the remit of their roles and responsibilities and are constantly developing and evolving, to ensure we offer the best experience of Channel/Prevent for clients/families and people who come through our services.

Leeds local Issues

The impact of COVID-19 has presented many issues for the people of West Yorkshire. The demographic of Leeds provides us with lots of challenges within our practice and daily life and communities continue to be affected by restrictions which may lead to an increase in people's susceptibility to radicalisation.

Local Authority/Police are working with local teams to address this change in risk and actively engage with families where young people may be exposed to negative influences online.

Schools and colleges having undergone periods of partial closures over the last 12 months and many people working from home the impact has been an increase in the amount of time people spend on the internet.

Vulnerable people have had more opportunity to be preyed upon, and those in isolation taken advantage of, with an increased opportunity for people to self-radicalise in the home. This increase of online traffic to these platforms raises concerns that the online presence may manifest into physical meetings with the easing of restrictions.

Leeds Community Healthcare (LCH) Response

Safeguarding accessibility has remained on full capacity throughout the pandemic and we will continue to offer support and advice through a range of media platforms.

LCH continues to have representation at Channel and Silver meetings, being an ideal platform for learning, reflection and ensuring that LCH continues to be compliant, effective and efficient around the Channel duty.

The PREVENT annual newsletter process is now live and we have received the 2nd newsletter produced this time by Leeds Teaching Hospital Trusts (LTHT).

Online e-learning on our electronic staff record (ESR) is now available and staff can access it with minimal disruption.

Advice and support from LCH safeguarding team.

Training for staff remains at a constant, which demonstrates the ongoing commitment from staff during these challenging times.

Latest quarterly training figures report: 97.1% level 3 uptake (B5 and above), 96.5% level 2 uptake (B4 and below)

Development of a resources page accessible for all staff will be available on the Safeguarding Intranet page, with additional support available from the Safeguarding team. This will ensure staff are able to access information swiftly whilst complement online learning.

Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Dementia

Key achievements 2019-20:

- The 3Ds Clinical Frameworks was submitted to NICE
- Planning and participation in multiagency city-wide public facing campaign, to promote Advance Care Planning within the city.
- Involvement in city-wide campaign to increase awareness and use of Lasting Powers of Attorneys (LPAs) including trust wide briefings.
- Organisation of city-wide learning event to increase practitioner's skills and practice of Advance Care Planning (event planned for March 2020, postponed due to Covid19, to take place within 2020/2021).
- Enhanced mechanisms in place for DoLS reporting within inpatient settings.
- Developed Electronic Patient Record (EPR) template to capture consent/MCA for children and young people.
- Adaptation of MCA training to continue with virtual delivery.
- Dementia training compliance: 96% for trust wide awareness training, 83% for tier 2 full day training.

Key ambition 2020-21:

- Full implementation of EPR template to capture and audit consent/MCA for children and young people.
- Readiness for implementation of MCA amendment bill of Liberty Protection Safeguards (LPS) legislation (pending on government guidance release).
- Implementation of Dementia Template within EPR to enhance care planning and transitions
- Conclude Delirium pilot within LCH contributing to the regional delirium work stream with NHS England and the Yorkshire & Humber Clinical Network
- Adapt current Tier two Dementia training and new 3-yearly refresher training into sustainable virtual delivery packages.

The purpose of MCA (2005) is *"to empower people to make decisions for themselves whenever possible, and protect people who lack capacity by providing a flexible framework that places them at the very heart of the decision making process".*
(Lord Falconer in the forward to the MCA 2005, Code of Practice).

Everyone working in health and social care who makes decisions for people who lack capacity has a legal responsibility to know and follow the MCA (2005). LCH has a statutory duty to ensure its staff comply with the legislations on consent and MCA (2005), to ensure the care and treatment delivered is lawful and best practice. This is also part of CQC's Key Lines of Enquiry (KLOE) Effectiveness domain which looks for assurances in this area.

The safeguarding team support the embedment of MCA (2005) into everyday clinical practice which can be evidenced for assurance purposes. Routine work that promotes best practice for MCA and Dementia include; giving specialist MCA & Dementia advice and guidance to staff, including the use of relevant legislations for consent and MCA (2005). Undertaking yearly audit to identify areas of development, facilitation of training and chairing the well-established MCA champions forum. This forum provides vital MCA clinical supervision, relevant case law updates, as well as sharing of learning from Serious Adult Reviews (SARs) where mental capacity has been a feature. Ensuring best practice for dementia care within LCH involves continuing as an active partner representing the trust at various citywide and regional strategic groups, ensuring learning, new developments, and consistent approaches are embedded into the trust's clinical frameworks.

Key Achievements:

Collaborative working

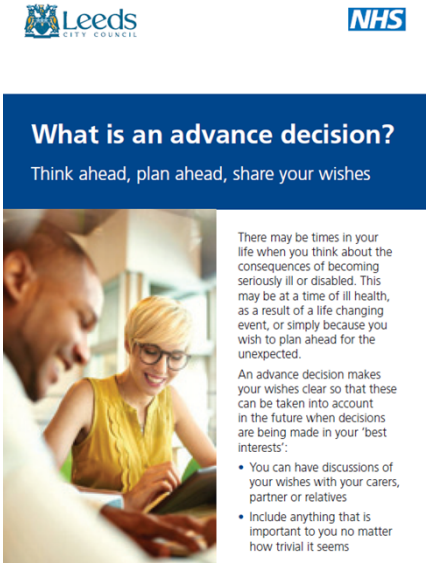
LCH continues ensure the priorities for MCA & Dementia within the trust are aligned with the citywide and regional strategic groups. The Named Nurse for MCA & Dementia continues to be an active member and deputy chair of the MCA- Local Implementation Network (MCA-LIN) which is a sub-group of the Leeds Safeguarding Adults Board (LSAB). LCH also contributes as an active member of the city's Dementia steering group, specialist Dementia & End of Life (EoL) group, and the Yorkshire and Humber Clinical Networks forum for Dementia (led by NHS England).

There is a concerted effort as the part of the MCA-LIN to focus on ensuring people's voices are heard, and to improve practice around this across the city. A conference was planned for March 2020 titled "Let's Talk, Planning Ahead" with the aim of increasing practitioner's knowledge and skills for capturing people's wishes. This learning event would promote the initiatives across the city such as Advance Care Planning, Lasting Power of Attorneys, and ReSPECT forms. Unfortunately this had to be postponed due to Covid-19 pandemic, there are plans to reschedule this during 2020/2021.

Through recognising the need to support carers of our patients and staff who care for someone living with dementia, the Named Nurse also has membership with the trust's Carer's steering group to ensure through the MCA & Dementia work stream the needs of carers can be identified and met. This has resulted in specialised dementia training sessions for LCH staff who are carers for someone living with dementia. Also collaborative working with Carers Leeds to deliver MCA Training to their volunteers who provide support to our patients and LCH staff who have caring responsibilities.

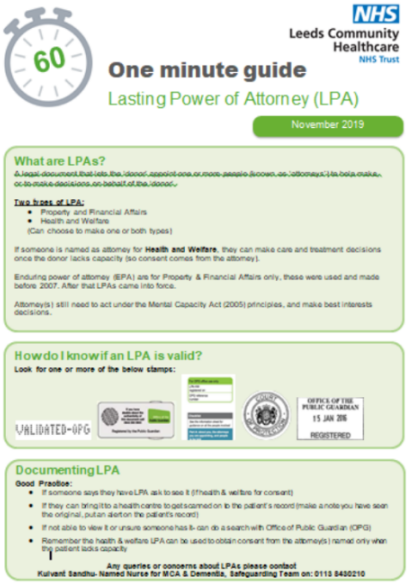
Making Safeguarding Personal

Best interests decisions made under the MCA (2005) are strengthened when we can establish the person's wishes prior to losing capacity; Advance Care Planning is one mechanism for this. Often completed well towards End of Life care, our aim is to improve the awareness and uptake of Advance Care Planning especially for those earlier on in their health conditions.
A public facing campaign took place in April 2019 involving all partner agencies within the MCA-LIN. Information leaflets were developed and used during discussions with members of the public about Advance Care Planning, at various locations across the city.



Following the event, a short video animation was also developed to further promote awareness across the health and social care sector, with plans for its use within GP surgeries and One Stop Centres across Leeds.

With initial support from The Office of the Public Guardian (OPG), another area of focus was promoting the awareness of Lasting Powers of Attorneys (LPAs) for Health and Welfare, which enables those named to make care/treatment decisions on behalf of those who have lost capacity.



LPA briefings were delivered to teams within Adult and Specialist Business Units, and a One Minute Guide (OMG) produced to equip teams with key knowledge and good practice when working with people who are considering or have an LPA. There was noted increase in safeguarding queries from staff around LPAs, who were ensuring correct LPAs were recorded, and where required raising safeguarding concerns with Adult Social Care and the OPG.

Quality improvement and assurance

This year also saw the development of a mechanism within EPR for recoding DoLS. This will enhance reporting within the inpatient Community Neurological service when a person may need to be deprived of their liberty to received care and treatment. This new mechanism allows for ease of reporting and monitoring for assurance purposes, and involved collaborative working with the service and trust's EPR team.

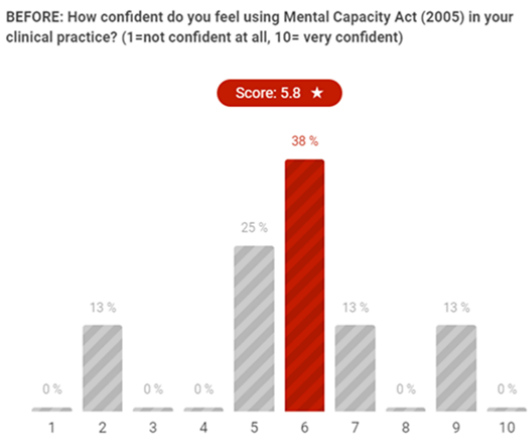
The Supreme Court judgement in September 2019 ruled that parents are no longer able to consent for the deprivation of liberties for their 16 and 17 year old's who lack mental capacity. Hannah House provide respite provision for children up to their 18th birthday, with many lacking mental capacity due to their complex health conditions. Training has taken place with staff to ensure good practice of MCA (2005) legislation, DoLS training. Processes are being developed to ensure the deprivation of liberty for these young people is authorised in accordance with the change in legislation.

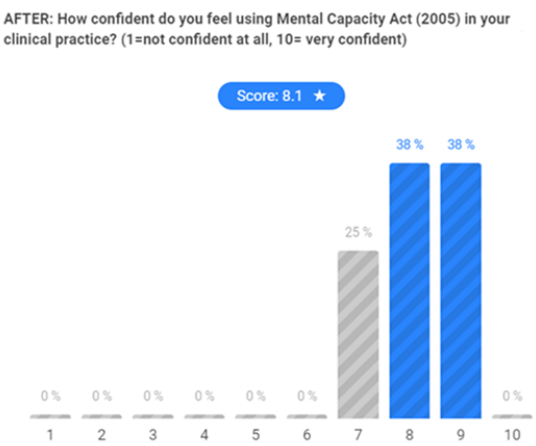
Further quality improvement work has taken place with colleagues within the Children's Business Unit to develop an EPR template to capture consent and MCA documentation for children and young people aged under 18 years. This will enable improvements in documentation and knowledge around the options for consent when working with children and young people, further promoting the child's voice in decisions around their care and treatment. The full implementation and roll-out across children's services will take place within 2020/2021.

Finally this year's MCA audit has focused on the Child and Adolescent Mental Health Services (CAMHS) inpatient unit Little Woodhouse Hall following the CQC inspection. The audit resulted in identifying areas of development around evidencing use of MCA (2005) and DoLS in clinical practice, these have been addressed with training. A re-audit will take place within 2020/2021 to evidence improvements made. This has also led to the development of another EPR template to enhance recording of consent and relevant legislations used for authorising deprivation of liberty, within the CAMHS service.

Developing the workforce and innovation

MCA facilitated training continues to evaluate highly in supporting clinical staff to embed the MCA (2005) and consent legislations into clinical practice, as demonstrated below in pre and post evaluations of this training.





Due to Covid-19 pandemic adjustments were made promptly to enable the MCA training to continue virtually. This has been successful with additional benefits of increased staff uptake and positive feedback for the new format. The MCA Champions forum has also continued successfully through virtual delivery adaptations.

"Thank You for the session today. It was really useful and you are very knowledgeable. I just wanted to say I know there's a sense that face to face training is better for all, that I actually felt the virtual training works really well. I noticed more people contributing than when in a training room session. Thanks again".

Participant from virtual MCA training

"One of the best training days I have been on in LCH. Teacher very professional and knowledgeable, so interesting. Many thanks".

"It was a really emotive and thought provoking session. I learned a lot and would definitely recommend it to anyone working with people living with dementia"

"Gave me a good understanding and support for both my work life and coping with my home life. Thank you".

Evaluation comments from dementia training

Dementia training continues to part of the trust's statutory/mandatory programme with increasing uptake, and is positively evaluated by staff who have attended. 96% of all staff within the trust have completed dementia awareness training (as mandated by NHS England) and 83% of staff who are required to, have completed the enhanced tier 2 full day training. This training equips staff with the knowledge and skills required to deliver person-centred dementia care. The year ahead we plan to develop the 3 yearly refresher tier 2 training package, with a view to adapt the current tier 2 package to enable virtual delivery.

Key ambitions:

The MCA amendment bill (2019) gained royal assent in May 2019, with the Department of Health & Social Care announcing plans to bring LPS into force on 1st October 2020. This new legislation will replace the current arrangements under DoLS whereby LCH will take responsibility to authorise the deprivation of liberties for those who lack capacity within our inpatient settings. Due to Covid-19 pandemic, the government has delayed publication of the of Code of Practice, this needed to progress LCH's planning of forming internal governance structures ready for implementing the new law. LPS legislation coming into force on 1st October 2020 is now likely to be delayed by the government, LCH will focus to resume this planning within 2020/2021 as soon as the Code of Practice is published, working with partners within the MCA-LIN.

Dementia

The development and release of a dementia template on EPR will aid staff to incorporate the dementia quality standards into care planning and delivery for patients living with dementia. This template will also aid future audit development, to improve the patient experience. Work is progressing with partner trusts to see how the information can also be shared to aid better transitions of care for those living with dementia.

A delirium pilot commenced this year with further training sessions delivered to embed the 3Ds clinical frameworks, the latter stage of the pilot will be concluded within 2020/2021, contributing to the regional's delirium work stream within the Yorkshire & Humber Clinical Network.

Finally the citywide dementia strategy is being refreshed during 2020/2021 where other key priorities will be identified and aligned to LCH's strategic work around dementia.

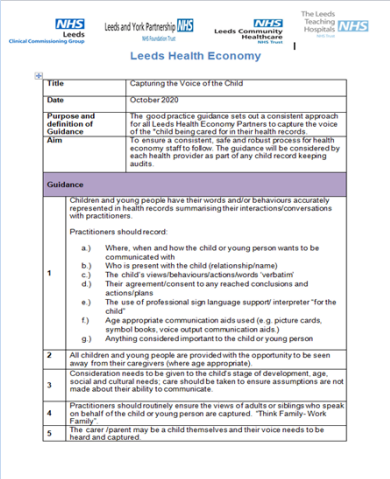
Safeguarding Children

Over the past year Leeds Community Healthcare (LCH) Children's Safeguarding team have demonstrated its leadership, service development and support in practice by:

Key achievements: 2020-2021

- Throughout the pandemic the childrens safeguarding team moved to mainly working from home using virtual platforms for communication. They maintained a proactive and supportive approach to LCH services and to the wider Leeds partnerships.

- In collaboration with other members of the Leeds health economy, the childrens safeguarding team contributed to the development of an overarching "Voice of the Child" guidance.



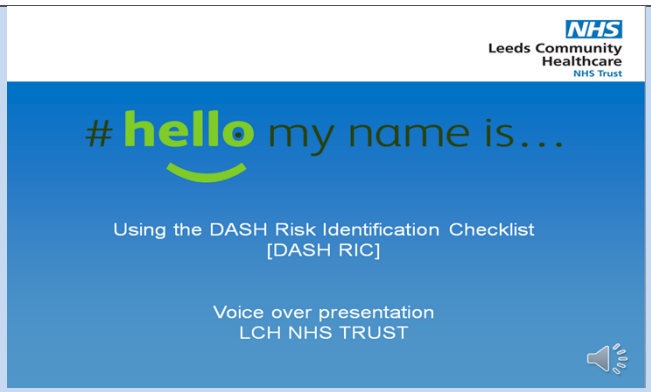
Leeds Health Economy

Title	Capturing the Voice of the Child
Date	October 2020
Purpose and definition of Guidance	The good practice guidance sets out a consistent approach for all Leeds Health Economy Partners to capture the voice of the "child being cared for in their health records.
Aim	To ensure a consistent, safe and robust process for health economy staff to follow. The guidance will be considered by each health provider as part of any child record keeping audits.
Guidance	
1	Children and young people have their words and/or behaviours accurately represented in health records summarising their interactions/conversations with practitioners. Practitioners should record: a.) Where, when and how the child or young person wants to be communicated with b.) Who is present with the child (relationship/name) c.) The child's views/behaviours/actions/words 'verbatim' d.) Their agreement/consent to any reached conclusions and actions/plans e.) The use of professional sign language support/ interpreter "for the child" f.) Age appropriate communication aids used (e.g. picture cards, symbol books, voice output communication aids.) g.) Anything considered important to the child or young person
2	All children and young people are provided with the opportunity to be seen away from their caregivers (where age appropriate).
3	Consideration needs to be given to the child's stage of development, age, social and cultural needs; care should be taken to ensure assumptions are not made about their ability to communicate.
4	Practitioners should routinely ensure the views of adults or siblings who speak on behalf of the child or young person are captured. "Think Family- Work Family".
5	The carer /parent may be a child themselves and their voice needs to be heard and captured.

- The Children's Safeguarding team have maintained ongoing support to the Front Door Safeguarding Hub (FDSH). Ensuring it's 3 main functions;

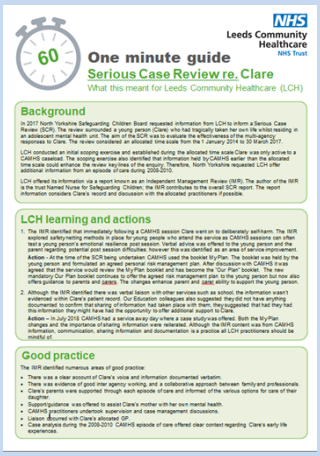
  - Providing support to social care colleagues at Duty and Advice.
  - Contributing to the daily MARAC (Multi-agency Risk Assessment Conference) meetings.
  - Working with West Yorkshire Police and Children's Social Care to facilitate Strategy discussions.

- LCH Safeguarding Advisors have developed a number of voice over power point, training presentations to increase practitioner accessibility and be more inclusive in our mindset.



- One of the Childrens Safeguarding Advisors continues to facilitate training via the Leeds Safeguarding Children Partnership (LSCP) and the LCH Named Dr for Safeguarding Children facilitated Child Protection (CP) medical briefings to Multi-agency professional also via the LSCP

- The Children's Safeguarding team made every effort to ensure LCH practitioners were able to develop and maintain Safeguarding training competency during the pandemic. At a challenging time when practitioner capacity was tight and availability of training resources needed amendment for a virtual arena. We also drew on NHS England training resources.



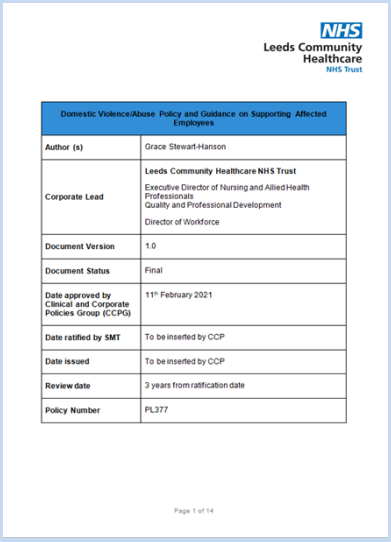
- The Children's Safeguarding team has maintained significant ongoing support of the Sudden Unexpected Death in Childhood (SUDIC) process, assisting to support families and identify patterns and themes emerging from these often tragic events.

- Working with the Named Dr and LCH Child Protection Medical team, safeguarding assisted improving understanding of Child Protection Medicals. St Georges Minor Injuries unit achieved building security sign off. This enables an additional environment for the young men from Wetherby YOI to receive care they may require from a child protection medical viewpoint.

- The Children's Safeguarding team have contributed to and raise awareness of various Safeguarding calendar events throughout 2020-2021, such as "16 days of action" White Ribbon day. Raising awareness of Child Criminal Exploitation & taking part in city wide Safeguarding Awareness week.

- LCH children's safeguarding team and service practitioners continue to bring expertise to the Local Safeguarding Children's Partnership (LSCP) & have contributed to work streams including:
    - ♦ Leeds Extended Learning Review: Youth and Gang Violence within Leeds.
    - ♦ Domestic Violence Review: Children Witnessing and Experiencing Domestic Abuse, How effectively are they supported in Leeds?

❖ Collaboratively working with LCH Adult Safeguarding colleagues, Human Resources, Staff Side and Freedom to Speak Up colleagues, the childrens safeguarding team have contributed to driving forward the ***Domestic Violence/Abuse Policy and Guidance on Supporting Affected Employees***. They have collated evidence that supports LCH seeking to achieve the Safer Leeds Domestic Violence & Abuse Quality Mark. They have also launched and are facilitating LCH Domestic Violence Champions meetings. The Champions are multi-disciplinary colleagues whose role will help increase awareness, signpost and share up to date messages with practitioners who support families with children and young people exposed to domestic abuse.



NHS
Leeds Community Healthcare
NHS Trust

Domestic Violence/Abuse Policy and Guidance on Supporting Affected Employees	
Author (s)	Grace Stewart-Hanson
Corporate Lead	Leeds Community Healthcare NHS Trust Executive Director of Nursing and Allied Health Professionals Quality and Professional Development Director of Workforce
Document Version	1.0
Document Status	Final
Date approved by Clinical and Corporate Policies Group (CCPG)	11th February 2021
Date ratified by SMT	To be inserted by CCP
Date issued	To be inserted by CCP
Review date	3 years from ratification date
Policy Number	PL377

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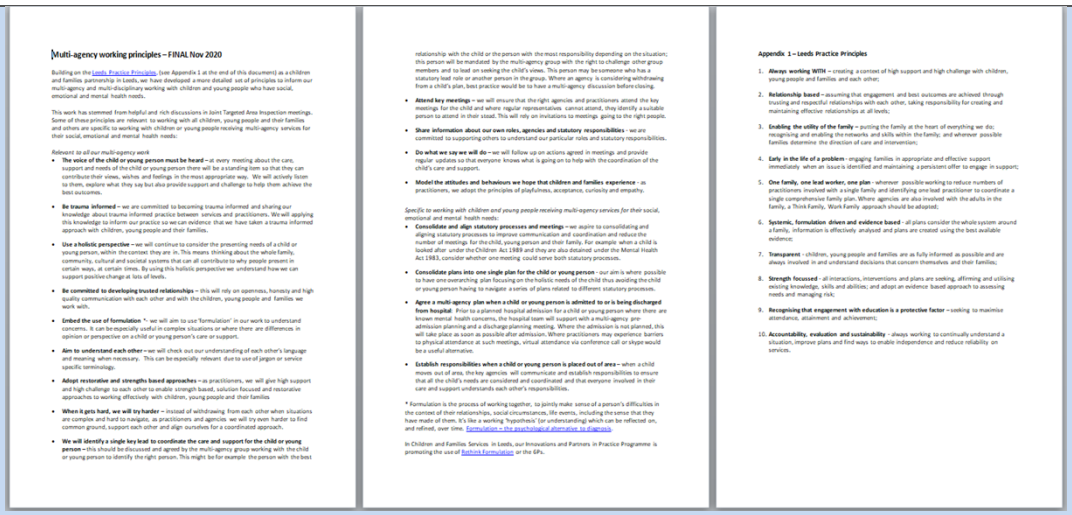
❖ LCH agreed signed up to the "**Multi-agency working principles**" of the LSCP. These principles were put together following Learning Lessons from the Joint Targeted Area Inspection process which LCH safeguarding team contribute towards.



Multi-agency working principles – FINAL Nov 2020

Building on the Leeds Practice Principles, (see Appendix 1 at the end of this document) as a children and families partnership in Leeds, we have developed a more detailed set of principles to inform our multi-agency and multi-disciplinary working with children and young people who have social, emotional and mental health needs.

This work has stemmed from helpful and rich discussions in Joint Targeted Area Inspection meetings. Some of these principles are relevant to working with all children, young people and their families and others are specific to working with children or young people receiving multi-agency services for their social, emotional and mental health needs:

Relevant to all our multi-agency work

- **The voice of the child or young person must be heard** – at every meeting about the care, support and needs of the child or young person there will be a standing item so that they can contribute their views, wishes and feelings in the most appropriate way. We will actively listen to them, explore what they say but also provide support and challenge to help them achieve the best outcomes.
- **Be trauma informed** – we are committed to becoming trauma informed and sharing our knowledge about trauma informed practice between services and practitioners. We will applying this knowledge to inform our practice so we can evidence that we have taken a trauma informed approach with children, young people and their families.
- **Use a holistic perspective** – we will continue to consider the presenting needs of a child or young person, within the context they are in. This means thinking about the whole family, community, cultural and societal systems that can all contribute to why people present in certain ways, at certain times. By using this holistic perspective we understand how we can support positive change at lots of levels.
- **Be committed to developing trusted relationships** – this will rely on openness, honesty and high quality communication with each other and with the children, young people and families we work with.
- **Embed the use of formulation** *- we will aim to use 'formulation' in our work to understand concerns. It can be especially useful in complex situations or where there are differences in opinion or perspective on a child or young person's care or support.
- **Aim to understand each other** – we will check out our understanding of each other's language and meaning when necessary. This can be especially relevant due to use of jargon or service specific terminology.
- **Adopt restorative and strengths based approaches** – as practitioners, we will give high support and high challenge to each other to enable strength based, solution focused and restorative approaches to working effectively with children, young people and their families
- **When it gets hard, we will try harder** – instead of withdrawing from each other when situations are complex and hard to navigate, as practitioners and agencies we will try even harder to find common ground, support each other and align ourselves for a coordinated approach.
- **We will identify a single key lead to coordinate the care and support for the child or young person** – this should be discussed and agreed by the multi-agency group working with the child or young person to identify the right person. This might be for example the person with the best relationship with the child or the person with the most responsibility depending on the situation; this person will be mandated by the multi-agency group with the right to challenge other group members and to lead on seeking the child's views. This person may be someone who has a statutory lead role or another person in the group. Where an agency is considering withdrawing from a child's plan, best practice would be to have a multi-agency discussion before closing.
- **Attend key meetings** – we will ensure that the right agencies and practitioners attend the key meetings for the child and where regular representatives cannot attend, they identify a suitable person to attend in their stead. This will rely on invitations to meetings going to the right people.
- **Share information about our own roles, agencies and statutory responsibilities** - we are committed to supporting others to understand our particular roles and statutory responsibilities.
- **Do what we say we will do** – we will follow up on actions agreed in meetings and provide regular updates so that everyone knows what is going on to help with the coordination of the child's care and support.
- **Model the attitudes and behaviours we hope that children and families experience** - as practitioners, we adopt the principles of playfulness, acceptance, curiosity and empathy.

Specific to working with children and young people receiving multi-agency services for their social, emotional and mental health needs:

- **Consolidate and align statutory processes and meetings** – we aspire to consolidating and aligning statutory processes to improve communication and coordination and reduce the number of meetings for the child, young person and their family. For example when a child is looked after under the Children Act 1989 and they are also detained under the Mental Health Act 1983, consider whether one meeting could serve both statutory processes.
- **Consolidate plans into one single plan for the child or young person** - our aim is where possible to have one overarching plan focusing on the holistic needs of the child thus avoiding the child or young person having to navigate a series of plans related to different statutory processes.
- **Agree a multi-agency plan when a child or young person is admitted to or is being discharged from hospital**. Prior to a planned hospital admission for a child or young person where there are known mental health concerns, the hospital team will support with a multi-agency pre admission planning and a discharge planning meeting. Where the admission is not planned, this will take place as soon as possible after admission. Where practitioners may experience barriers to physical attendance at such meetings, virtual attendance via conference call or skype would be a useful alternative.
- **Establish responsibilities when a child or young person is placed out of area** – when a child moves out of area, the key agencies will communicate and establish responsibilities to ensure that all the child's needs are considered and coordinated and that everyone involved in their care and support understands each other's responsibilities.

* Formulation is the process of working together, to jointly make sense of a person's difficulties in the context of their relationships, social circumstances, life events, including the sense that they have made of them. It's like a working 'hypothesis' (or understanding) which can be reflected on, and refined, over time. Formulation – the psychological alternative to diagnosis

In Children and Families Services in Leeds, our Innovations and Partners in Practice Programme is promoting the use of Rethink Formulation at the EIPs.

Appendix 1 – Leeds Practice Principles

1. **Always working WITH** – creating a context of high support and high challenge with children, young people and families and each other;
2. **Relationship based** – assuming that engagement and best outcomes are achieved through trusting and respectful relationships with each other, taking responsibility for creating and maintaining effective relationships at all levels;
3. **Enabling the utility of the family** – putting the family at the heart of everything we do; recognising and enabling the networks and skills within the family; and wherever possible families determine the direction of care and intervention;
4. **Early in the life of a problem** - engaging families in appropriate and effective support immediately when an issue is identified and maintaining a persistent offer to engage in support;
5. **One family, one lead worker, one plan** - wherever possible working to reduce numbers of practitioners involved with a single family and identifying one lead practitioner to coordinate a single comprehensive family plan. Where agencies are also involved with the adults in the family, a Think Family, Work Family approach should be adopted;
6. **Systemic, formulation driven and evidence based** - all plans consider the whole system around a family, information is effectively analysed and plans are created using the best available evidence;
7. **Transparent** - children, young people and families are as fully informed as possible and are always involved in and understand decisions that concern themselves and their families;
8. **Strength focussed** - all interactions, interventions and plans are seeking, affirming and utilising existing knowledge, skills and abilities; and adopt an evidence based approach to assessing needs and managing risk;
9. **Recognising that engagement with education is a protective factor** – seeking to maximise attendance, attainment and achievement;
10. **Accountability, evaluation and sustainability** - always working to continually understand a situation, improve plans and find ways to enable independence and reduce reliability on services.

Key ambitions 2021- 2022:

- Work with the resetting of LCH services, whilst maintaining an accessible safeguarding service.
- Establish new ways of supporting childrens safeguarding practitioners with their emotional health.
- Work with LCH services implement any Safeguarding Learning Lessons identified internally and externally from Leeds Safeguarding Children Partnership.
- Establish "Voice of the Child" within the trust Record Keeping Audit tool. Look at I.T templates that clearly support capturing the Voice of the Child.
- Work with Named Dr, the Child Protection Medical team and the health economy at responding to the Royal College of Paediatrics and Child Health RCPCH updates, Feb 2021 to Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children. Recognise how much we have in place already and identify areas for improvement. Work with the Health economy to arrange a multi-agency conference in Leeds regarding this subject.
- Continue the support of the FDSH with statutory strategy discussions and assist with implementation of the proposed new DRAMM model within the MARAC service arrangements.
- Embed the Domestic Violence Champions meetings within the trust.
- Continue collaboration within LSCP subgroups offering an LCH perspective.

Who are we?	What are we proud of?
Named Nurse for Safeguarding children (Full time practitioner) Senior Specialist Safeguarding Advisor (Part time) Childrens Safeguarding Advisor (Full time)	Working together to safeguard children, we are a dedicated experienced team providing a trust wide service to practitioners who are managing safeguarding complexity and risk. We offer compassionate specialist guidance, advice and direction to practitioners, escalating concerns where needed. We work closely with other parts of the health economy and with partner agencies contributing to city wide strategies. Our work is underpinned by statutory responsibility, evidenced based practice, reflection, peer review and supervision which assist our learning & supports consistency in decision making. Our team

Childrens Safeguarding Advisor (Part time)	demonstrates resilience and is committed to supporting LCH and wider colleagues by adopting a positive approach that enables others.

LCH is a strong and active partner of the Leeds Safeguarding Children Partnership (LSCP) contributing to multi-agency Strategies, Policies and Processes. LCH Safeguarding Children team ensure appropriate representation and contribution to the development of safeguarding practice in Leeds. This includes being active members of the LSCP subgroups and specialist meetings. Children and young people, their welfare, protection and the promotion of their best interests continue to be the Children's Safeguarding team priority.

Safeguarding remains a golden thread throughout all LCH children's services and its Safeguarding team seeks to support those services in a variety of ways. The Safeguarding team offer responsiveness and organisational leadership on emerging safeguarding issues, whether identified through CQC review, Safeguarding Practice Review (SPR), Learning Lessons Review (LLR) or case work. National, regional and local guidance is at the heart of the Safeguarding team practice.

The Safeguarding Children Policy sets out how the Trust fulfils its statutory duty to safeguard children and young people. This policy draws on and refers to other interlinked documents within trust and includes relevant legislations and statutory guidance such as Children Act 1989, Children Act 2004, Working Together to Safeguard Children (2018), Intercollegiate document (2019).

On-going work that the Childrens Safeguarding Team does to promote safeguarding includes:

- Daily availability of a safeguarding team Advisor for all LCH practitioners with safeguarding enquiries.
- Safeguarding practitioners maintain awareness of current issues occurring in Leeds and use them to inform "60 minute update" sessions. This has included exploring issues such as Neglect, Harmful Sexual Behaviours, the Prevent agenda, Child Exploitation and all its complexities, as well as recommendations from Learning Lessons Reviews and Safeguarding Practice Reviews.
- Standardisation of LCH Safeguarding Supervision model to ensure supervision that supports reflective practice and promotes staff resilience. Practitioners who become supervisors are asked for their experience of supervision annually via Survey Monkey to highlight good practice and offer opportunity for improvements.
- Data collection regarding practitioners who have attended Initial Child Protection Conferences (ICPC) and Review Child Protection Conferences (RCPC). This figure has remained consistently high over a number of years.
- Updates to the trust intranet page, advertising training, signposting to resources and sharing good practice.
- Supporting LCH practitioners with statement writing and court appearances.

Thinking about safeguarding quality assurance processes:

- LCH safeguarding Children team have a review processes in relation to Record of Contacts (referrals) with the Front Door Safeguarding Hub (FDSH). A member of the safeguarding team attends a monthly audit meeting.
- The team also receive information from the FDSH enabling us to cross check our information with theirs and explore anomalies.
- We consider data regarding strategy discussions from the FDSH exploring anomalies and supporting practice.
- We attend and contribute to Sexual Health Safeguarding Multi-Disciplinary Team meetings, Community Paediatric Governance meetings and LTHT Emergency Department Safeguarding Review meeting.
- We offer Group supervision sessions in line with the Child Protection Supervision Policy.

- We are specialist reviewers for Datix and contribute to internal Review & Serious Incident meetings.
- Working with services we develop annual work plans in line with the LCH Safeguarding Strategy and LSCP strategies and offer updates/share information at LCH Safeguarding Committee.

The LCH safeguarding children team consider a key opportunity going forward is in "resetting" the Safeguarding service following the COVID 19 situation and how we continue to support LCH practitioners to the best of our ability in the future.

Specialist Child Protection Medical Services (SCPMS)

Key achievements 2020-21:

- Significantly improved the working relationships with acute paediatricians in LTHT
- Instrumental in changing the ethos of children being admitted from Accident &Emergency with child protection concerns, ensuring there is a clear Standard Operating Procedure (SOP) to ensure children continue to be protected from harm without acquiring infections. Now having commissioning conversations about this change to service.
- Increasing engagement in strategy meetings and case conferences where child abuse or neglect is suspected – many by remote access eg skype.
- Continued to foster strong working relationships with colleagues at the paediatric Sexual Assault Referral Centre including handover of patients
- Strengthened relationships with sexual health and Genito-Urinary medicine doctors
- Involvement with the Risk and Vulnerability Subgroup of Leeds Safeguarding Children Partnership regarding child victims of Female Genital Mutilation.
- Attendance at Multi-agency Safeguarding Operational Group (MASOG) by Named doctor to look at operational processes for community paediatrics, police and social care
- Several team members trained on Advance Life Support Group, Child Protection Recognition and Response course
- New named doctor is increasing networking between the Named and Designated doctors for other areas and across Leeds.
- Named Dr joined a national named Dr group set up during lockdown. This continues to run but less frequently.
- Named Dr - Delivered training to a range of professionals – social work, education, police and health including General Practitioners, also the front door safeguarding hub team.
- A change in psychologist group supervison for the Specialist Childrens Medical Protection Service , this hasn't yet been started but looking forward to this.
- Royal College of Paediatricians Child Health key standards for Child Protection medicals published and we meet all standards apart from one, suggestion to provide paperwork to sws at time of medicals to aid communication. We are exploring this.
- We successfully obtained funding for new colposcope, one of which is portable. They are now in use.

Key ambitions 2021-22:

- Continue to ensure the rota means that children are seen in a timely way and there is no delay. We are in discussion with senior managers about the staffing of the rota and the prospective cover complication i.e we have to swap to have annual leave. All other clinics are cancelled with leave.
- Continue to work with the LTHT and deliver Childrens Medical Protection Service from an appropriate venue and all children who are medically well do not get admitted and are seen for CP medicals by us. We are continuing to explore whether re locating back to the LGI is the right approach.
- Continue to improve our interaction around strategy discussions and Child Protection conferences e.g. possibly using skype.
- Develop and implement clinical pathways in partnership with MHL for children with Sexually Transmitted Infections including e.g. ano-genital warts
- Continue to engage in regional peer review and Named Doctor regional meetings

- Continue to learn from patient experiences – giving particular attention to the voice of the child by improving child friendly feedback collection processes, this is being explored but no decision as yet.
- Engage with psychological support for staff when it is available.
- Produce training that can be accessed remotely, some of the training I deliver has photos in and I need to obtain appropriate images to add to the presentation.
- Maintain strong links with the LCH Children Looked After and Safeguarding team

Who are we?	What are we proud of?
10 community paediatricians, 2 band 5 nurses, 1 play therapist, 2.8 admin staff and 1 clinical services manager Part of ICAN (Integrated Children with Additional Needs) services; commissioned by Leeds CCG	Providing a daily **senior doctor led** clinic to see children (0-18)referred for all forms of child abuse **Trained and skilled administrative staff** to take referrals from 09:00-17:00 on weekdays **Compassionate, highly skilled nursing staff** to chaperone and support families & medical staff in clinic Clinical work underpinned by **peer review and supervision** to challenge practice & offer support **Dedicated team**, who show great strength and resilience to rise to the many changes this year Continuing to provide **medical training** in child protection **information sharing** and working together to safeguard children **Monthly governance programme** for continuing professional development and links with the regional peer review programme.

What did we do in 2020-21?

- Saw 337 children (315 acute, 22 follow up) between April 2020-March 2021. This is a drop of 65 acute medical referrals. We saw 14 cases that would have been seen by LGI, but were redirected to us on the new SOP.

- 56% physical abuse; 9% neglect; 3% anogenital examination for medical issues, no sexual abuse; 26% siblings of index children

- We aim to provide child protection medical reports to Social Care in 4 working days. Performance has improved over last few years , 70% reports sent within 4 days to social care; 93% within 7 days

- Clinical governance sessions have been well attended remotely and covered topics including – journal article reviews; review of RCPCH standards for CP medicals; DV training; training on new colposcope; notes audit etc.

- Held 52 peer review or colposcopy meetings last year.

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

(Abridged from the report produced for the Local Safeguarding Children Partnership)

Key achievements 2019-20:

- LCH SUDIC Team consistently met the key performance indicators
- Facilitation of a multi-agency study day on: Cot Death and how we can Influence Change
- 'Unsafe sleeping and SUDIC' Light bite sessions delivered in partnership with Safeguarding LTI GP Target Sessions across the city
- Effective contributions to the local Child Death Overview Process and LCH Mortality Sub-Group
- Witnessing changes made as a result of SUDIC and CDOP work
- Provided a full and robust service throughout COVID-19
- Evidence of strong multi-agency ways of working to facilitate the SUDIC process
- LCH now provide safe sleep advice to fathers going on paternity leave

Key ambition 2020-21:

- To maintain, and aim to exceed, the current high standards of facilitating the SUDIC process in Leeds by; ensuring we have the right people, with the necessary skills, knowledge and ability in the right place at the right time.
- Implement new ways of working to streamline processes
- In conjunction with SUDIC Strategic Reference Group partners organise a West Yorkshire wide SUDIC conference
- Develop in partnership with LSCP SUDIC Training Package
- Share SUDIC practice with teams across boundaries
- To ensure all team members have access to regular Psychological support to assist their health and mental well-being. Frequency to be determined.

'The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths' **(Chapter 5, Working Together (WT), 2018)**

SUDIC Activity 2019-20

During the period April 2019 to April 2020 there were 12 deaths of children, resident in Leeds, which met the SUDIC criteria. This is 7 fewer deaths than for the same period 2018-2019. The details are set out in Figure 1.

There was 1 instance where unsafe sleeping practice was identified in a baby under the age of 1 year. This is 3 fewer instances than during 2018-19.

During 2019-2020 the SUDIC process was finalised for the ongoing cases outstanding from 2018-19. Due to the ongoing criminal investigation into the Manchester Arena bombing, the SUDIC process for 1 young person's death from 2017-18 remains incomplete.

Figure 1

	Age & Gender	Details	Red indicates unsafe sleeping identified SUDIC Under 2yrs	SUDIC Process Complete April 2020	Home/scene visit
1	8 months female	Unascertained			Home & Scene
2	8yrs 6 months female	SUDIC in child with complex needs			Home & Scene
3	2yrs 2 months male	Collapse at home ? drowning			Police led potential crime scene and parent not available
4	3 months female	SUDI with Prematurity			Home & Scene
5	13yrs 2 months male	Status asthmaticus Anaphylactic reaction			Home and Scene
6	7 weeks male	SIDS			Home and Scene
7	5 days male	Renal Failure			Home
8	8yrs 2 months female	Sepsis/ haemorrhage			Home

9	11yrs 10 month female	Pneumonia			Home
10	14 weeks female	Hypoxic event prior to death in hospital			Police led and parent on bail
11	1yr 8 months female	Sudden death at home /? cause			Home & Scene
12	17 months male	Child with additional needs – aspiration pneumonia			Home only child died abroad

SUDIC Home & Scene Visits
Home Visits by SUDIC Team members were made in 10 of the 12 cases. The timeframe of the responses is set out below.

SUDIC Home/Scene Visits 2019-20				
24-48 hours	**48-72 hours**	**over 72 hours**	**No visit**	**Total**
4	3	3	2	**12**

For the 2 cases where visits were not made to the family both were subject to active police investigation and the parents declined a visit from the team. In these instances written information was sent to the family explaining the SUDIC process.

The team aim to visit the scene within 24 hours of the child's death as a priority for babies under the age of one year and this was achieved for the 3 unwitnessed deaths in this category. The timing of the home visit is influenced by the day of the week on which the child dies as the LCH SUDIC Team work on weekdays only. Therefore if, for example, a child dies on a Friday evening the earliest opportunity for the SUDIC team visit would be more than 48 hours after their death. In all instances where a child collapses at home and subsequently dies, the police carry out a Scene Visit on the day of their death. Their information is shared with the SUDIC Team at the Initial SUDIC Meeting or before if necessary

Initial SUDIC Meetings

This meeting seeks to; understand the circumstances of and, if possible, the reasons for the child's death, consider the immediate needs of all family members, and to contribute to the process of identifying any lessons to be learned about how best to safeguard and promote children's welfare in the future.

Initial multi-agency meetings were held in a sit down format for all 12 of the Leeds childhood unexpected deaths occurring during 2019-20. This is consistent with the previous year's performance.

28 Day Report to HM Coroner

During 2019-20, 28 Day Reports to HM Coroner have been provided by the SUDIC Consultant for all 12 of the deceased children.

9 of the 12 reports met the 28 Day deadline. For the 3 reports which did not meet the deadline, 1 was due to the late notification of a child who had died out of the country. The remaining 2 reports were completed within 30 days of the child's death.

SUDIC Final Case Discussion Meetings
During 2019-20, Final Case Discussion meetings and Final Reports to HM Coroner and the Child Death Overview Panel were completed for 9 of the children who died in the 2018-19 period.

Final meetings were held in a face-to-face format for 3 of the 12 children who died in 2019-20, one of which was both the Initial and Final SUDIC meeting. Final information gathering was carried out remotely to inform the Final SUDIC Reports for 6 of the children dying in the 2019-20 period due to the COVID-19 pandemic.

The team are awaiting the post-mortem reports for 2 children and have received the post-mortem report for a further child. It has been agreed that Final Meetings will be held face to face for these 3 children once the pandemic is past the peak, as each of their deaths occurred in complex situations. This decision is being kept under review and it has been agreed that the practitioners involved will be contacted to keep them informed of the plan and the reasoning behind the delay.

Governance
The SUDIC Team are members of the Leeds Child Death Overview Panel **(CDOP)**. The panel met 8 times in the year 2019-20. 1 meeting was cancelled due to the COVID-19 pandemic.

Each meeting was attended by the SUDIC Consultant and SUDIC Professional Lead.

The LCH SUDIC Team take responsibility for providing the SUDIC reports for each child to the Leeds Local Safeguarding Children Partnership (LSCP) CDOP and ensuring that the recommendations of the CDOP Panel are fed back to LCH Children's Death Review Group.

LCH Children's Death Review Group
All SUDIC deaths are reported into the LCH Children's Death Review Group along with the expected deaths of children under the care of LCH services. The deaths are reviewed with the aim of ensuring that a critical appraisal of LCH healthcare input is carried out and where necessary further action is taken to ensure that lessons are learned. Information from this group is reported to the LCH Mortality Review Group which provides assurance to the LCH Trust Board.

The SUDIC Strategic Reference Group (SSRG)
The SUDIC Strategic Reference Group, a sub-group of the Leeds LSCP, is chaired by the Clinical Commissioning Group Children's Services Commissioner. The Leeds Safeguarding Children's Partnership Child Death Overview Panel (LSCP CDOP) Administrator takes responsibility for the group administration. Two meetings were held during 2019-20 at six monthly intervals. Both meetings were attended by a SUDIC Consultant and the SUDIC Professional Lead.

The Group is represented by partner agencies in the Joint Agency Response and provides an opportunity to examine and address issues raised in the SUDIC process. Actions are agreed and monitored in the meetings. Actions are considered in relation to the following broad headings which also form the basis of the LCH SUDIC Team Work-Plan which is reported into, and monitored by, LCH Safeguarding Committee.

- SUDIC Process Awareness Raising
- Review of Links with Partners
- Process & Performance
- Family Engagement

SUDIC Process Awareness Raising

SUDIC processes were highlighted by the SUDIC Consultant at the LTHT Accident & Emergency Department study day in July 2019.

In November 2019 a Royal College of Paediatrics and Child Health (RCPCH) accredited event was facilitated by the team with the aim of raising awareness of child death review processes. The event was attended by 30 delegates and evaluated positively. A further study day will be held during 2020-21 and will incorporate suggestions made by participants in the feedback process.

During August 2019 the team facilitated a presentation and workshop to the LCH Safeguarding Committee giving an overview of child death review processes and the SUDIC Team's role in the process.

Partnership working and actions related to identified modifiable factors

'Safe Infant Sleep Messages' was presented by the SUDIC Professional Lead and the LTHT Deputy Named Safeguarding Midwife as a 'Hot Topic' at the three Leeds GP Training Events during February 2020. The

aim of the session was to present the local picture in relation to infant deaths linked to unsafe sleep practices and to encourage colleagues in primary care settings to have non-judgmental conversations with families in relation to safe sleep.

During 2019-20 Leeds Local Safeguarding Children Partnership (LSCP) produced information on safe sleeping aimed at fathers. This was developed in conjunction with local fathers and targeted at the relevant demographic on social media during Safer Sleep Week. Work is underway within LCH workforce department to incorporate the Baby Safe Sleep Checklist into the information given to fathers when they are taking paternity leave.

Following the tragic death of a young cyclist in Leeds, the Student LSCP were tasked with raising awareness of the importance of being visible when cycling at night. The “Keep them safe, keep them seen” campaign targeted all adults in Leeds, aged 18 – 65+ which included, parents, carers, aunts and uncles and grandparents, all of which could be buying bikes or cycling equipment for a child or young person over the Christmas period.

The LSCP hold an annual event during the summer holidays encouraging parents to be aware of unsafe places that children may play and to talk to their children about those dangers. This event was developed following the death of a young person who fell through the roof of a disused building.

The SUDIC team, working with colleagues from Police, Highways Agency and the Local Authority, has influenced additional road safety measures in part of the city and have also contributed to a "Safe Bathing" campaign due to be launched by the LSCP June 2020 (Safeguarding Week).

Two of the SUDIC cases have been considered for Safeguarding Practice Review and are being taken forward as Learning Lessons Reviews.

Children Looked After (CLA) and Care Leavers

Key Achievements 2019/20

- Continued delivery of the service during the Covid Pandemic, with audit indicating high standard of health assessments.
- Maintaining the delivery of training and quickly developing virtual packages in response to changing work patterns for those supporting Looked After Children. Feedback from training is very good/excellent.
- All recommendations from CQC with regards to quality of analysis within health assessments have been implemented by the Specialist Looked After Nursing Team. Training to introduce the new assessments will take place for PHINS and SILC nurses in September this year, and all review assessments completed by nurses will follow this format from October.
- Significant input into the Corporate Parenting Strategy 2021-25, with aspirational targets in place for social care which will improve both quality and timeliness of Initial Health Assessments.
- Designated Nurse input into Local Authority commissioning groups; thematic review of Independent Foster Agency and Children’s Social Care External Residential Board.
- Establishment of interservice/agency group to improve Care leaver sexual health offer – with fast track form now offered for Leeds sexual Health services and service’s committing to support the Care Leaver Hub, once this is up and running.
- Links made with key workers supporting UASC’s and access to health information in languages and format to promote UASC health.
- Links made with Looked After Children and Care Leaver groups using virtual technology.

Key Ambitions 2021-22

(Themes for 2021-22 reflect the service improvement plan.)

- To work with our social care colleagues to improve Health's ability to provide the Initial Health Needs Assessment (IHNA) to inform the planning at the first childcare review, 20 working days after the child is taken into care, as per statutory requirements.
- To work with Health Colleagues in the trust to raise the profile of looked After Children and Care Leavers and to start conversations about how we work together to reduce the lifelong health inequalities they experience and implement the new NICE guidance which is due to be published later this year.
- To move FASD service forward for Looked After Children.
- To provide training for GP's regarding unaccompanied asylum seeker health needs and safeguarding concerns.
- Ensure clear pathway of support available for Looked After children moving to adult services.
- Complete thematic analysis – strengths and difficulties questionnaire (SDQ's) and how they are used to support Looked After children.
- To explore along with other geographical areas the best model of health care for Looked After children and Care Leavers and seek to ensure we have the best possible services we can for this extremely vulnerable group.
- To complete work around business reporting to ensure we are collecting data that monitors service quality and promotes service improvement, whilst holding the needs of looked after children and care leavers at the core.

Looked After Children and Care Leavers.

A child is legally defined as 'Looked After' by a local authority if he or she:

- is accommodated by the local authority for a continuous period of more than 24 –hours,
- is subject to a Care Order to put the child into the care of the local authority (including secure settings),
- is subject to a Placement Order (child placed for adoption)
- is an unaccompanied asylum seeker and under the age of 18.

The Looked after children population who live in Leeds are a mix between those who originate from Leeds and are under the care of Leeds City Council and those who are under the care of other local authorities and live in Leeds. A proportion of children and young people who are looked after by Leeds city council are placed out of area in other authorities.

Looked after children may be: placed with their parents under a Care Order; placed for adoption or fostering (voluntarily or under a Care Order); Unaccompanied Asylum Seeking Children (UASC); and those living in Residential Children's Homes in Leeds, including secure settings. Trends show a significant shift towards placing children in Kinship care.

Most children and young people come into care having experienced neglect and or abuse, usually from their primary care givers. Children who experience adverse childhood experiences, especially in the early part of their life, have significant risks of health inequalities with increased risk of suffering long term effects to both their emotional and their physical health, including higher risk of cancer, strokes and heart disease as adults. The effect of health inequalities impacts throughout Care Leavers lives and is strongly linked to their ability to achieve and attain within education, their employment opportunities, earning potential and life chances. The importance of promoting and developing good physical health and mental resilience must have a high priority throughout their time in care and beyond to help mitigate against these risks.

A core contractual requirement and remit of the CLA Health Team, Community Paediatricians, Public Health Integrated Nursing Service (PHIN's) and SILC nurses is timely completion of statutory health assessments. Leeds use the Comprehensive Health Assessment Plans (CHAP) assessment tool. The CHAP informs health, education, and local authority partners of how best to optimise and support the potential of each child and young person supporting the provision of a coordinated package of health care. The assessments are six monthly from birth to five year olds and annually from the age of five to eighteen. There are quality assurance audits in place to monitor the quality of CHAP's.

All children who attend SILC's (Special Inclusive Learning Centres) are seen for review assessment by the SILC nurses or Community Paediatrician. PHIN's see children and young people for review health assessments in main-stream schools up to the end of school year 8 when they then transfer to the care of the Specialist Nursing team. The Specialist Nursing team see all over 13 year olds from year 9, additionally see those living within a 20-mile radius of Leeds for their review health assessments and have oversite of all Leeds children placed out of area beyond the 20 mile radius, to monitor the health plan.

A care leaver is a young person aged 16-25 years old who has been 'looked after' at some point since they were 14 years old and were in care on or after their 16th birthday. Care leavers are entitled to some ongoing help and support from Children's Services after they leave care.

While there is no statutory requirement to assess the health needs of Care Leavers, there has been a commissioned health offer to Care Leavers since 2015 which describes the process for accessing support from the nursing team and is publicised to Care Leavers through their CLU'd Up webpage. The offer to care leavers is:

1. Support transition to adult services
2. Complete a leaving care health summary explaining how to register with GP's and dentists; giving links to service's including sexual health and mental and emotional health and the One You Leeds offer and has details of how to contact the CLA and Care Leaver's Nursing team.
3. Care Leavers can be referred or self-refer to the service at any time for support/signposting.

Leeds Looked After Children population

The number of Children in Care in Leeds has fallen by 22 in 2020-21, there were 1304 Leeds children in care 30/6/21. The number entering care averaged 20 per month over the 14 months to May 21, this is significantly lower than previous years and thought to be a direct result of lockdown. There is a real expectation that as society opens over the coming months there will be an increase in the children being taken into care. Over the past 3 months the number of children subject to section 47 enquiry has increased. Leeds has a higher proportion of children going into care per 10,000 than regional and national. The numbers of teenagers entering care continues to increase as a proportion of the whole and the number of care leavers continue to increase as more young people are remaining in care until their 18th birthday with statutory Care Leaver rights.

The number of Leeds children placed out of Leeds is 453. 321, 70%, live within 20 miles of Leeds and are therefore seen by the Leeds CLA health team for their health assessments. There are 1387 Looked after children living in Leeds, this includes 332 children placed in Leeds by other authorities.

There has been a significant shift over the past 4 years; children under the age of 4 continue to be the highest co-hort taken into care however the length of time in care for the majority is short term. There are increasing numbers of young people over the age of 12 being taken into care and they tend to remain in care until they become care leavers. Since 2017 there has been an overall increase of 100 Young People in care.

At the same time Leeds city council have intensified moves to bring Children placed further afield back to or nearer to Leeds, with more children and young people being brought back to surrounding area postcodes within the 20 mile radius.

Impact of Covid 19 on CLA Health Team

The past 12 months have seen new challenges to delivering the health assessments due to changes in service delivery brought about by Covid 19 pandemic, with children and young people being assessed over the phone and virtually. The challenges were amplified as both the Specialist Nursing Team and PHINS have ongoing capacity issues and a number of the PHINS nurses were deployed to other areas during the early pandemic stages however the completion of virtual RHNA's continued as a service priority in line with statutory requirements.

The specialist CLA nursing team worked closely with partners in CSWS to identify the most vulnerable children and young people both in terms of health and placement stability to enable contingency planning for a reduced workforce. Information for those identified as vulnerable on the PHIN's caseload was shared accordingly. Specialist Nurses contacted carers, children and young people on the caseload to discuss safety and health during Covid Pandemic.

Information was produced to highlight health services that continued to be available, including online and postal services for young people. This was shared with Social Care, Residential Homes, PHIN's, Care Leaver Services and Foster carers.

Following trust guidance for reset and recovery almost all assessments are now completed face to face. This is particularly important when working with such a vulnerable group, who experience significant health inequalities.

Training delivered to PHINS, SILC nurses and other partners has been conducted virtually since March 2020. The feedback for this has been consistently good and attendance significantly improved when compared to pre pandemic levels. Audit identified an issue with quality of CHAP's for a particular co-hort and despite Covid 19 Pandemic challenges, training was quickly arranged for the nurses. Further quality audit 4 months later demonstrated a significant improvement in quality standards, with assessments meeting national guidance criteria.
The looked after health team intends to continue with online training unless there is a clear need to do otherwise.

Key Performance Indicators (KPI's)

Timely completion of CHAP's 2020/21

The KPI's on timely health assessments for all Leeds CLA are reported monthly. Below is a quarterly summary from April 2020 to March 2021 of percentage achieved within statutory timeframes taken from monthly HNA reports.

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Initial Health assessments Completed within 20 days of coming not care.	37.5%	56%	43%	33%
Initial Health Assessments completed within 20 day of notification	67.1%	81.25%	65.7%	97.7%

The compliance of achieving the 20-day working deadline for initial health assessments has continued to be a challenge with the issues of delayed or incomplete consent forms remaining an issue. This has been the case for a number of years and is monitored through the corporate parenting CLA safeguarding subgroup. It should be noted also that the reasons for not meeting the 20-day deadline can also be due to other issues for example carers cancelling on or near to the appointment date.

Since February there has been improvement in notification times from social care following new processes being put in place to promote this. This has highlighted another issue which is impacting ability to meet the 20-working day target, as admin have been challenged to find clinic spaces that would enable completion of IHNA within statutory time frames. This needs further investigation to understand the issues and find solutions.

Review Health Assessments continue to meet national and local targets for timely completion (85% and 90% respectively).

Immunisations, Dental and SDQ.
Table to show percentage compliance with key health indicators.

Key indicators	April 2020 %	April 2021%
Immunisations up to date Target 85%	83.5%	81%
Dental checks up to date	74%	69%
SDQ	53.5%	53.5%

The DN and DD have monthly updates of performance of key indicators.

I**mmunisations**
Decline in the number of CLA having up to date immunisations was noted in April 2020. Consequently, reporting on immunisations was broken down to age range to give a better understanding of the issues. This highlighted that the key area of concern is in the 13 plus population. Processes have been put into

place to counter this alongside discussions with social care to see how we can work together to promote immunisations with this cohort. This was beginning to have some effect prior to the last lock down and efforts are continuing to turn the curve and increase the rates.

Dental
The Covid 19 Pandemic had a significant impact on the delivery of dental health services. Consequently, for much of 2020 Dentists were only seeing emergency cases. Routine appointments have re-commenced however there is an acknowledgement that dentists cannot work at 100% capacity and that there is a significant backlog of cases.

LCH CLA Designated Nurse is working with local NHS and Public Health commissioners and there is a plan to deliver flexible commissioning for vulnerable children and adults. Dental practices across Leeds have been identified to take part in the project and a referral pathway has been developed.

SDQ (Strengths and difficulties questionnaire.)
The SDQ is an evidence-based tool used to assess children and young people's emotional and mental health. There is guidance for support and referral for those children and young people who have medium and high scores. All CLA and young people over the age of 4 have SDQ assessments, which should inform the CHAP. Health are required to facilitate the completion of questionnaire for all CLA between the ages of 11 and 16. Social workers are responsible to ensure the carer SDQ is completed for 4 to 16 year olds.

There are links to education attainment and completion of SDQ. The Designated Nurse has worked with the virtual head in Leeds (all local authorities are required to have a virtual school, which monitors and promotes the education of CLA and care experienced children, working alongside all other education providers to ensure CLA needs are met). The CHAP action plan for all CLA now includes that the SDQ score should be discussed at all CLA Personal Education Plan meetings and should inform support that the child receives.

The table above shows the percentage completion by Health. The figures of 53.5.% is low, and though this could be because of many virtual or phone assessments over the past year, it does not differ from the previous year when the majority of assessments were completed face to face. Audit of health assessments, which see a high number of SDQ completion, is at odds with reporting. This is possibly due to how information is inputted into system one; business support are currently looking to resolve this and so reduce duplicating input of information and ensure all completed SDQ information is captured for reporting and informing service development. The Specialist CLA Nursing team have received guidance and have been asked to ensure completion of SDQ at all reviews, unless there is a compelling reason such as the child, young person refusing to complete which should be recorded on the CHAP. All future training around Health Needs Assessment will have a focus on the importance of SDQ completion and how to input the information onto System one.

Safeguarding Annual Report Conclusion

2020-21 has been another busy and productive year for the safeguarding team with the additional challenges brought by the COVID 19 Pandemic.

key themes emerging from this report point to the priorities for the team being:

- The setting and maintaining of quality standards across all safeguarding
- Fast effective responses to COVID_19 and the fulfilling of safeguarding duties
- Development of EPR templates to support best safeguarding practice
- The essential development and maintenance of internal and multi-agency relationships and networks to ensure high quality service delivery with safeguarding of vulnerable children and adults remaining at the core of all we do.

2022-22 will see the Safeguarding Team:

- Resetting of services post COVID_19
- Continued response to, and review of the training and support needs of LCH staff
- Develop and deliver more effective/cost effective training
- Continue to work with the Safeguarding Boards to review and develop Safeguarding in Leeds.
- Maintain good working relationships with partners
- A move towards more virtual training packages

- A move towards virtual supervision sessions
- Ensure LCH practice in Children Looked After and Safeguarding is of a high standard and responsive to the needs of the people of Leeds.
- Continuation of excellent working relationships with partners

Appendix 1

Examples of social media campaigns and screensavers used for Safeguarding Week 21

Safeguarding Awareness Week

22 - 26 June

For further information, please contact the Safeguarding team on 0113 843 0200

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (50)

Title: Review of standing orders and standing financial instructions

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Category of paper: for approval
History: Audit Committee 23 July 2021

Responsible director: Executive Director of Finance & Resources
Report author: Company Secretary and Deputy Director of Finance & Resources

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Executive summary

The Trust has an established set of standing orders and standing financial instructions which also include a schedule of powers reserved to the Board and a scheme of delegation. Together, these provide a governance framework that enables the organisation to demonstrate it is well governed and meets the requirements of key corporate governance codes.

In order to ensure that the Board is discharging its role effectively it should regularly review the components of the standing orders and standing financial instructions and receive assurances that it is meeting the requirements contained within these documents.

This paper summarises a number of amendments and updates. Once approved, a fully updated version of the whole document will be made available electronically to Board members and more widely through the Trust's intranet and website.

Recommendations

The Board is recommended to:

- Approve the updating of the standing orders and standing financial instructions in line with the summary of changes outlines in the attached paper.

1.0 Introduction

This report is to inform the Board of the review undertaken in updating the Trust's standing orders and standing financial instructions. This paper summarises recommended changes to be made in order to amend and update content and takes account of: Department of Health standard model documentation, national governance guidance, new regulations and legislation, changes in NHS organisational structure, changes in the Trust's structure and changes that the Trust's executive directors wish to introduce to better regulate good governance and management.

2.0 Background

NHS trusts are required to adopt standing orders and standing financial instructions and to establish a schedule of powers reserved to the Board and a scheme of delegation.

Under its terms of reference, the Audit Committee is required to review the adequacy of policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements. The Audit Committee reviewed the proposed amendments at its meeting on 23 July 2021 and agreed to recommend that the Board should approve these changes.

Standing orders and standing financial instructions are essential foundations for the good governance of the Trust and set out:

- Mechanisms for how the Trust Board conducts its business
- Decision making powers delegated from the Board
- Expectations of the Trust as to the conduct of individuals entrusted with public resources
- Principles and procedures that direct financial conduct

3.0 Current position

The Trust's Board approved the current version of the standing orders and standing financial instructions on 7 August 2020 (version 3.0).

The current standing orders and standing financial instructions are fully functional but there are a number of aspects that, on review, require updating to take account of: national governance guidance, new regulations and legislation, changes in NHS organisational structure, changes in the Trust's structure or changes that the Trust's executive directors wish to introduce to better regulate good governance and management.

4.0 Proposed changes

The table shown at appendix 1 summarises the changes to be made in order to amend and update content. The revised version, if approved, will be numbered as version 3.1 and retained by the Company Secretary.

5.0 Impact

5.1 Resources

There are no resource consequences resulting from this paper and its proposals.

5.2 Risks

Failure to establish, implement and assure compliance with standing orders and standing financial instructions may impact on the Trust's decision making and assurance processes, and may adversely affect its reputation and CQC rating.

5.3 Regulatory and Legal

These changes to the standing orders and standing financial instructions ensure compliance with all applicable legislation and NHS regulations and guidance.

6.0 Next steps

Once approved, an electronic version of the full amended document will be made available to Board members and managers and staff. Use will be made of the Trust's intranet and website to publish the documents.

7.0 Recommendation

The Trust Board is recommended to:

- Recommend that the Board approves the updating of the standing orders and standing financial instructions in line with the summary of changes outlines in the attached paper.

Appendix 1

Leeds Community Healthcare NHS Trust
Summary of changes to standing orders and standing financial instructions

Section	Change
Section B: Standing orders	
B (1.2.9)	Definition of Committees in Common added
B (1.2.17)	Definition of Memorandum of Understanding (MOU) added
B (1.2.24)	Definition of Trust Company Secretary role added
B (2.5)	Description of Senior Independent Director role added
B (2.9)	Accountability of The Trust Board members collectively as the agent for the corporate trustee (the Trust) for the Leeds Community Healthcare Charity has been added
B (7.0)	The requirement that all staff must comply with HSG(93)5 'Standards of Business Conduct for NHS staff' and "The Code of Conduct and Accountability". Managing Conflicts of Interest NHSE has been added
B (9)	The duty to ensure that existing Directors and Board members and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions has been added
B (9)	A list of documents that have the standing of Standing Orders has been added
B (9)	A documented requirement to conduct an annual review of the Standing Orders has been added
Section C: Schedule of Reservation and Scheme of Delegation	
C	'Receipt and approval of the annual report and accounts for funds held on trust' has been removed, as this responsibility is delegated to the Charitable Funds Committee
C	Decisions reserved for the Board now includes the approval of the Business Continuity Management Policy
C	Decisions delegated to Charitable Funds Committee includes the revised approval levels for expenditure (agreed by the Board on 28 May 2021)
C	Payroll duties were incorrectly assigned to the Executive Director of Finance and Resources in the scheme of delegation, and have now been reassigned to the Director(s) of Workforce. This now aligns with the information in the standing financial instructions
Section D: Standing Financial Instructions	
D (17.5.3)	Text amended to add clarification that a tender waiver requires authorisation from two directors, one being the Director of Finance*. Where the value exceeds £30,000, it needs further approval by the Chief Executive. This reflects current practice. *unless the waiver originates within Director of Finance's department.

Trust Board Meeting held in Public: 6 August 2021

Agenda item number: 2021-22 (51)

Title: Quality Strategy 2021/2024

Category of paper: Approval
History: Quality Committee

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

Executive summary (Purpose and main points)

The aim of a Quality Strategy is to put quality right at the heart of service development and delivery. It recognises that the quality of care patients' experience when accessing the NHS is what matters most to them.

Our Leeds Community Healthcare NHS Trust (LCH) Quality Strategy for the next three years has been developed with our communities as the central focus.

We have also considered how we best learn from our experience of the international COVID 19 pandemic where we have responded to the challenges presented with innovation, standardisation and a focus on improvement.

We continue to work in a challenging landscape and have aimed to incorporate how we will capitalise on the opportunities the pandemic has brought to deliver care in alternative ways.

This means we can build our services back better with the learning and experience we have gained from our pandemic response to ensure we continue to provide services that are clinically effective, safe, well-led, and responsive to patient's needs, offering a positive patient experience.

Our Quality Priorities for 2021 to 2024 are:

Learning

The Patient Safety Strategy

A focus on equity in quality and safety

We will work across the PLACE of Leeds as a full partner to develop collaborative governance structures and priority programmes that support our ambitions for better, more integrated care in the city

Recommendations

Board is asked to approve the Quality Strategy.

Leeds Community Healthcare NHS Trust Quality Strategy 2021 - 2024

Amended wording to Quality Strategy

1 Foreword from our Executive Director of Nursing and Allied Health Professionals Stephanie Lawrence

It is a pleasure to welcome you to our Quality Strategy where we will share our aims and priorities for high quality care over the next three years.

Our Strategy has been developed during our response to the international COVID 19 pandemic where we have responded to the challenges presented with innovation, standardisation and a focus on improvement. We continue to work in a challenging landscape and will capitalise on the opportunities that have been available to deliver care in alternative ways. This means we can build our services back better with the learning and experience we have gained from our pandemic response to ensure we continue to provide services that are clinically effective, safe, well-led, and responsive to patient's needs, offering a positive patient experience.

We have continued to work collaboratively with our teams, our health and care partners and our communities during this time and have sought their feedback to inform our Strategy to understand what high quality care means to them. Those relationships will be a key focus of our priorities for high quality care throughout 2021 to 2024.

We are stronger, more effective and have the greatest opportunity to make a positive difference for the people we serve when we work together and harness our collective knowledge, skills, and experience.

Our Quality Strategy aims and priorities are therefore underpinned with a theme of collaboration and working together to achieve the best outcomes for our communities.

2 Introduction

Leeds Community Healthcare NHS Trust (LCH) has a commitment to providing high quality care and reducing health inequalities within our communities. The Trust aims to innovate, build and standardise in order to deliver high quality, safe and effective care that provides patients, families and carers with the best patient experience. In the words of one colleague, the provision of '***evidence-based care, delivered with compassion and integrity, by appropriately skilled, trained and supported professionals'.***

LCH provides services from pre-conception to end of life across different specialities and professionals disciplines that include both physical and mental health. This includes services to promote and maintain health, and to provide care and treatment to manage existing conditions or ill health. We primarily serve the population of Leeds, though we also provide some services across the region.

We are proud to provide outstanding care to our communities of over 790,000 people.

The most recent Care Quality Commission inspection in 2019 rated LCH as 'Good' overall with Community Sexual Health Services rated as 'Outstanding', an improvement from the last inspection. We will build on our overall rating of good and share learning and excellence in practice across each of our services as we strive to become an outstanding organisation.

In this Quality Strategy we have set out our ambitions for quality in a way that is designed to be meaningful to our patients, carers, staff, commissioners, and other stakeholders. We have asked what high quality care means to them to inform our Strategy, one patient said that ***'quality of care is essential, it's reassuring to the patient and builds trust and confidence'*** and a colleague shared high quality care as being '***individualised, empathic, person centred, timely and fair. Clear and transparent care plans delivered with compassion, skill and transparency in collaboration with the service user'***. We hope the Strategy clearly demonstrates our commitment to collaboration and working together to provide outstanding care.

We set out what outstanding means to us and provide an overarching framework to support the achievement of our Trust

Strategic Goals:

- Ensure our workforce community is able to deliver the best possible care in all of the communities that we work with
- Deliver outstanding care
- Work in partnership to deliver integrated care, care closer to home and reduce health inequalities
- Use our resources wisely and efficiently

3 Our Trust in Context

LCH is one of only 20 distinct NHS Community Care provider Trusts in England. As the largest provider of community services in Leeds, our focus is to deliver care in patient/client homes, community based clinics or local community based facilities.

Leeds Community Healthcare NHS Trust (**LCH**) is one of three NHS providers which, along with primary care colleagues in the Leeds **GP Confederation**, the Yorkshire Ambulance NHS Trust and an increasing number of non NHS providers, delivers NHS services to the population of over 790 000 across Leeds. We work in all parts of the city and deliver some services across a broader geographical footprint (notably our criminal justice services). We are privileged to work with many thousands of people in their own homes, as well as in a full range of other health and care settings.

The publication of the NHS Long Term Plan highlighted the important role community services will have as part of Primary Care Networks, the bedrock upon which NHS care is delivered. Leeds Community Healthcare NHS Trust is working very closely with Leeds **GP Confederation** and primary care through the **19 primary care networks** in Leeds, with a view to developing a strong and progressive partnership aimed at transforming the delivery of primary care services in the city.

Regionally health and social care is being developed through West Yorkshire and Harrogate Integrated Care System (**ICS**). The **ICS** plan puts places at the centre of what is to be achieved enabling each place to develop what is right for them; a 'place' can be defined by a **Local Authority**, **CCG**, **Acute Trust footprint** or the geography of a town or city.

Leeds has a successful history of partnership working with strong focus on keeping people at the heart of Leeds. Our partnerships enable a genuine whole system approach to maximising the health and social outcomes for our communities and populations and has been demonstrated in our Leeds wide response to the COVID 19 pandemic.

The shared goals we have achieved collectively with health, social care and third sector colleagues alongside our communities working together equips us with the learning, experience and skills to realise our city wide ambitions of an integrated care partnership to progress and realise integrated health and care across Leeds.

Leeds Community Healthcare NHS Trust has a strong commitment to improving the quality of the care delivered and will be an integral member of the Leeds system to work with partners and maximise high quality, effective and responsive care to the people of Leeds.

4 Our vision, values and behaviours

Our vision, values and behaviours guide how we work and exemplify the way we deliver our services. 'Our Eleven' of our vision is that '**we provide the best possible care to every community'** and is underpinned by our values and implemented through our behaviours. (Figure 1.)

Our aim is that service users experience our care in the way we intend it to be felt and delivered, and that ***'care means exactly that, care'.***

Figure 1: Leeds Community Healthcare Vision and Values

5 How We Developed Our Quality Strategy

In order to understand what was important to our communities we engaged and listened to our service users and colleagues, this is what they said high quality care meant to them, and is therefore, what it means to us:

What our service users said:

Makes me feel valued as a patient	Personal care rather than a one size fits all approach.	Care means exactly that care	That there are people to help when you need them	Being listened to and seen by professional medical personnel.
Continuity and holistic approach.	Keeping abreast of the Patients requirements	Correct effective content designed around the patient	A careful patient approach	Everything, especially in older age groups
Quality of care is essential, it's reassuring to the patient and builds trust and confidence.	Care for the patient as if they were your family.	A personalised, approach where service users receive an individualised programme of care.	"Jargon" for offering the best thorough treatment available on a one to one basis	Listening and explaining what the problem is and how you can help me but also how I can help myself
Good advice and information and follow up throughout treatment	Quality of care is to get rid of pain in the body.	The commitment to maintain a high standard of health and social care.	Caring about the level of care they give & 'x' really cared	Patients feel that their issues are important to be treated with empathy.
To me it means the words that are said and the way someone actually cares rather than just ticking the boxes. Feeling like you are actually listened to.	Feeling as though you have had considerate, useful help with your problem and being able to get continued support should you need it.	It means everything to me, you are trying to help me keep mobile as I'm elderly with loads of problems I appreciate all help given to me, to help me to have a good quality of life. Thank you.	Providing a professional service on time and understanding and meeting the patients needs	Feel that I have been listening to and that my care is tailored to me, not just a generic response.

What our colleagues said about high quality care:

Personalised, accessible, collaborative, safe, evidence based clinical care that has been shaped with service user involvement and welcomes service user feedback	Care that is patient specific, centred and relevant to the patient. Something that you would want to receive or have your family receive if they had treatment. The best possible care you can offer.	Using best available evidence and best practice. Making every contact count. Personalised care collaborative planning	Giving care of the highest standard treating a patient how you would expect to be treated , been professional at all times , providing dignity and respect towards patients and staff . Maintaining confidentiality
Listening and empathy & expertise in the field. Offering workable solutions to suit the situation of the patient. A good outcome for both parties is the best that can be achieved.	Collaborative working with client on goals that produce positive outcomes based on evidence based practice	Delivery of a service that meets the standards set by guidelines, professional bodies, local standards. It should also be scrutinised by regular review/audit.	Relevant, working within scope of practice, up to date knowledge and evidence based practice, treating patients with dignity and respect, appropriate management of patients in a holistic manner
Evidence-based care, delivered with compassion and integrity, by appropriately skilled, trained and supported professionals.	Listening to patients and their concerns. Addressing patient concerns. Giving the best, most efficient treatment for patient's problems	Quality of care means being person centred at all times while being safe. Always acting on what you have promised to do and explaining if there is something you cannot do.	Individualised, empathic, person centred, timely and fair. Clear and transparent care plans delivered with compassion, skill and transparency in collaboration with the service user.
A service which provides caring, prompt, joined up care that is easily accessible (where at all possible). Communication with the patient and within the service(s) is clear and uncomplicated. A patient should be treated as an individual in a holistic manner.	Personalised, holistic, clearly communicated and delivered in a timely fashion. Best possible evidence based care in a timely manner	A patient focussed, evidence based package of care which serves to equip and empower the patient to self manage over the long term. This may involve different team members or different teams if the needs are more complex.	Treating people as individuals. Working with care teams / parents / school teams. Enabling and facilitating equity and equality. Giving people the best chances that they can to achieve their goals. Caring for the people who provide the care to our patients. Looking at the needs of the entire family unit

Our quality priorities are informed by what is important to our services users and colleagues. It is also informed by local and national strategies for high quality care and is influenced by our LCH Trust Priorities and the work we are doing in the reset of our services as we continue our recovery from the COVID 19 pandemic.

6 National Drivers

The **NHS Long Term Plan** articulates the need for continuous improvement and to build on success. There is a clear focus on long term conditions like diabetes, cardiac failure and respiratory failure. There is also a drive towards digital innovation to offer new and innovative ways to support patients. Digital approaches to care have been accelerated during the COVID 19 pandemic where restriction of face to face contact led to opportunities to work digitally. In Leeds we have embraced new ways of working whilst aiming to minimise digital exclusion for people where digital methods of engagement are a challenge.

Shared Commitment to Quality is an associated document to the Long Term Plan and clearly states that high quality must be the organising principle of our health and care service. It is what matters most to people who use services and what motivates and unites everyone working in health and care.

Patient Safety Strategy describes how we will continuously improve patient safety. It aims to maximise the things that go right and minimise the things that go wrong and is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience. The strategy sets out what the NHS will do to achieve its vision to continuously improve patient safety by building on two foundations of a patient safety culture and a patient safety system that will underpin three strategic aims of improvement, insight and involvement.

Improvement programmes will enable effective and sustainable change, alongside an aim to improve our thorough analysis of patient safety information that will provide greater **Insight.** Together they will support the third aim of **Involvement** so that people have the skills and opportunities to continuously improve patient safety throughout the whole system. This includes the development of patient safety partners, patient safety specialists and a curriculum of training based on a systems approach. Key features of the Patient Safety Strategy include psychological safety, diversity, leadership and teamwork, and an openness to learning.

7 LCH Trust Priorities

The LCH Trust Priorities build on current COVID 19 recovery plans and key initiatives aligned to city priorities and the NHS Long Term Plan, as well as work that has been agreed internally as priority. There are five priorities that reflect the Board's wish to provide greater focus on key priorities, the necessity of continued response to the impact of COVID 19 and a reflection that our priorities will continue to be supported by existing LCH strategies. The Trust Priorities are:

- Build our services back better
- Play a full part in #TeamLeeds' ongoing response to Covid-19, standing ready for further surges, supporting the vaccination programme, supporting system resilience and patient flow
- Promote and support the health and wellbeing of our workforce
- Develop integrated provision with a stronger focus on prevention, self-management and pro-active care
- Work pro-actively across the organisation and with #TeamLeeds to understand and improve health equity.

8 Our Quality Priorities for 2021 to 2024

At LCH, we have a strong belief that delivering high quality care is grounded in collaboration and truly understanding our communities. Through the engagement for this Strategy a key theme emerged that we would like to focus our Priorities around, that high quality care: ***'makes me feel valued as a patient'.***

We considered how we could best focus the Priorities around our patients and ensure the implementation of the Priorities would align to the feedback we received. We were also keen to build on the great work we are already doing, that has been informed by our ongoing engagement with our patients, communities, and partners.

Learning

In LCH we are proud of our open, learning culture. When we identify learning, we share it, develop local action plans and ensure we are continually improving our services in response. Over the next three years we will strengthen our approach to learning to ensure it is even more effective and responsive and is utilised on a much wider scale to improve our services:

- We will develop a repository of learning to secure the organisational memory.

- We will work to ensure that all learning within the organisation is known and effectively captured to be able to share across the organisation and with partners.
- We will share and disseminate learning in a way that reaches the greatest number of colleagues, teams and partners in the timeliest way possible.
- We will develop and support methods to embed learning in practice and provide assurance that learning has been implemented and embedded where appropriate.

How does this Priority support our patients and consider their feedback? We hope that by strengthening our approach to learning to improve services that we demonstrate that we ***'care for the patient as if they were your [our] family'.***

Patient Safety Strategy

We have always had a strong approach to patient safety and investigation to ensure we use every opportunity to improve practice. We have started to align the way we manage patient safety incidents to the Patient Safety Strategy that was published in 2019. We have aligned this Priority to the continued implementation of the requirements of the National Patient Safety Strategy:

- We will investigate less and learn more with a focus on meaningful investigations that achieve insight and understanding of patient safety incidents to inform learning and improve practice.
- We will involve patients, and their family and carers where appropriate, in our investigations to ensure their experience of our care is understood and fully informs the investigation, learning and improvements.
- We will involve colleagues in our investigations to ensure their experience of care delivery is understood and fully informs the investigation, learning and improvements and ensure all colleagues are offered support.

How does this Priority support our patients and consider their feedback? We are committed that our approach to the Patient Safety Strategy will keep our patients at the heart of our patient safety ethos and will translate to ***'correct effective content designed around the patient'*** that also demonstrates our caring values by ensuring a ***'careful patient approach'.***

Focus on equity in quality and safety

In LCH, we recognise that there are unfair and avoidable differences in the health of different groups and communities, and have developed an overarching Health Equity Strategy to articulate our commitment to reducing those areas of inequity. We will ensure our Quality Strategy supports this work through a focus on health equity to reduce and address inequity:

- We will embed equity in proactive approaches to quality, including research, evidence-based guidance and outcomes

- We will review incidents and patient experience to understand any inequalities affecting particular communities or communities we are not hearing from and act to address these.
- We will embed equity as part of our Quality Challenge+ Programme.

How does this Priority support our patients and consider their feedback? By ensuring we work equitably by embedding ***'personal care rather than a one size fits all approach'*** we will reduce and address inequity that will be demonstrated by our delivery of ***'a personalised, approach where service users receive an individualised programme of care'.***

We will work across the PLACE of Leeds as a full partner to develop collaborative governance structures and priority programmes that support our ambitions for better, more integrated care in the city

As a key partner in the development of the local Integrated Care Partnership, LCH is part of the plan that focuses collaboration and partnership working. Patients and communities are at the centre of what we aim to achieve as a wider health economy across Leeds. By working together we will maximise the health and care outcomes for our populations:

- We will work with partners in patient safety across the city to consider joint responses to patient safety initiatives and develop collaborative approaches to safe, effective care.
- We will develop strategies to share learning across the city to maximise the impact of our quality improvement work and ensure our patients benefit from quality improvements and learning from across Leeds.
- We will ensure there is a focus on equity in our approach to patient experience, patient safety and clinical effectiveness.

How does this Priority support our patients and consider their feedback? By working together across Leeds we will keep patients at the heart of our services. We will ensure ***'that there are people to help when you need them'***, and that our patients ***'feel that I [they] have been listened to and that my [their] care is tailored to me [them]'***.

In doing so we will achieve an outcome that is crucially important to LCH, our patients, and our partners: *'**the commitment to maintain a high standard of health and social care'.***

9 Quality Assurance and Governance

Our Quality Strategy is supported with a robust approach to quality assurance and clinical governance processes. Quality improvement will be supported through the Trust's governance arrangements, which provide communication and escalation pathways between teams and the Board to maximise assurance, reporting and feedback across all areas.

The Quality Committee is the sub-committee of the Board with responsibility for seeking assurance on the delivery of the Quality Strategy and will seek assurance and monitor evidence through the following governance processes. These processes will ensure our service delivery is '***personalised, accessible, collaborative, safe, evidence based clinical care that has been shaped with service user involvement and welcomes service user feedback'***.

Overarching Quality	Patient Safety	Clinical Effectiveness	Patient Experience
Trust Wide Priorities	**Patient Safety Incident Reporting and Management**	**National Audit**	**Complaints, Concerns, Compliments**
Business Unit Priorities and Thematic Deep Dives	**Serious Incident Management**	**Local Audit**	**Feedback**
Equality and Quality Impact Assessment	**Just Culture and Freedom to Speak Up**	**NICE Guidance concordance**	**Always Events**
Workstream Strategies: Quality Improvement Engagement Health Equity	**Learning from Deaths**	**Policy, Guideline and Procedure Governance**	**LCH Charity Commission Annual Report and external audit**
Performance Data	**Thematic Reviews**	**Quality Challenge Plus**	**Engagement Champions**

Appendix A - Supporting LCH Strategies

The Trust Quality Strategy is supported and informed by a number of other organisational strategies.

Patient Engagement Strategy – In order to provide the best possible care to every community we serve and to do this successfully we need to engage and work with the people that use our services.

As a Trust we are committed to ensuring we engage patients and the public in everything that we do and this strategy aims to outline to the organisation how we will achieve this. This includes engagement from board level to front line services, to ensure the patient voice is loud and clear in all we do. There has been a lot of great work over recent years from individual services to ensure we engage with patients whenever possible and we are keen to build on this to create an organisational culture that engages patients and the public in all that it does

Third Sector Strategy – Our aim is to deliver outstanding care to the people we serve. By developing effective partnership working with the third sector, maximising use of their expertise and contribution, we can achieve a culture change in LCH where our people fully recognise their value and support third sector resilience.

Quality Improvement Strategy – Our Quality Improvement Strategy aims to stimulate, inform and guide quality improvement thinking in LCH, leading to the empowerment of all staff to initiate and lead quality improvement work in their services. This will then in turn drive the development of the culture of continuous quality improvement in LCH.

The city of Leeds has an exciting and vibrant approach to partnership working across all agencies, with the aim of improving the health and wellbeing of everyone in the city. There is an aspiration to build a shared QI capability across the whole city of Leeds. As joint work and the ‘whole system approach’ become more prevalent, QI teams in different organisations have the opportunity to work together more to ensure the patient’s journey is the best it can be at every step.

Health Equity Strategy – In order to deliver the best possible care in every community, we must know and work with our communities 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 services make to people's health. We call this fairness 'health equity'.

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 in contributing to improvements.

Appendix B – Quality Standards

LCH works alongside national providers and national quality standards to maximise the safety, efficacy, and timeliness of our service delivery. We deliver our services in a way that demonstrates our caring approach and strong leadership throughout our workforce. There are key national bodies and standards we work with, these include but are not limited to:

Care Quality Commission who we are independently regulated by to provide safe, effective, responsive care that demonstrates a caring, well led approach.

Health Education England who support the delivery of excellent healthcare improvement to the patients and public of England by ensuring the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.

NHS England policy and guidance. For example, the Patient Safety Strategy.

National Quality Board and their 'A shared commitment to quality' and their shared single view of quality that is high quality, personalised and equitable care for all, now and into the future.

National Institute of Health and Care Excellence (NICE) whose role is to improve outcome for people using the NHS and other public health and social care providers by:

Producing evidence-based guidance and advice for health, public health and social care practitioners.
Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
Providing a range of information services for commissioners, practitioners and managers across health and social care.

Professional bodies for our colleagues, including:
General Dental Council
General Medical Council (GMC)
General Pharmaceutical Council (GPhC)
Health and Care Professions Council (HCPC) and associated professional bodies
Nursing and Midwifery Council (NMC)

Leeds Community Healthcare NHS Trust

Agenda item 2021-22 (52)

Version 2: 29 07 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			
Mortality report	4 x Year	EMD		X	X		X plus annual report 2020-21		X		X
Staff survey	annual	DW				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 Safety Report	2 x year (Feb and August)	EDN&AHPS			X				X		
Patient experience: complaints and concerns report	2 x year (Feb and August Annual report)	EDN&AHPS			X Six monthly report				X Annual report		
Reducing restrictive interventions –Little Woodhouse Hall until 31 March 2021	4x year	EDN&AHPS		X first report	X						
Freedom to speak up report	2 x year	CE		X					X Annual report		X
Guardian of 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 (Trust) priorities position paper	Annual	EDFR				X 2021-22 new					
Trust priorities update	4x year				XQ3		x End of year report Defer June	X End of year Q4	XQ1		XQ2
Third Sector Strategy	2x year		X First report		X Deferred		x			X	
Estate Strategy	2xyear (March and October)	EDFR								X	
Digital Strategy	2x year	EDFR	X			X				X	
Engagement Strategy	2 x year (Mar &Oct from 2020)	EDN&AHPS	X			X				X	
Health Equity Strategy	3 x year(March, August and December in 2022)					X taken at Board workshop 5 March 2021	X first report		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	X New strategy for approval	
Research and Development Strategy	annual (August)	EMD			X Deferred to August 2021				X		
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

Trust Board meeting held in public: 6 August 2021
Agenda item number: 2021-22 (54)

Title: Patient Experience Report.

Category of paper: For assurance

History: Quality Committee 26 July 2021.

Responsible director: Executive Director of Nursing and Allied Health Professionals

Report author: Patient Experience and Engagement Lead

Executive summary

Purpose:

1. This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH).
2. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).
3. The report provides a review of complaints and concerns, feedback via surveys, engagement activity, and wider feedback for the 6 month period 1 January 2021 to 30 June 2021; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years and presents key information in relation to Covid-19.
4. The report includes Friends and Family Test (FFT) information.

Main points:

1. There has been a 24% reduction in complaints received 1 January- 30 June 2021, compared to 1 January- 30 June 2020.
2. The top 5 themes of complaints received remain consistent with the previous year.
3. The Trust received a total of 4 Covid-19 related complaints throughout 1 January – 30 June 2021; this was 10% of all complaints received by the organisation.
4. Work continues to focus on reintroducing patient experience activity and supporting services to engage with people digitally and online where appropriate.
5. Patient and Carer experiences are being captured through use of paper and online surveys, focus groups and the development of patient/parent and carer user groups.

Recommendations

The Board is recommended to:

- Note this report

1 INTRODUCTION

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

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

2 BACKGROUND

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

This report will include the impact of Covid-19 on complaints, concerns, compliments and patient experience.

3 LCH PATIENT EXPERIENCE

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

4 COMPLAINTS, CONCERNS & COMPLIMENTS

From 1 January 2021 – 30 June 2021, LCH received 39 complaints which were managed under the 2009 regulations. There was a 42% decrease in incoming complaints compared to the latter half of last year, when 67 complaints were received between 1 July - 31 December 2020.

In comparison to the same period in the previous year 1 January 2020 - 30 June 2020, there has been a 24% reduction in complaints received, from 51 to 39 complaints.

The reduction in complaints is consistent with other NHS Trusts locally and Nationally and is believed to be in response to Covid-19, it is anticipated that number will begin to rise going forward.

Work to engage with people to understand how accessible the LCH Complaint process is and make improvements will commence in Summer 2021.

97% of all complaints received by the Trust were acknowledged within 3 working days (38 out of 39)- one complaint was recorded by the service but PET were not notified which caused a delay, however immediate resolution was offered to the complainant by the Service.

Of the 39 complaints received by LCH 1 January 2021 - 30 June 2021, 37 complaints entered into the formal complaint process. 1 complaint was withdrawn by the Trust due to the issues being raised relating to a partner organisation and the other complaint was subsequently passed on to another organisation.

23 out of the 39 complaints received between 1 January 2021 - 30 June 2021 have been closed. In addition to these, the Trust closed 22 complaints that were received prior to 1 January 2021 and are therefore counted within this report period.

36 out of 45 (80%) of closed complaints were closed within 40 working days of receipt. 3 complaints were extended due to a delay in receiving the patient's consent; 1 complaint was placed on hold as per the complainant's request; and 5 complaints were extended over the 40 working day period due to an internal delay; these delays were related to staffing, staff sickness and capacity and were agreed with the complainants.

100% of all closed complaints were responded to within 180 days of receipt (45 out of 45).

Of the 45 complaints closed 1 January 2021 – 30 June 2021, 20 (44.4 %) were not upheld; 12 (26.7%) were partially upheld, 11 (24.4%) were fully upheld, 1 (2.2%) was withdrawn and 1 (2.2%) was passed on to other providers.

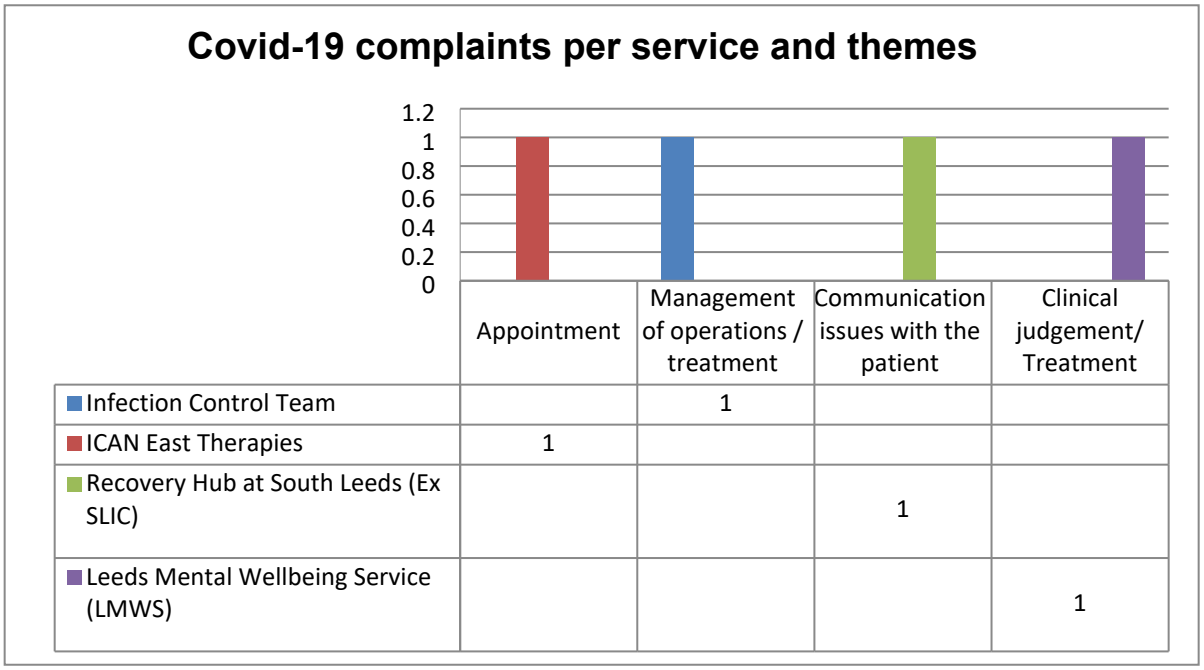
From 1 January- 30 June 2021, the Trust received 228 concerns; this is a slight increase (14%) in the number of concerns in comparison to the same time period in the previous year when the Trust received 196 concerns.

The Trust has received a total of 488 compliments during 1 January- 30 June 2021, this is a 13% decrease compared to the latter half of last year when we received 562 compliments (1 July- 31 December 2020). However, by comparison to the same period for the previous year (1 January- 30 June 2020) where the Trust received 416 compliments there is a 15% increase in compliments received. Work to understand why compliments have reduced is ongoing.

5 COVID- 19

The Trust received a total of 4 Covid-19 related complaints throughout 1 January – 30 June 2021; this was 10% of all complaints received by the organisation.

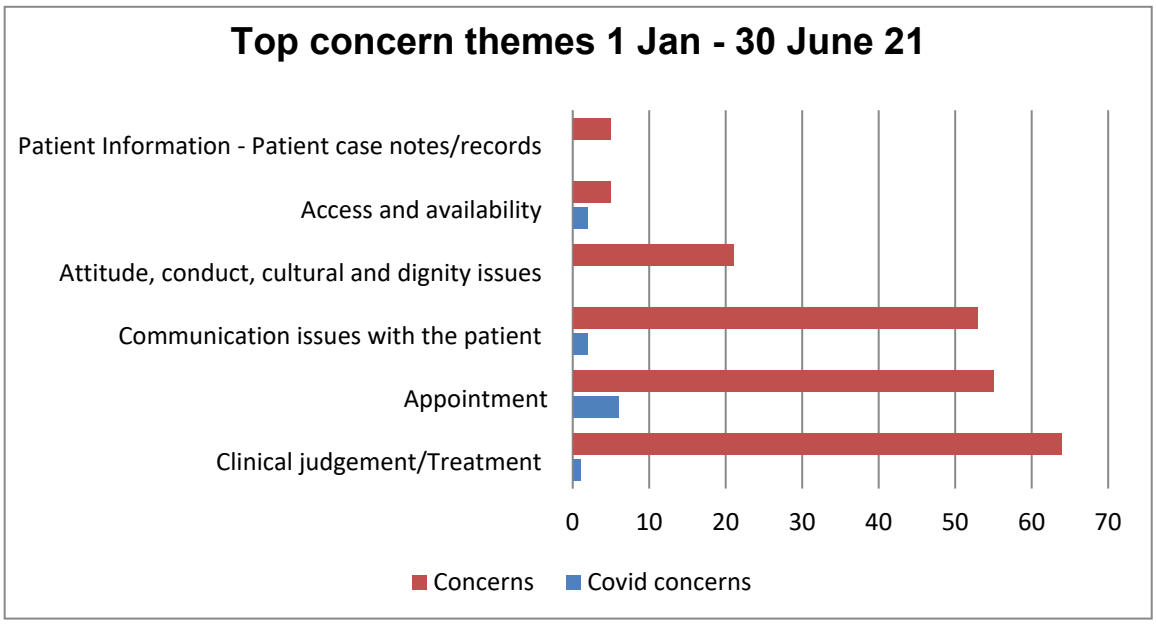
The graph below shows complaints received related to Covid-19 and themes per service for 1 January- 30 June 2021.



	Appointment	Management of operations / treatment	Communication issues with the patient	Clinical judgement/ Treatment
Infection Control Team		1		
ICAN East Therapies	1			
Recovery Hub at South Leeds (Ex SLIC)			1	
Leeds Mental Wellbeing Service (LMWS)				1

The Trust has received a total of 11 Covid-19 related concerns for the period 1 January- 30 June 2021; making up 5% of all concerns received by the organisation.

A graph to show concerns received and themes, with a breakdown of Covid-19 related concerns for 1January- 30 June 2021.



6 PATIENT EXPERIENCE (COMPLAINTS) TRAINING

Due to capacity within the Patient Experience Team, and within teams to attend training, there have been no complaint training sessions delivered between January and June 2021. Support has been provided to teams where needed and guidance given. The Complaint training is in the process of review, with bespoke sessions planned for later in the year.

The Patient Experience; dealing with compliments, concerns and complaints policy was reviewed in May 2021 and has been approved.

The policy review has included the complaints process being revised to better capture the learning from complaints. Action plans must now be completed by the service where learning has been identified to ensure a quality improvement approach is being utilised.

7 OVERARCHING THEMES

This section provides an overview of the categorisation of issues raised 1 January - 30 June 2021.

The top 5 themes within LCH's complaints for period 1 January - 30 June 2021 ranked in the following order:

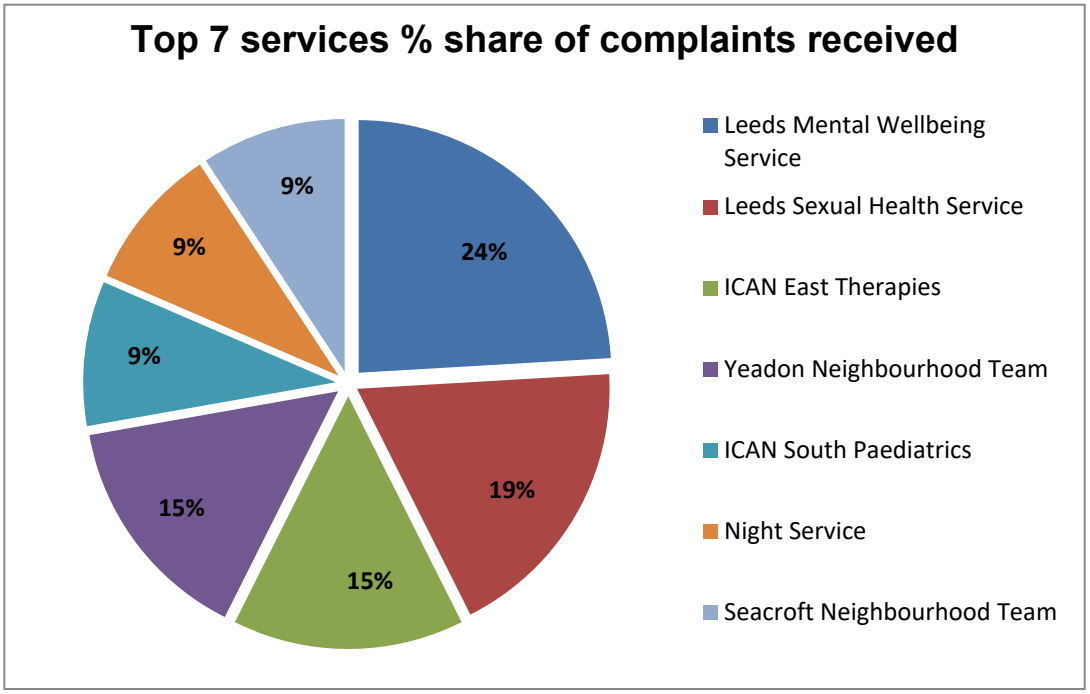
- Clinical Judgement / Treatment
- Communication issues with the patient
- Attitude, conduct, cultural and dignity issues (includes Staff attitude and communication)
- Appointment
- Handling complaints

The top 5 themes for LCH over the last 6 months are consistent with the previous 6 months and with the same period in the previous year, with the exception of handling of complaints which has replaced the management of operations/treatment.

	ABU	CBU	SBU	Corporate	Total
Clinical judgement/Treatment	5	4	4		13
Communication issues with the patient	2	4	5		11
Attitude, conduct, cultural and dignity issues		1	3		4
Appointment	1	1			2

Handling complaints		1		1	2

A graph to show the services that received the highest number of complaints 01 January- 30 June 2021.



7.1 TRENDS WITH CLINICAL JUDGEMENT/POOR TREATMENT

The “top line” theme of clinical judgement / poor treatment has consistently been in the top three subject areas for complaints at LCH for the past 5 years. This is in line with the information that has been previously reported nationally.

During 1 January - 30 June 2021, 33% of all complaints received (13/39) were due to issues pertinent to clinical judgement/poor treatment and saw the biggest share of all complaints received across the organisation. The number of complaints related to clinical judgement/treatment was highest in the Adult Business Unit with 5 complaints received, followed closely by the Children’s and Specialist Units with 4 complaints respectively.

Out of the 13 complaints received; 7 have been closed to date; 4 complaints were fully upheld, 1 was partially upheld and 2 were not upheld.

An example of learning from a complaint within the Adult Business Unit following the investigation identified that the service were unable to confirm if equipment ordered via Leeds Equipment Store had been delivered to him. The expectation would be that any delay with the ordering or delivery of equipment would be escalated to the Trust’s Senior Leadership Team. This did not happen on this occasion. A new process has been initiated within the Neighbourhood Team to track and monitor progress with all equipment requests moving forward.

In addition and for the same complaint, a referral to the Speech and Language Team was recommended to assess the patient's swallowing ability which needed to be initiated by the patient's GP. A task referral to his GP was completed however there was a delay in the referral being made. Following this, the Neighbourhood Team have also ensured that additional training and guidance is provided to staff working in our Neighbourhood Teams to improve communication and to support timely and effective referrals to this service.

A complaint was received stating that used PPE had not been dated in the patient's house. The Leeds Community Healthcare policy states that PPE should be bagged, dated and not placed in household waste for 72 hours. Following the complaint investigation, a training need was identified and will be provided to all staff. The service is now auditing compliance with the PPE policy for assurance of improvement within this aspect of care.

8 TRENDS WITH COMMUNICATION ISSUES WITH THE PATIENT

For the period 1 January - 30 June 2021 28% (11/39) of all complaints received were due to communication issues with the patient. The Specialist Business Unit received 5 complaints, the Children's Business Unit 4 complaints and the Adult Business Unit 2 complaints.

Out of the 11 complaints received; 8 were closed; 2 complaints were fully upheld, 1 complaint was partially upheld and 5 complaints were not upheld.

In one complaint, the complainant felt his wife's pain was not controlled in an effective way. Staff did follow both national and local guidance correctly for this aspect of the patient's care; however, it was identified that the team could have communicated their rationale and actions more clearly. This may have provided more reassurance to the complainant and his family at the time. We explained in our complaint response that all staff receive training and supervision to support with advanced communication skills and this learning has been shared with trainers to help improve staff competence in this area of practice.

In another instance the patient and their family felt there was a breakdown in communication when it came to the ordering of the patient's medication. As a result of the complaint and issues raised, the Pharmacy Technician at Seacroft Neighbourhood Team has put a robust plan in place for all future ordering of medications from the GP practice. This will ensure that medications will always be available in the patient's home and reduce the risk of the patient missing doses. As an added safety net, it is now to be clearly documented on the front of the patient's Medicines Administration Record (MAR) charts the date that the next prescription should be ordered from the GP. The responsibility for this will sit with the patient or nominated next of kin and the date will serve to encourage staff to prompt the patient to order their medication. Medications should be ordered no later than 7 days in advance of the existing supply running out. This

process has also been discussed at weekly medication meetings that are held at Seacroft Neighbourhood Team so that all staff are aware. This has also prompted a conversation with all staff at Seacroft to remind them that standard process is at the first visit to a new patient, to have a conversation and agreement should be made between the Neighbourhood Team and the patient / family as to who will be responsible for the ongoing ordering of the patient's medication. This will then be clearly documented in the patient's medical records and in the medication assessment template.

9 TRENDS WITH ATTITUDE, CONDUCT, CULTURAL AND DIGNITY ISSUES

Of all complaints received during 1 January- 30 June 2021 10% (4/39) were due to issues concerning attitude, conduct, cultural and dignity and this subject area received the third biggest share of all complaints received. The Specialist Business Unit received a higher number of complaints related to this subject area with 3 complaints; the Children's Business Unit received 1 complaint whilst the Adult Business Unit received nothing.

Out of the 4 complaints received; 2 have been closed to date; 1 was withdrawn by LCH and the other was passed onto another organisation. The 2 other complaints are currently open and under investigation and as such, we are not able to capture the learning for the purpose of this report.

10 TRENDS WITH APPOINTMENT RELATED ISSUES

During 1 January - 30 June 2021, 5% of all complaints received (2/39) were due to appointment related issues and saw the fourth biggest share of complaints received. The Adult and Children's Business Units received 1 complaint respectively whilst the Specialist Business Unit received none.

Of the 2 complaints received; 2 were closed; 1 complaint was fully upheld and the other was partially upheld.

One complaint related to the difficulties experienced when trying to book an appointment with the Leeds Sexual Health Service, which was also a theme for the high number of concerns received for the service. We explained that due to the pandemic, the service were unable to deliver a walk in service due to the need to adhere to social distancing to keep both patients and staff safe. On the 20 March 2020, with the approval of our Commissioner, Leeds Sexual Health Service moved to telephone triage which meant access into the service was via a telephone appointment line. Following feedback from both patients and staff, the service has recently undertaken an audit of the telephone calls into the service and confirmed the service received 6-7,000 telephone calls in the 5day audit period (Monday to Friday).

The Trust has now invested in a new telephone system that is due to be implemented, by late summer. Work is ongoing to try to bring this date forwards. The new system will allow the service to manage the telephone calls more

appropriately and to have messages on the system advising patients of their position in the queue. It will also allow for different triage options to reduce the wait. It is hoped that this will greatly improve the experience for the patient.

In another complaint, the patient's family were not informed of a planned Occupational Therapist and Physiotherapy joint appointment until the day before. It was found the despite the visit being planned some time before, this was not communicated by the school involved, or the Trust directly to the family. The standard within the Integrated Children's Additional Needs (ICAN) therapy service is that all school appointments are communicated with parents / carers when these are agreed and booked in and as such, the service has recommunicated to all therapists and therapy administrative staff to ensure this standard is adhered to in the future.

11 TRENDS WITH HANDLING COMPLAINTS

During 1 January - 30 June 2021, 5% of all complaints received (2/39) were due to issues raised about the handling of the complaint, the Adult and Children's Business Units received 1 complaint respectively.

Of the 2 complaints received; 1 was closed and fully upheld, the other is currently under investigation.

In one example a patients' concerns were communicated to the Clinical Service Manager for the ICAN East Team and it was informally understood that a local resolution would be achieved. In this case following conversations with the therapists and Multidisciplinary Team it became apparent that the patient was expecting a call from the service, and when the Service Manager spoke with the therapists and Multidisciplinary Team, she was expecting a local resolution to be undertaken. It appears that there was a miscommunication within the team and therefore the patient did not receive a call at the time. To ensure that this doesn't happen again the Service Manager has spoken to staff to agree and document a decision on how to progress concerns which includes timescales that must be adhered to.

12 CLAIMS

LCH has received one Claim during 1 January - 30 June 2021. The claim falls under the Liabilities to Third Parties Scheme; Employers Liability and is related to a staff member slipping on uncleared leaves at the entrance of an LCH health centre.

There have been no closed Claims during 1 January - 30 June 2021.

13 PATIENT ENGAGEMENT

13.1 FRIENDS AND FAMILY TEST

Following the re-commencement of national reporting for the Friends and Family Test (FFT) in December 2020, LCH has received 1768 FFT responses between 1 January - 30 June 2021.

Overall, 96.78% of respondents said they had a very good or good experience with our services (1711 out of 1768) and 1.02% of people reported a poor or very poor experience (18 out of 1768).

Positive feedback from service users described the professional, kind, efficient and friendly staff and care they received. Respondents were grateful of reassurance given during their care, particularly throughout the Covid-19 pandemic, and feedback highlighted the importance of good communication and people having their questions and concerns answered clearly and promptly.

Included in Appendix 1 are two Word Clouds highlighting the main comments and phrases from themes including Staff Attitude and Clinical Service Quality.

Both print and online FFT versions are now offered in easy-read format to ensure better accessibility to service users who may have additional requirements.

Work has also taken place with some support from NHS England to translate the online FFT into the top 5 used languages in Leeds. These are Urdu, Punjabi, Polish, Romanian and Slovak. This work will now be completed by Civica, our FFT database providers, and is expected to be completed by the end of July. For all other languages, services can follow the Trust interpretation and translation procedures.

Following the introduction of online FFT in late 2020, 904 responses have been received online across services between 1 January- 30 June 2021.

Services have been creative in sharing the online URL and QR codes available, including sending via text message, email, creating posters and laminating copies of the QR code to carry with them on visits and in clinic appointments. This allows patients and carers with smartphones or smart devices to scan the code and complete the FFT following their appointment and also means the clinicians can adhere to infection control and wipe clean the laminated card between uses.

An example of feedback received comes from the Specialist Weight Management Service. This related to inconsistencies in clinicians leading appointments, there was some confusion around appointment changes and cancellations, and people feeling support is generally lacking.

The service responded that 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 had 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. They are continuing to monitor their FFT feedback monthly.

The 0-19 Public Health Integrated Nursing Service (PHINS) received feedback via FFT that highlighted concerns from new parents/carers regarding lack of contact from East Leeds Health Visiting service, meaning patients and carers felt like support was lacking, particularly as the service paused the baby weighing clinics during the Covid-19 pandemic. The service ensured they used this feedback to support their communication to parents and carers via their website and social media, ensuring up to date information on service offer and key information regarding new ways of working is always available, such as virtual clinics and groups such the breast feeding support group. They also now ensure that parents and carers know they can contact a named practitioner and where required home visits are offered for further support.

The service also regularly use their online platforms to signpost to sources of information to support parents and carers, and have also been building relationships with third sector organisations such as Leeds Dad, Bosom Buddies and Mumbler and signposting parents and carers for support.

14 ENGAGEMENT WORK

Community Diabetes developed a patient survey, asking for evaluation and feedback around their structured Education programmes, the LEEDS Programme which provides support and self-management guidance to patients with Type 2 Diabetes and has been delivered virtually during the COVID pandemic. Initial responses to the survey highlighted some of the difficulties people were having in accessing these virtual offers from the service.

The service reported that this feedback has been used to ensure that staff are having better conversations with patients accessing virtual appointments. These conversations focussed on the functionality of the virtual offer if they access using a smartphone rather than computer as this can limit some of the options including the live chat and Q&A. The service has also developed a troubleshooting guide to support people in accessing the LEEDS structured educational programme via MS Teams.

Community Cardiac Service launched a patient survey asking for feedback from patients accessing the Cardiac Activity Programme. Questions focussed on:

- How easy to follow the activity programme is
- How confident people feel in managing their heart condition

- If the telephone support and information pack was sufficiently supportive during the COVID pandemic.
  Feedback suggests the programme is easy to follow and the telephone support invaluable in keeping patients motivated whilst undertaking the programme. The feedback is being used to develop future programmes and following some comments, the service have adjusted the time frame of involvement with some patients to ensure it suits individual need and are offering a more varied programme again to offer a more person-centred programme.

  Following a Focus Group workshop at the Engagement Champion meeting in April, the Musculoskeletal Service (MSK) have gone on to host a Focus Group with service users to review their new service website. Feedback from the group was positive; they felt the information was comprehensive, accessible and information offered around self-management was particularly useful. MSK have also developed a small reader group with service users, who have recently reviewed new service leaflets for clarity and accessibility.

15 ENGAGEMENT STAFF CHAMPION GROUP

The LCH Engagement Champion Group has continued to meet monthly between January and April 2021, with attendance at meetings at around 15-20 champions.

The group has agreed that from May, Trust-wide Champion meetings will run bi-monthly with drop-in sessions offered in the interim months.

The Engagement Champion Celebration Event was held on 30 June, with guest speakers from the LCH Youthboard, NHS England & Improvement Always Events and sessions held included Accessible Information Standards and a chance for the Engagement Champions to reflect on the past year, their role as champion and their priorities for the next 12 months, that will help to shape our meetings moving forward.

A Patient and Carer group matrix has been developed to highlight current groups within business units where patients and carers can receive additional support, advice and help develop and influence LCH services. Work is ongoing with Inclusion Nursing and ICAN Engagement Champions to support them to develop Parent/Carer groups. The Inclusion Nursing service are looking to link with existing groups within other Specialist Inclusion Learning Centres to share and signpost to service information and any changes, gather feedback from parents and families and seek out opportunities for future engagement.

16 ACCESSIBLE INFORMATION STANDARDS

Work has been ongoing over the last six months to update the Communication template in SystmOne. From 19 July 2021 the new template will be launched across all LCH services that use SystmOne. Plans to update other patient systems will follow.

The Communication template will be mandatory, and services will be required to report on compliance (via the Performance Information Portal and the Performance Dashboard) by the end of October 2021.

The template will be supported by the newly updated Patient Information and Accessibility pages on MyLCH which includes all guidance on providing information in formats to meet the Accessible information standards.

Training and guidance will be delivered via the Engagement Champion and Digital Champion networks across the Organisation.

17 DIGITAL INCLUSION

20 digital tablets were purchased in February following a successful application to the LCH Charity. The tablets are to gift to unpaid carers to enable those who may be digitally excluded to access to appointments, health information and to help combat social isolation.

Of the 20, 6 tablets have been gifted to carers accessing the Health and Homeless Inclusion Team, 0-19 PHINS Heath Visiting, CAMHS and Armley Neighbourhood Team.

We have also been in touch with Carers Leeds and 100% Digital Leeds, who are keen to help us identify unpaid carers who have accessed their organisations and who are accessing or supporting someone to access LCH services to encourage uptake of the tablets. A list of LCH services has been produced to help Carers Leeds and 100 Digital to signpost appropriately.

Updates due to be introduced across all service using SystmOne in July include the introduction of a Digital Literacy questionnaire to allow staff to assess if a patient can engage with our services digitally; this include online and over the phone.

The Digital Literacy questionnaire is supported by the new Digital Inclusion page on MyLCH which includes a range of information for staff to help signpost patients to digital support.

100% Digital Leeds will deliver bespoke training session to all LCH Digital Champions in July and August to upskill staff in having digital conversations and supporting engagement with digital services.

18 NEXT STEPS

The post of Charitable Funds Administrator has been increased to 22.5 hours and will be made permanent from November 2021 to support the LCH Charity aims.

Work to support the implementation of the Health Equity and Third Sector Strategies will continue to help improve access and experience of vulnerable communities and those at highest risk of health inequalities.

Patient experience will play an integral role in key Organisation projects such as the Neighbourhood Transformation Project and Improving Patient Flow and Prioritisation Programme.

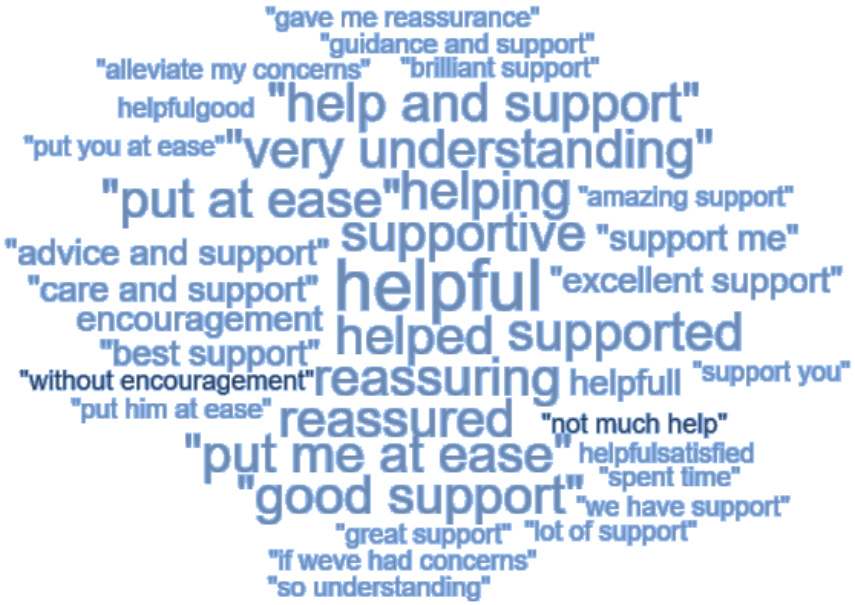
19 RECOMMENDATIONS

The Board is recommended to:

- Note this report

Appendices

Appendix 1



Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (55)

Title: Patient Safety Report

Category of paper: For assurance
History: Quality Committee 26 July 2021

Responsible director: Executive Director of Nursing and Allied Health Professionals
Report author: **Incident and Assurance Manager**

Executive summary (Purpose and main points)

A report on Patient Safety is produced bi-annually to provide the Board of Directors with the assurance that Patient Safety is being well managed, the incidents are appropriately investigated, and that learning is acted upon to improve patient care.

Patient Safety is inclusive of patient safety culture, patient safety incident management, and the management of Central Alert System notifications that affect the safety of patients.

Recommendations

The Board is recommended to:

- Receive and note the contents of this paper

1.0 BACKGROUND

1.1 This report will focus on Patient Safety themes, the learning emerging from incidents, and how we share this across the Trust to ensure continuous quality improvement.

1.2 The report will provide an overview of our concordance of the Central Alert System patient safety notifications.

1.3 The Quality Committee will continue to receive a 6 monthly report of notable exceptions, assurance, improvement, lessons learned and a any relevant supporting data relating to patient safety.

2.0 PATIENT SAFETY

2.1 Overview

During the reporting period work has continued in readiness for implementation of the Patient Safety Strategy. A Patient Safety Strategy Working Group has been established and an implementation plan developed to support Leeds Community Healthcare NHS Trust's (LCH) continued improvement journey.

The implementation plan includes greater involvement of staff throughout the incident management process, from recognition of a patient safety incident through to participation in any resulting investigations or reviews. There is also a strong focus on involving patients and families in any reviews for patient safety. To secure greater involvement whilst optimising the potential for learning the approach and timeframe for investigations will be adapted in line with the Strategy, to ensure we learn more whilst investigating less.

In support of this work, and to improve the robustness of our serious incident management process, an internal review of the serious incident decision (now Rapid Review process) and serious incident management process has been completed with the support of the Organisational Development Team.

The review included consideration of our compliance with the statutory duty of candour process. Duty of candour will now be completed wholly within teams to ensure there is continuity from the initial identification of the incident through to completion of the initial duty of candour letter to the patient or family. The Clinical Governance Team will continue to oversee this process with the support of the Business Unit Quality Leads.

The new process has been shared with the Business Units and a formalised Standard Operating Procedure (SOP) is in development.

3.0 THEMATIC REVIEWS

3.1 Monthly Patient Safety Workstream meetings have been introduced and are attended by the Quality Leads to promote routine thematic review and triangulation of the information known across the Clinical Governance Team. This approach has led to the identification of areas for thematic review, or deep dive. The aim has been to provide assurance, or to understand whether there are any early indicators of concern within teams. Early identification of concern has highlighted areas for pro active support to optimise patient safety and experience. The findings and outcomes are reported in the Quality Lead monthly report and the bi monthly Performance Brief.

3.2 Between January 2021 and June 2021, 15 deep dives have been identified and completed by the Quality Leads and Business Units. Details of these reviews are detailed below, presented by Business Unit:

3.3 Adult Business Unit

3.3.1 Seacroft Neighbourhood Team (NT) - Following on from an increase in medicines incidents relating to the ordering of medications for patients, support was provided to the team from Medicines Management. Weekly medicines 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, that is led by patients and optimises self-care and independence. This resulted in a reduction in medication incidents from 30 in March to 7 in April.

3.3.2 Seacroft NT have since had an increase in medication incidents in June 2021. Themes of expired insulin, wrong dose medication and missing medications have been noted at initial review. These themes are currently being reviewed and will be reported in the Performance Brief.

3.3.3 Yeadon NT - There has been a triangulated theme identified for the team relating to safeguarding. This included delays in referrals to adult social care for a patient with a learning difficulty and a delayed referral for assessment of a patient swallow which came from a complaint.

A local improvement plan is in development along with increased monitoring of weekly patient safety incidents with oversight from Business Unit Senior Leadership Team and Quality Lead. The Named Safeguarding Nurse is supporting the team with training and supervision.

3.3.4 Yeadon NT - A deep dive completed in June for all cases of Moisture Associated Skin Damage (MASD) confirmed the MASD was appropriately managed and reviewed. The incidents had been correctly categorised, with a moisture source identified, and appropriate actions taken by staff. No new learning was identified, and assurance was provided to the Business Unit.

3.3.5 Meatal Tears - A deep dive was completed to consider any themes in an increase in meatal tears. This included any correlation to the change in catheter type being prescribed in LTHT to a more rigid silicone catheter. Following discussion with LTHT, they were also reviewing their own data to identify any upward trend in reporting. Although specific correlation was not identified, LTHT has changed its catheter type.

Meatal tear was introduced as an incident category during 2020/2021 with an ongoing increase in recognition which will lead to high incident reports from the increase in positive reporting culture. Learning from reviews has related to advice regarding fixation of catheters and timely education for catheter care, starting in hospital and continuing into community. Actions agreed and taken so far have included:

- The catheter template is being updated in SystmOne to clearly capture when education is provided, including fixation and catheter care.
- An education leaflet has been developed and shared with LTHT with a request that this is issued to patients in hospital.
- 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.
- There is ongoing feedback to LTHT via Quality Lead/Incident Manager discharge meetings.

3.3.6 Hospital Discharge - Following the escalation to LTHT for an increase in hospital discharge related incidents in January 2021, a deep dive and review of the data was completed over quarter four. The previous 2 years incident data was reviewed and did not highlight a sustained increase in reporting nor 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 monthly meetings with the Director of Nursing (operations) in LTHT to review all moderate and above harm hospital discharge incidents. LTHT will now contribute to the rapid review process as appropriate. Learning will be shared by LTHT to ensure that feedback and learning reaches the hospital ward.

3.4 Children's Business Unit

3.4.1 ICAN - During May 2021 there was an increase in incidents related to blood testing and processing. The incident related to the service provided at LTHT but impacts on LCH service users and staff.

The Lead Nurse for ICAN liaised with LTHT and, in partnership, re designed the sample collection process to ensure the blood samples were received and examined within an appropriate timescale. This will mean those children affected will not require repeat blood samples for missing or spoiled samples. The learning was shared at the June 2021 Patient Safety Summit as an example of partnership working leading to improved support and reduced harm for children and young people.

3.4.2 Pressure Ulcers - A requested deep dive into pressure ulcer occurrence in children was completed. Themes were shared with the Business Unit from the 15 occurrences over the 3 years reviewed.

The majority of incidents had occurred within Children's Continuing Care and Short Breaks Team. Examples of learning included:

- Ensuring there were enough dressings in the home,
- Appropriate dressings were available in the patient home,
- Liaising with the Wound Management Team,
- The importance of accurate body map completion.

Lessons learned and individual incidents were managed at the time and the themes were from the review were shared with the CBU Clinical Lead. The pressure ulcer training schedule for Children's was also clarified.

3.4.3 Incident Report Numbers - A recent deep dive of activity identified that 23/27 services reported less than 5 LCH patient safety incidents in quarter 4. Datix training is available weekly in addition to targeted new Datix Handler training. Ongoing promotion of Datix training is being completed. There are additional ongoing messages regarding the importance of reporting near miss incidents to ensure early learning is implemented to reduce the risk of future harm incidents. CAMHS and 0-19 PHINS have now requested further Datix training.

3.5 Specialist Business Unit

3.5.1 Neurology - Non completion of postural blood pressure assessment, which is part of the Tier 2 falls assessment was identified last year and an action plan was formulated to improve adherence. A recurrence of this theme during the reporting period resulting in assurance being sought from the service to evaluate whether the action plan has been embedded in practice. An assurance audit was completed, and an action plan developed to include:

- Ensuring blood pressure equipment is available for initial assessments,
- Clear follow up actions are recorded where blood pressure cannot be completed

- Support for clinicians to improve confidence to assess and interpret the results of blood pressure monitoring.

3.5.2 Podiatry - A deep dive was completed following an increase in moderate and major harm incidents in Podiatry in 2020/2021. The increase included five Serious Incidents. The deep dive found themes relating to the triage of patients, referral pathways between services and escalation of deteriorating wounds. Actions have been established to address the themes and an Improvement Plan has been developed.

3.5.3 HMWYOI - There were a number of incidents of children displaying repetitive minimal harm abusive and self-harming behaviours. This resulted in the declaration and completion of a thematic serious incident. Due to a national lack of appropriate hospital provision for these children they continued to be supported in the unit. The serious incident was also supported by Director led escalation to NHS England re the lack of appropriate provision.

NHS England provided additional care support and the numbers of children in the unit reduced who were self-harming.

A further deep dive has been identified for an increase in medicines incidents and is currently being reviewed.

3.5.4 CIVAS - There was a trend of 3 reported incidents of deep vein thrombosis in patients with long terms arm lines insitu. An integrated review was completed and a risk assessment tool for the prevention and management of deep vein thrombosis for patients with long term arm lines has been developed with LTHT. This has been shared across the Community Intravenous Antibiotic Service, Hospital Line Team, Anaesthetists LTHT and Emergency Department Team via the above LTHT/LCH incident meetings.

3.5.5 Leeds Mental Health and Wellbeing Service (LMWS) - Following an increasing number of deaths within LMWS a detailed review was completed in February 2021. The review found no increase in the number of suicides from 2019/20 to the same period in 2020/21.

The number of recorded natural deaths was found to have increased. It was also noted that the service had expanded over the last year and referrals had increased with the inclusion of Primary Care Mental Health that may have led to the increase.

An action plan was developed from additional identified learning that included an audit of triage data to understand any areas for improvement, to complete a baseline of current practice at referral meetings, and to ensure all clinical leads have access to the SystmOne unit.

3.5.6 Datix Reporting - An overall theme of accuracy within Datix reports has been identified within each Business Unit and will be supported by an action on the Patient Safety Strategy Implementation Plan.

4.0 PATIENT SAFETY INCIDENTS

Over the reporting period LCH has adopted some of the methodology from the Patient Safety Strategy in how additional reviews are completed.

Serious incidents continue to be predominantly managed under the 2015 Serious Incident Framework. Details will be reported in the bi annual Serious Incident report. Additional methods of understanding and achieving learning from incidents have included incident walkthroughs and focused safety huddles. In line with the Strategy, LCH is moving towards consideration of human, system and contributing factors as opposed to relying on root causes and contributing factors to inform learning.

During this reporting period, the continuing challenge of the COVID 19 pandemic resulted in some recurring contributory factors that have potential links to the pandemic. They included the impact of increased levels of sickness across teams from COVID-19 illness, the requirement of staff to shield and soft intelligence related to secondary illness like stress.

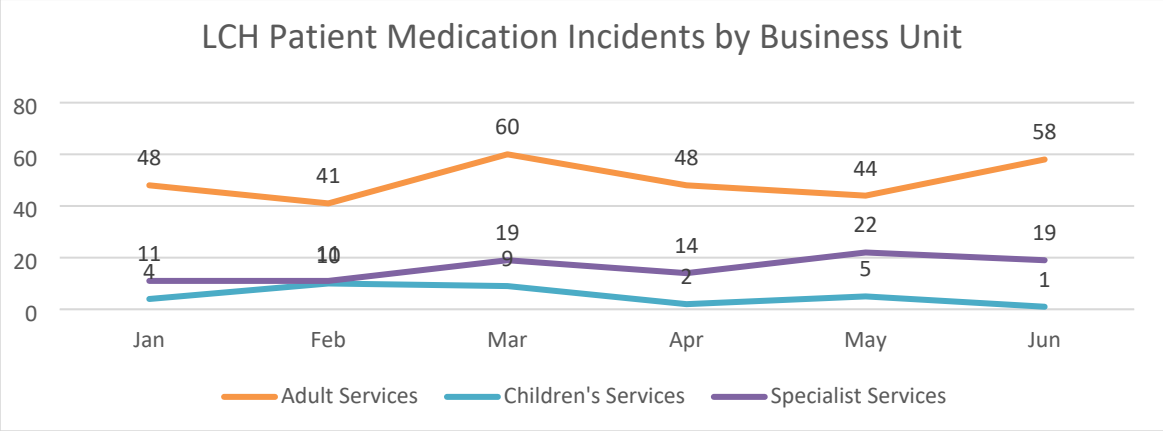
This has also impacted on the timeliness of receiving Rapid Review reports that continues to be a concern. Protected time for governance activities is being supported within the Neighbourhood Team Model Transformation Project.

Overall, whilst the Patient Safety Strategy is driving improvements, the developments in LCH systems and processes will require a continued, significant amount of work and resource to deliver.

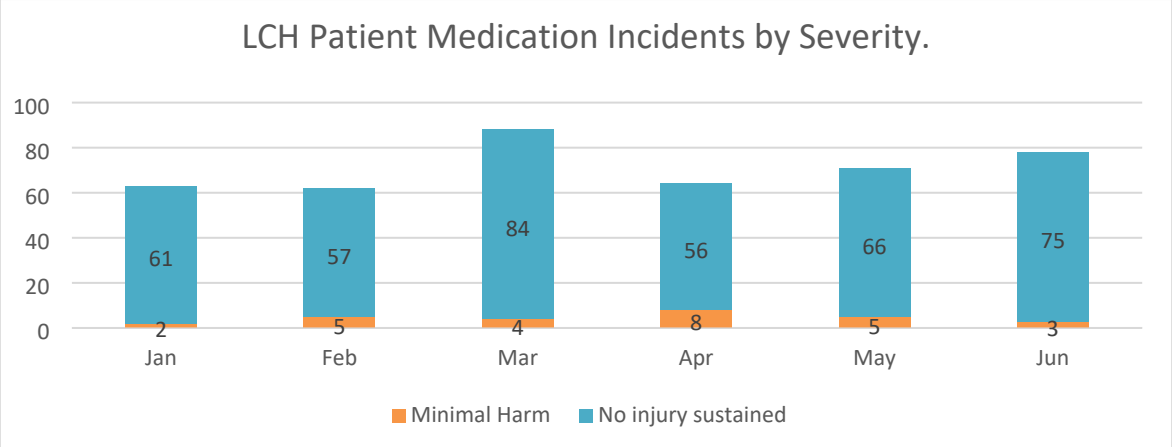
The areas of highest incident reporting are detailed below.

4.1 Medication Incidents

4.1.1 A total of 426 incidents involving medication were reported during this six month reporting period; Adult Business Unit reports the greatest proportion of LCH incidents. *Graph 1* below.



The number of medication incidents resulting in minimal harm is attributable to the Adult Business Unit, the remained were no harm incidents. *Graph 2 below.*



There were no moderate or major harm medication incidents reported this reporting period.

4.1.2 Highlights

The Medicine Management Team successfully concluded a review of the medicine incidents within Seacroft NT as discussed above; this led to weekly medicine incident review meetings and a reduction in those incidents. An increase in incidents in Seacroft NT in June 2021 is being reviewed.

A variable dose insulin chart is in development to support the safe delivery of diabetes care by Neighbourhood Teams for patients with complex treatment regimens.

In conjunction with Microbiology Specialists at LTHT, a review of the city-wide catheter prophylaxis guidance for the primary is underway. The guidance

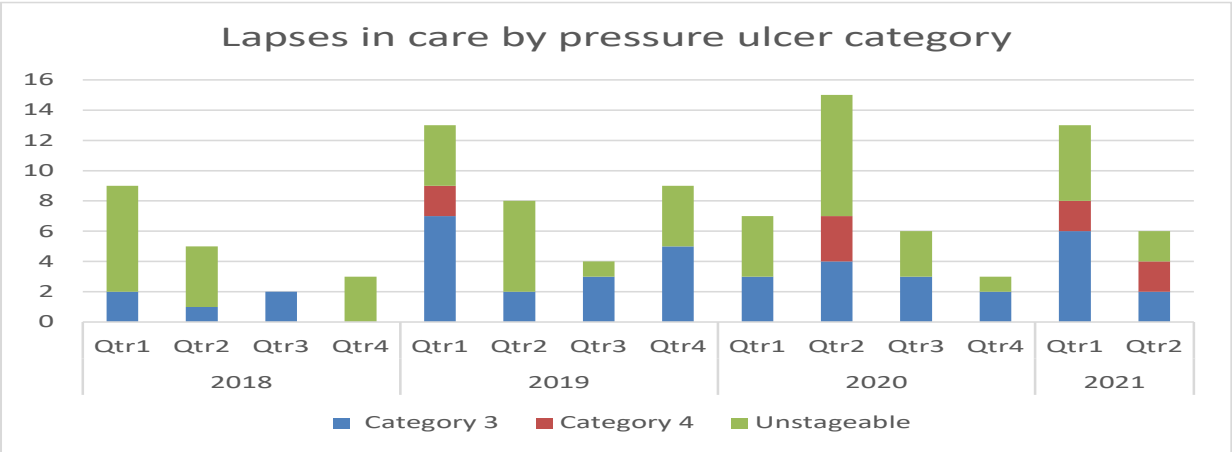
aims to clarify when prophylaxis is required for catheter changes and the choice of antimicrobial

Full details of LCH medication incidents is held in the Medicines report.

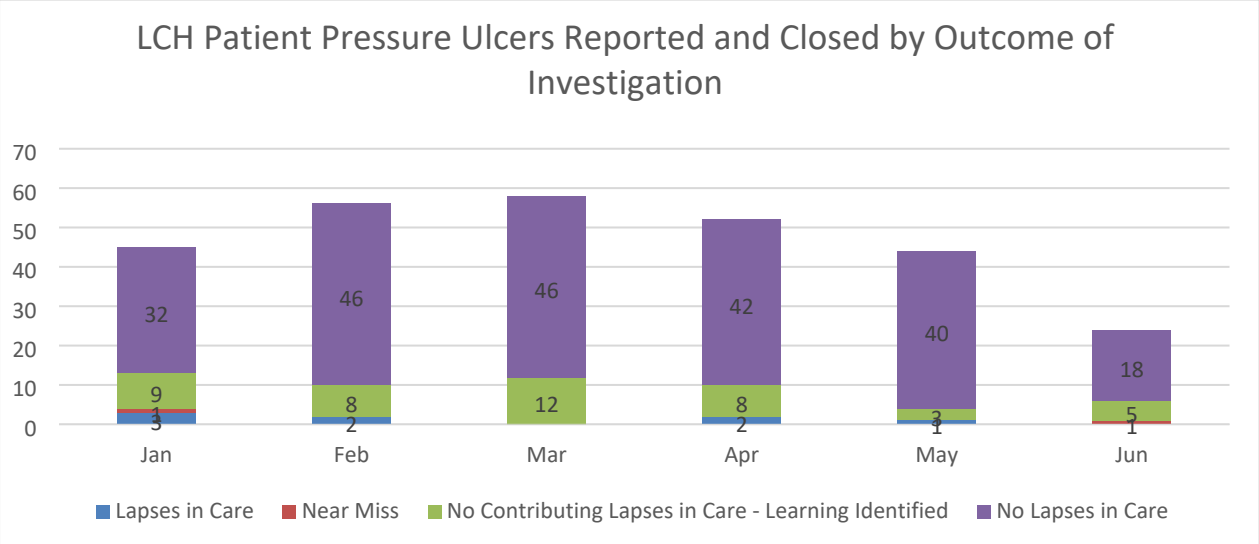
4.2 Pressure Ulcer Incidents

All Category 3, 4 and Unstageable pressure ulcers are subject to a Rapid Review (formally Serious Incident Decision Meeting). Where there is assessed to be an opportunity for learning, an additional review is completed.

4.2.1 The table below shows incidents recorded by date reported as an SI



The table below shows PUs Outcome after Investigation



4.2.2 Highlights

A pressure ulcer assessment matrix was introduced during the reporting period to support more accurate assessment of the harm attributed to Category 3 and Unstageable pressure ulcers (Appendix 2). This has been implemented to assess the most appropriate level of investigation based on harm and episode of care rather than solely on the pressure ulcer category as was previously the case.

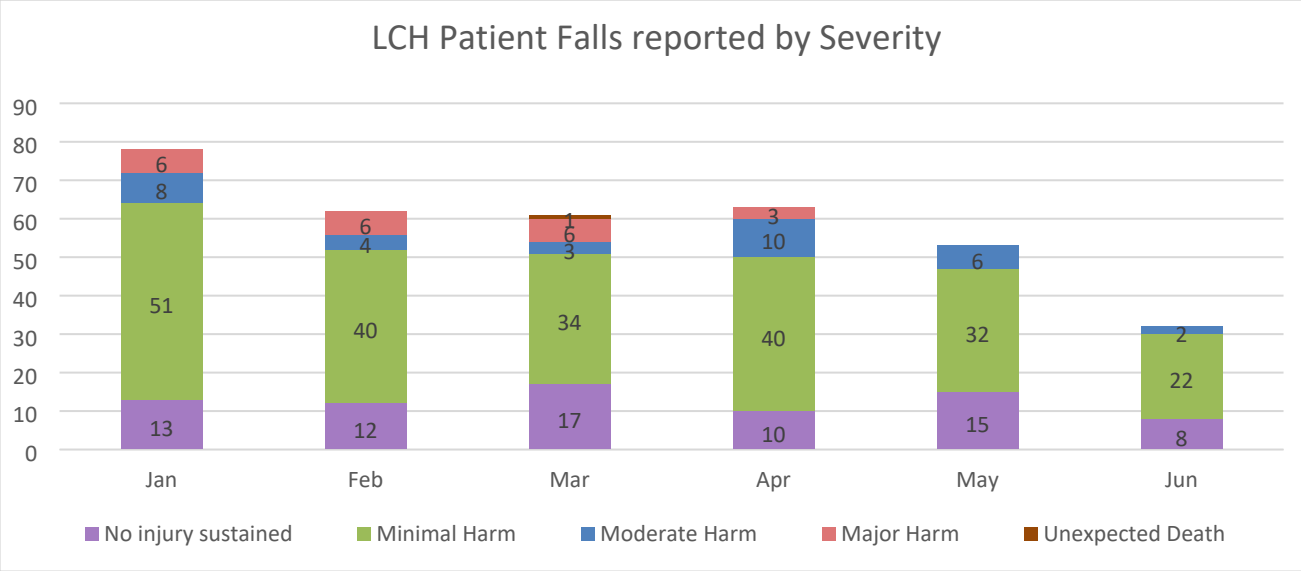
This has supported the start of our alignment to the Patient Safety Strategy to ensure we are investigated the most appropriate incidents using the most appropriate method.

For each review learning and/or good practice is identified and shared at the most appropriate level: individual, team, Business Unit or system level. Learning has also been shared via the Performance Brief and the Patient Safety Report to Quality Assurance and Improvement Group. Learning from incidents has also been triangulated to inform wider learning and areas for thematic review and deep dive as previously discussed.

We are working towards a standardised approach to cross referencing the learning from pressure ulcer incidents to the Pressure Ulcer Steering Group's improvement plan. The first stage of this has been the comparison of themes identified during a thematic analysis of pressure ulcer serious incidents for 2020/2021 to the improvement plan.

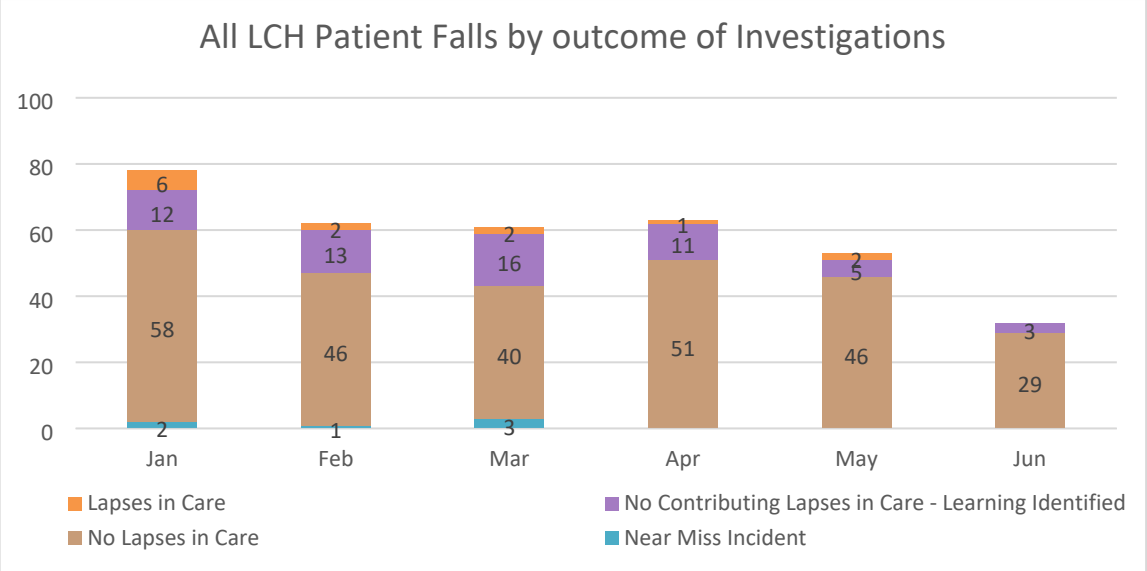
4.3 Falls Incidents

4.3.1 The below graph shows the total number of falls reported during this reporting period by severity.



Of the 351 incidents recorded, 21 were major harm, 33 moderate harm, 220 minimal harm, and 76 were no harm. The remaining fall was reported as an unexpected death; further review concluded that the fall did not contribute to the patient's death.

All falls incidents recorded as moderate and major harm were reviewed at the Rapid Review Meeting, chaired by the Assistant Director of Nursing, Assistant Director of AHPs, Head of Clinical Governance or Quality Leads; the outcome from this reporting period is shown below.



These are reviewed in line with the incident and serious incident management process and are also being aligned to the Patient Safety Strategy. The themes and learning from the concluded reviews are shared, these have included:

4.3.2 **Highlights**

Key learning from recurring themes and the actions taken or underway are detailed below:

- Learning shared that the Tier 1 falls risk screening questions should be completed on the initial assessment,
- The existing Tier 2 falls risk assessment template in SystmOne has been reviewed to ensure the most appropriate review is completed when a patient falls on caseload. The new template is currently being trialled by the Community Falls Service for completion by a registered clinician.
- Learning from incidents memo (Appendix 1) disseminated to the Neighbourhood Teams in January 2021 to reiterate correct procedure for measuring lying and standing BP as part of a falls risk assessment. An action to ensure Neuro and Stroke Teams have the equipment needed for lying and standing measurements is underway.

- The SystmOne observations template and blood pressure recording section is being updated to incorporate lying, sitting, and standing after 3 mins, to encourage clinical staff to complete full readings,
- Neighbourhood Team Clinical Quality Leads are encouraged reiterate the risk factors for osteoporosis detailed on Tier 2 falls risk assessment to Neighbourhood Team clinical staff.
- Plan to review the therapy triage criteria as part of general Neighbourhood Team therapy review, additional plan to review the Neighbourhood Team therapy model as part of the Neighbourhood Team Model Transformation,
- The Community Falls Service has completed falls and physio specific training sessions to existing and new registered Neighbourhood Team physiotherapy staff from September 2020 through to April 2021.

8.0 Central Alerting System (CAS) Safety Alerts

There were seven alerts issued that required a response from the organisation during the reporting period.

Of these, two were medicines supply disruption alerts cascaded to the Medicines Management Team and no action was required.

Three were National Patient Safety Alerts (NPSA) from the Medicines Regulation Health Authority of which two required no actions to be taken. The third related to the recall of Phillips ventilators, on review the issuing organisations (LTHT) were responsible for the alert. LCH have supported LTHT in the recall of two identified devices, no further action is required by LCH.

The remaining two are National Patient Safety Alert Improvement alerts. One regarding the incorrect connection of flowmeters to medical air supplies that has been assessed not relevant to LCH. The second relates to the ingestion of super strong magnets and is due for completion by the deadline of 19 August 2021, a pathway for treatment is currently being reviewed by internal stakeholders.

A detailed overview of the CAS Alerts received and managed will be contained in the bi monthly Performance Brief in future.

Learning from Incidents

Leeds Community Healthcare NHS Trust

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(BF as part of Tier 2 falls ris assessmer

What happened

There have been a number of patient safety incidents relating to patient falls where, as part of the Tier 2 falls risk assessment, a lying and standing BP has either not been measured at all or not been taken in line with the LCH Standard Operating Procedure (SOP). Postural hypotension is a risk factor for falls and in these cases an inappropriate / incomplete clinical assessment has resulted in lack of identification of a modifiable risk factor and subsequent harm to patients

Correct procedure for measuring lying and standing BP

The following is based on the Royal College of Physician's guidance on how to measure a lying and standing BP as part of a falls assessment:

- Ask the patient to lie down for at least five minutes
- Measure the BP
- Ask the patient to stand up (assist if needed)
- Measure BP after standing in the first minute
- Measure BP again after the patient has been standing for three minutes
- Notice and document symptoms of dizziness, light headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations
- If the result is positive* or any concerns highlighted, liaise with the patient's GP (for Neighbourhood Teams liaise with the patient's Community Matron/Associate Matron), and take immediate actions to prevent falls and/or unsteadiness

***A positive result is:**

- A drop in systolic BP of 20 mmHg or more (with or without symptoms)
- A drop to below 90mmHg on standing even if the drop is less than 20 mmHg (with or without symptoms)
- A drop in diastolic BP of 10 mmHg with symptoms (although clinically less significant than a drop in systolic BP)

(Royal College of Physicians)

Lessor learr

- As part of a Tier 2 falls risk assessment, a **lying and standing** BP should be taken as per Trust SOP. Postural hypotension is commonly associated with Parkinson's Disease and such patients may present with unsteadiness on standing but not necessarily report dizziness symptoms, therefore this is a particularly important clinical assessment
- If it is not possible to complete a lying and standing BP, (e.g. if the individual is unable to stand safely even with assistance or unable to stand for long enough), this should be completed once the patient is able to safely do so. It should be recorded in the patient's notes why a lying and standing BP was unable to be measured at the time of the assessment
- If it is not possible to complete a lying and standing BP, as the individual patient is unable to lie flat or for long enough, a sitting and standing BP could be justified as long as it is recorded why a lying BP was unable to be measured

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

Appendix 2 – Pressure Ulcer Matrix - LCH guidance for reporting and investigation of Category 3,4 and Unstageable Pressure Ulcers

Extent of damage	Assessments	Re-assessments	Concordance	Level of investigation
Superficial pressure ulcer <1cm No changes to surrounding skin (such as redness, swelling hardness, or 'boggy' tissue) Expected to heal No additional nursing input required	Appropriate clinical risk assessments completed, in line with aSSKINg	Evidence of re-assessments of clinical risk assessments as dictated by clinical need / policy Evidence of skin checks and wound assessments	Documentation or memory recall of advice being provided to patient / family / carers Appropriate assessment of mental capacity with regards to pressure prevention care	• 72hr rapid review **not** required • Update level of harm in Datix to "low" • Update Datix "investigation" tab with details of finding of review (clinical record & staff conversation) and learning identified • Add 'actions' to Datix for improvement activity to address the learning identified and ensure learning appropriately shared
Pressure ulcer >1cm or pressure ulcer < 1cm with changes to surrounding skin (such as redness, swelling hardness, or 'boggy' tissue) Expected to heal without complications No / minimal additional nursing input required	Minimal gaps in clinical risk assessments completed, in line with aSSKINg	Evidence of re-assessments of clinical risk as expected in individuals situation Evidence of skin checks and wound assessments	Some evidence of advice being provided to patient / family / carers Appropriate assessment of mental capacity with regards to pressure prevention care	• 72hr rapid review completed to identify learning , reviewed at 72hr review meeting • Add 'actions' to Datix for improvement activity to address the learning identified and ensure learning appropriately shared
Pressure Ulcer >2cm but potential for delayed healing	Inconsistent documentation of clinical risk assessments in line with	Limited evidence of re-assessments and care being evaluated in	Limited evidence of offloading advice, equipment, advice provided to patient / family /	• 72hr rapid review completed to identify learning, including memory recall of staff involved. Reviewed at

Additional nursing input required	aSSKINg	response to changing patient need +/- policy standard	carers Lack of assessment of mental capacity	72hr review meeting • If consensus that further learning could be obtained, proceed to internal review (concise template) • Add 'actions' to Datix for improvement activity to address the initial learning identified
Pressure Ulcer >3cm Increase in nursing / specialist input required for pressure ulcer management Significant safety concerns	Poor documentation of completion of clinical risk assessments, in line with aSSKINg	Minimal evidence of re-assessments and care being evaluated in response to changing patient need +/- policy standard	Limited evidence of offloading advice, equipment, advice provided to patient / family / carers	• Full review (RCA & StEIS reportable) +/- 72 review to confirm if required • Add 'actions' to Datix for improvement activity to address the initial learning identified • Ensure final learning themes included within LCH Pressure Ulcer Improvement plan

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (56)

Title: Serious Incident Summary Report

Category of paper: For assurance

History: Quality Committee 26 July 2021

Responsible director: Executive Director of Nursing and Allied Health Professionals

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Report author: Incident and Assurance Manager

Executive summary

A report on Serious Incidents (SI) is produced bi-annually to provide the Board with the assurance that they are being managed, investigated and that learning is acted upon appropriately to improve patient care and experience.

All Serious Incident investigations are subject to a Root Cause Analysis (RCA) investigation. The investigation seeks to understand the chronology of events and where care has not been delivered in line with the expected standard why this is the case. The investigation process explores LCH systems and processes and contributory factors to pateitn safety incidents, in order to identify learning for improvements.

The learning identified, and reflected within this report, has been shared with individuals, services and Business Units as apparopriate to facilitate reflection, discussion and improvement.

Recommendations

The Board is recommended to:

- Receive and note the contents of this paper

1 Introduction

This paper looks specifically at LCH patient safety incidents which have been reviewed and reported as Serious Incidents (SIs) following the guidance from the NHS England's Serious Incident Framework published in March 2015.

On completion, SI reports are reviewed in a Serious Incident Review Meeting chaired by the Executive Director of Nursing and Allied Health Professionals or Executive Medical Director.

2 Background

A report on Serious Incidents (SI) is produced quarterly to provide the Board of Directors with the assurance that they are being managed, investigated, and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations to ensure improvements in patient care and experience.

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

The individual learning from these incidents about specific staff, services and Business Units have been shared for reflection, discussion and improvement. A selection of SIs is also identified every Quarter to be shared at the LCH Safety Summit. Over this time period 2 Safety Summits have taken place, 1 in March and 1 in June 2021.

3 Current Position - StEIS reportable Serious Incidents in Q4 2020-21 & Q1 2021-22

Over the period Jan 2021 – June 2021, the Trust reported 33 serious incidents on the StEIS system. Following further review tow of these were de-logged from StEIS as they did not meet the SI criteria, therefore 31 were progressed to a full RCA investigation.

LCH SI's by category and Quarter reported

Incident category	Jan - Mar	Apr - Jun	Total
Pressure sore	9	2	11
Slips, trips, falls and collisions	4	3	7
Other Skin Damage	5	0	5
Other (Death caused by Incident)	1	2	3
Moisture Associated Skin Damage	1	0	1
Self-harm in primary care	1	0	1
Self-harm during 24-hour care	1	0	1
Transfer	1	0	1
Traumatic Skin Damage (tear)	1	0	1

The standard 60 day timeframe for completing SI investigations has been relaxed during the Covid-19 pandemic. However, as a Trust we continue to strive to achieve this wherever possible.

The Trust had no never events in this reporting period.

As of 8 July 2021, eleven of the above remain under investigation and twenty have been completed and had Executve Director sign off. Action plans generated from SI investigations are agreed at the final review meeting and added to Datix® for monitoring purposes.

4.0 StEIS Reporting Timeframe in Q4 & Q1 2021

All SI's are identified at the Rapid Review Meeting (RRM) and reported on the StEiS database within 48 hours of the decision being made.

During this reporting period 100% were reported on STEIS within 48 hours of the decision being made of laspes in care identified.

4.1 Serious Incident Outcomes

Of the 20 completed SI investigations, 18 concluded that there were lapses in care. The remaining 2 were confirmed to have no causative / contributory lapses in care; however, significant learning was identified for the teams involved and therefore they remained logged on StEIS.

4.2 Serious Incident Root Causes and Contributory Factors

During this reporting period, the SI templates were reviewed to improve the identification of contributory factors, care and delivery problems and root causes to ensure relevant, propoertionate and meaningful action plans were developed. In addition, improvement work in Datix® has taken place to improve the recording of learning to enhance the quality of reporting and monitoring.

The tables below depict the root causes and contributory factors identified during this reporting period.

Root Causes	Number
Lack of effective case management / senior review	3
Patient concordance	2
Lack of effective pressure ulcer or falls management	2
Communication breakdown with external services	1
Inappropriate clinical judgement / reasoning (triage or at visits)	1
Risk Assessment not completed / patient risks not identified	1
Communication breakdown within LCH services	1
Total	**14**

Contributory Factors	Number
Inappropriate clinical judgement / reasoning (triage or at visits)	5
Patient concordance	4
Staff capacity issues	4
Failure to follow pressure ulcer prevention and management policy or agreed procedure (e.g. infection framework)	4
Lack of / inadequate staff training	1
Total	**21**

4.3 Recurring Themes and Learning from SIs in Q4 & Q1 2020-21

The top learning identified from Investigations includes but not limited to:

Learning from closed SIs
Importance of thorough triage of clinical information
Missed opportunities for reporting pressure ulcer development
Lying to standing B/P to be recorded after 1 and 3 minutes to identify any postural drop
Valid consent for care to be completed for all elements of care delivery and updated when there are any changes to capacity/care delivered in best interests.
Staff to seek advice from Wound Management regarding review of current care, wound management and ongoing pressure ulcer prevention
Following up on equipment requests
Ensure conversations with the Specialist Tissue Viability Nurse if any deterioration or no improvement is noted.
Ensure evidence of re-positioning is documented
Improve Communication with care homes.

There is noted recurrence themes from learning identified from SIs meetings. There is an organisational Pressure Ulcer and Falls Improvement Plan via the respective steering groups. Themes are shared from the SI review into those groups. This process will be strengthened to ensure all themes are considered for the formalised improvement plans required in the future as Patient Safety Strategy and Quality Strategy requirements.

An NCT role has been introduced to order and follow up equipment in Neighbourhood Teams to release clinical capacity and ensure timely pressure relieving equipment. The process is currently being worked through to measure the impact.

5 Assurance

Alongside learning via the leaflet for learning, themes are identified and triangulated against sources such as feedback and staff involvement via safety huddles, the quality leads reports to the business units, monthly thematic reviews and deep dives and feedback from learning identified at the RRM to the respective services.

To enhance wider learning across the Trust, we have held 2 patient safety summits in this reporting period. Both have taken place via MS Teams with good attendance and additional learning identified from cross Business Unit conversations. A *safety summit snapshot* newsletter is circulated with key learning messages after each summit to support a further spread of learning (Appendix 1 & 2).

In line with the expected changes associated with the national patient safety strategy changes, the Clinical Governance Team provides a quarterly report to both the LCH Pressure Ulcer and Falls Improvement groups. This quarterly analysis allows the respective steering groups to consider themes and trends of learning incorporated into the Trust improvement plans. This process is expected to be further formalised and strengthened by introducing the Patient Safety Incident Response Framework (PSIRF), Patient Safety Strategy and Quality Strategy requirements.

A recurrent theme from both rapid reviews and SIs related to falls with harm was the absence of a lying and standing blood pressure, which is best practice for the identification of a postural drop (blood pressure drop when standing that can cause dizziness). As a result, the Trust has taken the following actions:

- The Falls Team lead is working with the SystmOne team to improve the recording template for lying and standing blood pressure
- A learning memo has been developed and circulated, providing the evidence base and procedure for performing a lying and standing blood pressure
- The SystmOne template has been updated to ensure the required review of falls risk assessments is more precise for clinicians

During this reporting period, the falls rapid respond template was reviewed to improve on identifying contributory factors, early learning and to inform action plans and improvement

After the restructure of the LCH SI training, we have trained a further 86 members of staff during this reporting period; feedback received has remained positive.

The patient safety strategy will drive more meaningful involvement of patients, families, and staff in investigations embedded across LCH.

6 Duty of Candour

All incidents in this report are subject to the statutory Duty of Candour process as notifiable safety incidents. Once considered at a rapid review meeting to meet the SI criteria, the team providing care informs the person/people affected, provides an apology, explores any requirements for the investigation from the patient or family perspective and explains the LCH investigation process.

A letter confirming this initial discussion is then sent. The CQC Regulation 20 states this should take place as soon as practicably possible. Within LCH, we have continued to monitor our performance against a 10 day timeframe.

30 of the 31 SI's this period have achieved this standard with either a letter being sent within the 10 days or clear documentation that the patient/family have stated they do not wish to have any communications sent to them. the final one within 11 days.

The letter sent at 11 days was due to the patient being in the hospital, with no next of kin contact was available.

7 Recommendations

The Board is recommended to:

- Receive and note the contents of this paper

Appendix 1

Safety Snapshots newsletter

Leeds Community Healthcare NHS Trust

Our 3rd Patient Safety Summit took place on Thursday 24 June 2021. Two scenarios were shared, one from Children's Business Unit and one shared jointly from Specialist and Adult Business Units followed by great learning conversations #wearecontinuously listening,learningandimproving

We want to ensure the highlights of those conversations are shared with those of you unable to attend, so please find our 3rd Safety Snapshots Newsletter.

Scenario 1: Blood sampling incidents in ICAN

This scenario focuses on incident trends analyses which identified three incidents relating to processing of blood samples sent from ICAN to LTHT.

Learning	Action
In all 3 cases, the children had to have a further blood test taken putting them through unnecessary distress.	• This shows the importance of identifying and acting where you see a recurring trend of the same / similar incidents, to prevent unnecessary distress or harm to our patients. • Conversations with the right people, both within LCH and with our partner organisations is critical to ensure learning and best practice is embedded.
The service labelled their samples with red **URGENT** stickers expecting this to ensure they were prioritised for processing.	• Conversations with the right people in partner organisations identified that over 60% of samples received daily were highlighted as 'Urgent' and therefore this internal process was not achieving the desired result. This allowed the team to review their process, in agreement with partners, to ensure samples received were processed as a priority.
The incident identified that blood samples didn't go directly to the specialist laboratory at SJUH and went via LGI instead.	• Professional curiosity ensured historical practice was challenged. As a result of asking 'why?' a review of the transportation of blood samples has taken place so samples now go directly to the correct laboratory for processing. • Do you have illogical processes to follow in your services that have a negative impact on staff / patients? Have you explored why and if that could be undertaken differently?

Scenario 2: Fall resulting in subdural haematomas (serious condition where blood collects between the skull and the surface of the brain)

This lady was under the care of both an LCH Neighbourhood Team and the LCH Stroke Service. Whilst receiving care from both services, she suffered a fall resulting in the above head injury and subsequent hospital admission.

Learning	Action
The teams were not clear on when a lying and standing Blood Pressure should be completed.	• A previously circulated 'Learning from incidents' memo, was re-circulated (see attached). • A Standard Operating Procedure (SOP) was developed to give clear direction within the team of when to perform lying and standing BPs and expected actions if this has been unable to be taken on a 1st assessment. • The service are checking that quality improvements have been embedded in practice by undertaking an audit. Being able to evidence improvements are in place, and have been sustained, are a fundamental part of patient safety and high quality care.
There were occasions where both teams visited the same patient on the same day, and undertook the same clinical assessment.	• Do you provide shared care for any of your patients with other LCH services? Do you speak to each other to ensure care is streamlined for the patient and to ensure no duplication across services? • Following the summit we are developing a list of useful contacts for Adult / Specialist services to facilitate easier communication.
Documentation in the patient record did not always clearly articulate the clinical decision making.	• Clinical record keeping is a professional responsibility and a measure of high quality and safe patient care. • At your next visit, reflect… Does your documentation enable the colleague who next visits your patient to understand your clinical decision making, what care you provided / omitted and why and therefore what care is needed at their visit?

Appendix 2

Safety Snapshots newsletter

Leeds Community Healthcare NHS Trust

Our 2nd Patient Safety Summit took place on Thursday 25 March. Two scenarios were shared, one from Adults Business Unit and one from Specialist Business Unit followed by great learning conversations #wearecontinuouslylistening,learningandimproving

We want to ensure the highlights of those conversations are shared with those of you unable to attend, so please find our 2nd Safety Snapshots Newsletter.

Scenario 1: Community follow up after poor hospital discharge

This young gentleman was discharged home with complex needs and an unsafe environment in which to meet his ongoing needs.

Learning	Action
Patients will sometimes return to community with less than adequate discharge planning	• It is critical to continue to Datix ® report such incidents as this data feeds in to quarterly conversations with partner organisations to identify themes and trends requiring improvements. #workingtogether #caringforourpatients • Incidents of a more significant nature involving partner organisations will be raised immediately through the LCH patient safety team, so please continue to escalate these. #caringforourpatients • LCH services then need to consider the clinical risk and how together, we can mitigate that risk for patients #workingtogether #findingsolutions #leadingbyexample
How can we best support our patients with known dependencies e.g drugs/ alcohol?	• The LCH Homeless and Health Inclusion Team (HHIT) will develop some 'top tips' for other LCH services inclusive of partner agencies to contact for support / guidance. #workingtogether #findingsolutions
We continue to see people with complex health and social care needs in our communities and need to be able to work together to meet those needs	• When considering mental capacity, ensure people are informed of the advice and also the implications of not following advice so they can make informed choices. #caringforourpatients #makingthebestdecisions • The LCH Homeless and Health Inclusion Team (HHIT) and Adult Business Unit (ABU) to review triage questions to ensure early consideration of complex needs. #caringforourpatients #findingsolutions • Collaborative working across teams, services, business units and organisations is critical. How do you 'huddle' as a team, share issues and generate solutions together? If you think this could be better or you do this great please share this with your Quality Lead so we can share success and support improvements. #workingtogether #findingsolutions #caringforoneanother #makingthebestdecisions

Scenario 2: Wrong site spinal nerve block injection (Never Event)

A Never Event is defined as a serious incident that is wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

This scenario related to a lady receiving a spinal injection to the wrong side of her spine. The lady received a second injection to the correct side and came to no harm.

Learning	Action
How do we effectively learn when things have gone wrong?	• The service completed a 'walk-through' of this procedure following the incident. This involved all the staff involved at the time, alongside service managers, quality lead and patient safety representatives. The aim of the walk-through was to clearly understand what went wrong and why and also enabled the service to trial how things could improve. #leadingbyexample #workingtogether #findingsolutions • The focus on learning facilitated openness, honesty and inclusion of everyone involved and enabled practical processes requiring improvement to be identified, which would not have been identified without this physical walk through. #leadingbyexample #adaptingtochangeanddeliveringimprovements • Improvements were implemented the day after the walk through so there was immediate benefits to patient safety. #adaptingtochangeanddeliveringimprovements • Do you have recurring incidents, or incidents around procedures which may benefit from this approach? If so speak to your Quality Lead for support.
What steps do you take before administering treatment / carrying out a procedure to ensure patient and staff safety? And what if you are distracted?	• The team introduced a **"Stop before you block"** process, an opportunity to take time out to make a final check (or re-check) of safety before undertaking the procedure. This can be undertaken as a team to ensure everyone is happy to proceed for procedures such as this, but can equally be undertaken as an individual before administering an intervention. #adaptingtochangeanddeliveringimprovements #caringforourpatients • This is particularly important when you have been distracted following initial checks. So think, "Stop before you..." #caringforourpatients • This concept is being rolled out across SBU in relation to other invasive procedures e.g tooth extractions. If you undertake invasive procedures speak to your Quality Lead to explore how you can introduce "Stop before you..."
The impact of incidents of this nature on our staff	• Patient safety incidents always have an impact on the staff involved, even though these are unintended incidents and as a result of trying to do the right thing • Involving staff in investigations and learning is critical to our learning / patient safety culture. How do you involve staff in investigations? #caringforoneanother • As an organisation we want to investigate less and learn more. We want all staff to feel engaged with learning from events, whether incidents, complaints, compliments, and to be supported in a consistent, open and fair way. This approach is supported by the national Just Culture. If you want more information or support in how to use this in your role please speak to your Quality Lead. #caringforoneanother https://improvement.nhs.uk/documents/2490/NHS_0932_JC_Poster_A3.pdf

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (57i)

Title: Mortality Report Quarter 1 2021/22

Category of paper: For assurance
History: Quality Committee 26 July 2021

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

Executive summary

Purpose of this report:

To provide the Board with assurance regarding the Mortality figures and processes within LCH NHS Trust in Quarter 1 2021/22.

Main points to note:

- Quality Assurance & Improvement (QAIG) Group has met regularly and is quorate. The latest meeting was on the 22nd July 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.
- Addendum is included to the Annual Mortality Report 2020/21 reflecting the verbal narrative submitted to the Quality Committee in May 2021.

Adults

- Mortality levels during Q1 have been maintained below the prior peaks of the pandemic, and consistent with those seen during Q4 of 19/20.
- Wetherby neighbourhood team has breached their upper control total limit during Q1 (June only) with no similar patterns noted in other neighbourhood teams. This will be monitored closely.
- Work continues to improve Primary Care input into Mortality Review meetings
- Improvement is noted in identifying Learning Disability deaths and representing them in the data
- The higher percentage of people wishing to die at home as their preferred place of death has being maintained

Children

- Mortality in children has not shown any significant deviation from numbers expected over the course of Q1
- LCH NHS Trust remains actively involved in the Child Death Overview Panel (CDOP) and Sudden Unexpected Death in Children (SUDIC) process

Addendum to Annual Mortality Report 2020/21

- Deprivation data shows nearly a quarter of all deaths occur in the most deprived areas
- The appears to be underrepresentation in LCH mortality figures of all ethnic groups apart from White British (who are overrepresented) compared to the Leeds population
- Additional work is proposed to include access, experience, and outcome markers to LCHs end of life offer

Recommendations:

- The Trust Board is recommended to receive this assurance regarding Trust mortality processes during Q1 2021/22
- Note the addendum to the Annual Mortality Report 2020/21 containing additional detail including ethnicity and deprivation data

RAG rating

Q1 Adult Mortality and LeDeR Review April to June 2021

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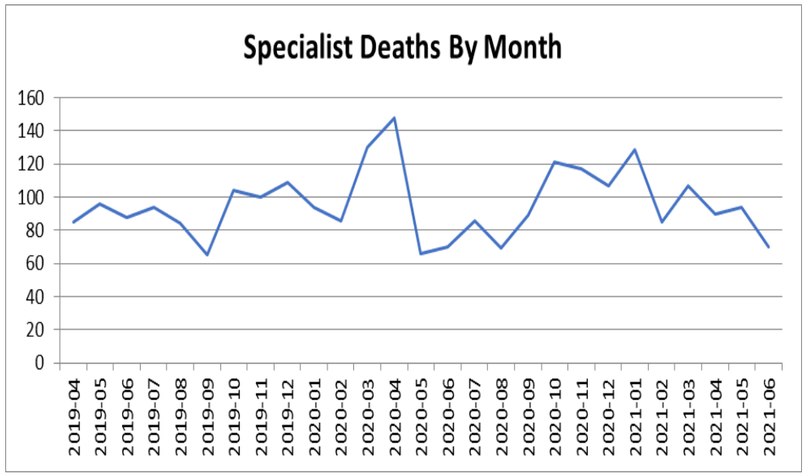
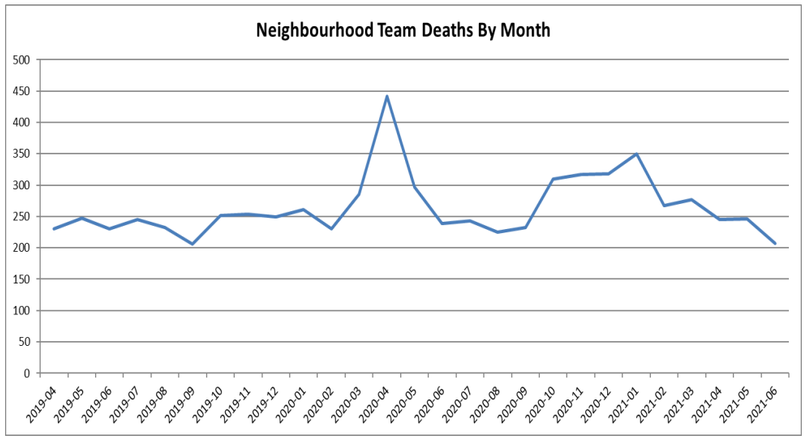
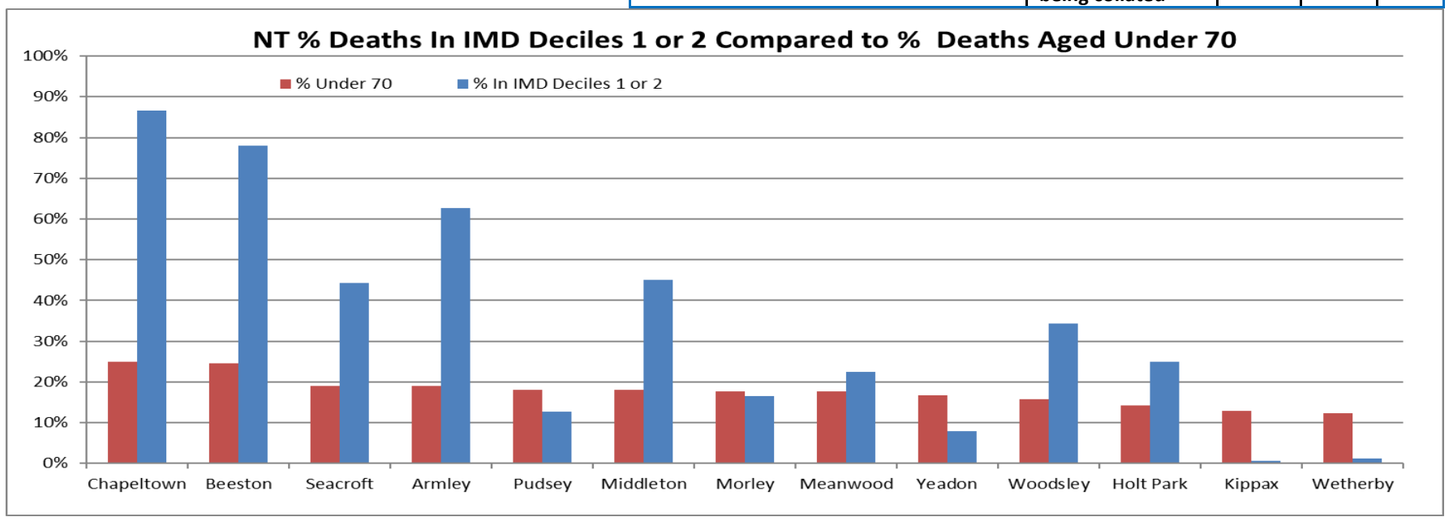
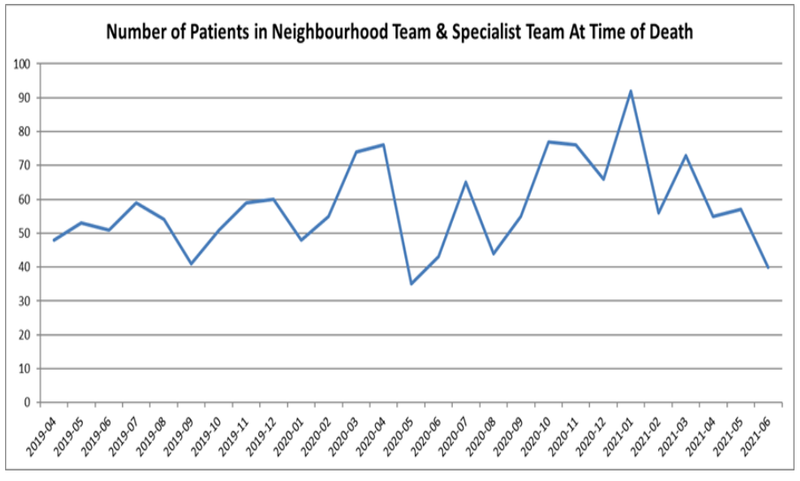


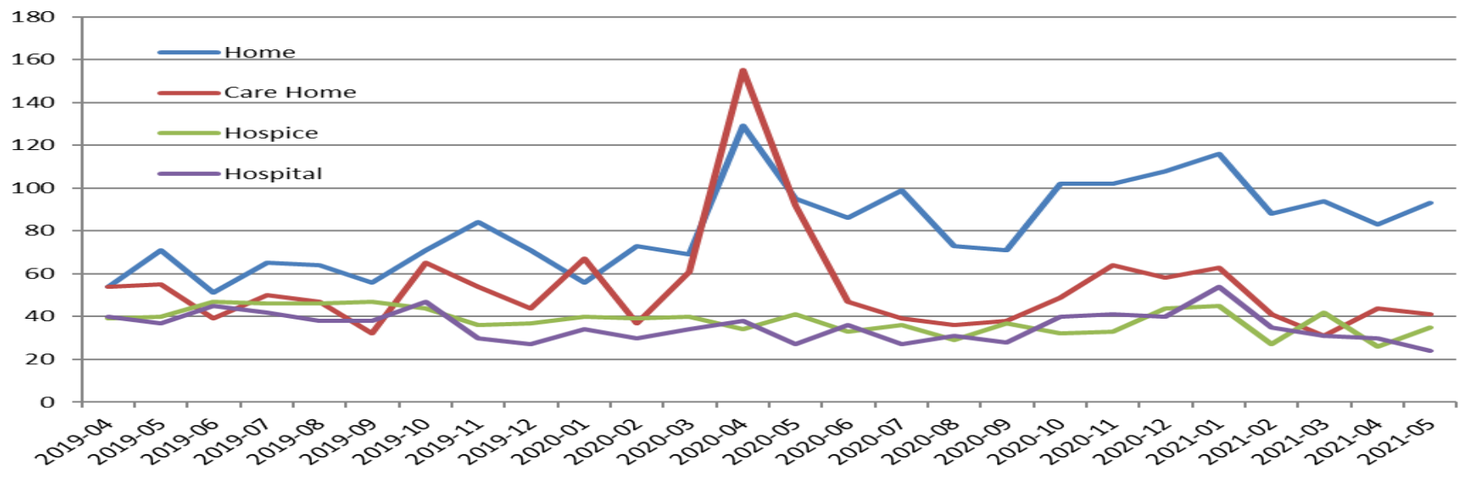
Apr -Jun 21 Mortality Figures for NTs & Selected Specialist Services				
Deaths	Apr-21	May-21	Jun-21	Q1
Total	280	283	237	**800**
NT	245	246	207	**698**
Specialist	90	94	70	**254**
Specialist not in NT	35	37	30	**102**
In NT & Specialist	55	57	40	**152**
Specialist Deaths in Multiple Units	14	10	6	**30**

Adult Data	Q1	Q2	Q3	Q4
Level 1	**987**			
Level 2	**290**			
Unexpected deaths	**78**			
Expected deaths	**352**			
Alliance CCB deaths	**4**			
Non-Alliance CCB Deaths (a/a)	**None notified by CCG or CCB**			
Virtual Ward deaths	**8**			
LeDeR	**8**			
Serious Mental Health	**0**			
Death within 30 days of Hospital discharge	**TBC June data still being collated**			









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

Q1 Adult Mortality and LeDeR Review April to June 2021

Leeds Community Healthcare NHS Trust

Analysis

- Adult deaths are now on a reducing trajectory.
- Total Adult deaths in Q1 = 800.
- Adult business unit = 698 Specialist Business unit=102. 102 deaths were in Specialist services only and 152 occurred whilst on both Neighbourhood and Specialist team caseloads
- 78 deaths in Q1 were reported as unexpected with two cases being subject to serious investigation. An internal concise review was completed for a case in SBU where safeguarding concerns where identified with no learning as an outcome. An SI is ongoing within ABU for a patient who potentially died unexpectedly from Sepsis from leg ulcers whilst under Neighbourhood Team care.
- 8 patients died whilst on an active caseload who had a learning disability
- 8 patients died whilst receiving care on the Virtual Ward for frailty. No concerns related to the quality of care provided were noted.
- 46% increase in patients dying in their own homes and a 23% increase in Fast Track referrals
- 83% of patients achieved their preferred place of death
- 79% patients had a verification of expected death completed in their own home and 60% were completed in a care home.

Themes

- Diabetes Training is required for all Adult services to raise awareness of the difference between insulin dependent and Insulin treated patients— LTHT/ clinical education team/Community Diabetes teams will update training material. There is both benefit and positive impact for patients when cared for by both Neighbourhood and Specialist Teams (where appropriate) in terms of improved quality of care.
- Identified need for chaplaincy in CCB's—Action for commissioning team.
- Three deaths have been jointly reviewed with LTHT to ensure wider learning is identified and embedded across the system.
- Two cases discussed at the Adult Mortality Review Meeting identified learning that would benefit further discussion at the next LCH patient safety summit.
- In Q4 2021 we were still experiencing covid 19 deaths. In Q1 21/22 this reduced to 7 C-19 deaths compared to 38 in Q4. We are now seeing more non Covid 19 deaths from cancer/ other respiratory disease and also greater numbers within the under 60yrs population.

Contribution to Making Stuff Better

- Learning Identified at mortality review meetings relevant for acute hospitals trust is being fed back directly to LTHT via Quality Lead LCH and Exec Director of Nursing and AHPs meeting with LTHT on a monthly basis.
- Working with Senior Ops Admin team to create a digital solution to manage and streamline the mortality process.
- Working with business intelligence team to improve data accuracy and analysis.
- Add respiratory/virtual ward for frailty to Datix to track mortality data. SBU QL to work with Respiratory service to progress.
- Explore ways to fully engage primary care colleagues in the mortality review process.
- Conversations are progressing with CCG with the objective that CCG adopt the current LCH CCB mortality process.
- Exploring workforce requirements and models of support for staff and teams across the city to better reflect Neighbourhood team mortality activity and to provide addition supervision and psychological support.

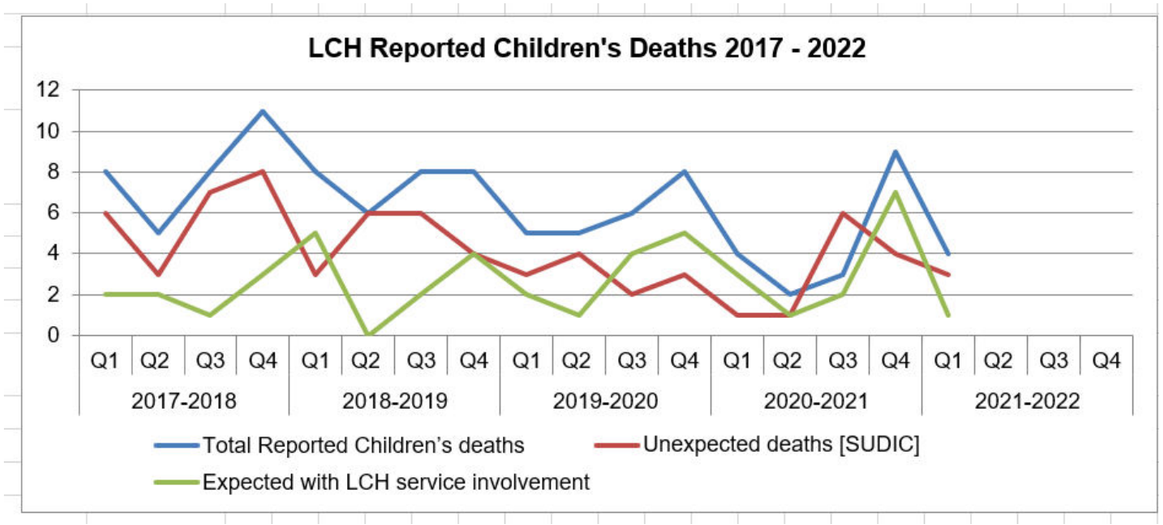
Risks

- Continued limited capacity to facilitate current level of reporting required
- Capacity within the leadership team to undertake the timely review of level 2 investigations to ensure appropriate cases are brought to the Adult Mortality Review Meeting
- Slow progress to increase Primary Care engagement in Adult Mortality Reviews.

Children's Mortality Group Q1 2021/22

Leeds Community Healthcare NHS Trust

Quantitative data



2021-2022	Total number of mortality reported incidents				Total
Total Reported Children's deaths	Q1	Q2	Q3	Q4	
	4				
Unexpected deaths [SUDIC]	3				
Expected with LCH service involvement	1				

Narrative

- Sudden and Unexpected Death in Infancy and Childhood— Activity and Governance Report 2020-21.

  During the period April 2020 to April 2021 there were 12 deaths of children, resident in Leeds, which met the SUDIC criteria. This is the same number of SUDIC deaths as occurred in the year 2019-2020.

- One shared LCH record of child deaths established.

Making Stuff Better

Bath Time Duck was developed in 2020. Due to further death involving drowning this has been re-shared during Q1 2021/2022 to PHINS and wider CBU.

Risks /Issues

Chair of LCH Child Death Review Group is standing down and new chair has not yet been identified.

Further work to do on death notifications across the system and to LCH practitioners.

Contribution to Reset & Recovery Programme

As above

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

Children's Mortality Group Q1 2021/22

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Month/ref	Issue	Actions taken
May 2021	• 16 year old young person involved in a road traffic accident as a rear seat passenger • Police investigation ongoing	
May 2021	• 17 month old child drowned in bath at home • Police investigation ongoing. • 0-19 PHINS Home Safety Advice given	• Identified as case for Children Safeguarding Review– Wendy Brown will be LCH lead in the process
May 2021	• 13 year old young person • Haemophagocytic lymphohistiocytosis (HLH) diagnosis • Admitted to LTHT 10 days prior to death	• LTHT Child Death Meeting to review prior to Child Death Overview Panel
June 2021	• 8 week old male twin • Low birth weight, admitted to neonatal care initially • Cardiac arrest • 0-19 PHINS Home Safety Advice given including safe sleeping	• Ongoing family support from 0-19 PHINS team (Care Of the Next Infant) • 0-19 PHINS looking at pathway of Emergency Department automatically generating a task on SystmOne. • To be discussed at next LCH Child Death Review Group
Aug 2020	• 11 month old died in road traffic collision in Kenya with mother who also died	• Child Death Review Panel discussed— to flag re child deaths in other countries.

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

Addendum to Annual Mortality Report 2020-21

1.1 The data presented here supplements the annual mortality report previously submitted to the committee and follows on from the verbal presentation of these findings delivered at the last meeting.

1.2 Patient level data was provided by business intelligence to enable a more in-depth analysis of equity in mortality for the years 2018/19, 2019/20 and 2020/21. In line with the health equity strategy data were analysed by deprivation and ethnicity. Deprivation was calculated by converting postcode into IMD (Index of Multiple Deprivation) deciles whilst census ethnicity categories were used to analyse ethnicity.

1.3 For comparison, IMD and ethnicity breakdowns for the Leeds population are shown. When considering equity, it is vital to take underlying need into account. Whilst the IMD and ethnicity breakdowns provide a useful comparator they do not necessarily reflect underlying need. Mortality throughout the COVID-19 pandemic has not been equally distributed across communities. People from more deprived areas and ethnic minority groups have been shown to have a higher chance of dying from COVID-19. To meet the needs of our communities we may expect these communities to be over-represented in LCH data. This has been discussed below where relevant but more complete data on overall mortality rates would help interpret LCH data.

2.0 Deprivation

2.1 Overall mortality

IMD Decile	2018/19 deaths		2019/20 deaths		2020/21 deaths		Leeds population
	Count	Proportion	Count	Proportion	Count	Proportion	
1	700	24%	737	25%	865	24%	24%
2	271	9%	286	10%	316	9%	10%
3	255	9%	288	10%	321	9%	9%
4	103	3%	102	3%	111	3%	4%
5	254	9%	233	8%	317	9%	11%
6	276	9%	278	9%	382	11%	9%
7	443	15%	405	14%	469	13%	11%
8	244	8%	216	7%	294	8%	8%
9	234	8%	220	7%	247	7%	8%
10	169	6%	194	7%	217	6%	6%
Totals	**2949**	**100%**	**2959**	**100%**	**3539**	**100%**	**100%**

Whilst the number of deaths rose in 2020/21 compared to previous years, the proportion of deaths in each IMD decile remained broadly similar. Comparing the IMD breakdown of LCH deaths to the Leeds population shows that LCH deaths were largely in line with what we might expect. As discussed in the introduction, for the year 2020/21 we should question whether the patterns shown above accurately reflect the underlying need in our communities. As further analysis of COVID-19 mortality is carried out across the city we should review our data again to see whether the 2020/21 patterns in LCH mortality reflect wider patterns.

2.2 Mortality in over 70s

IMD Decile	2018/19		2019/20		2020/21		Leeds 70+ population
	Count	Proportion	Count	Proportion	Count	Proportion	
1	515	22%	573	24%	654	22%	16%
2	214	9%	221	9%	262	9%	8%
3	211	9%	231	10%	264	9%	8%
4	74	3%	72	3%	84	3%	4%
5	208	9%	185	8%	278	9%	10%
6	229	10%	247	10%	325	11%	9%
7	398	17%	357	15%	411	14%	14%
8	202	8%	189	8%	259	9%	11%
9	191	8%	180	7%	213	7%	11%
10	135	6%	163	7%	182	6%	9%
Totals	**2377**	**100%**	**2418**	**100%**	**2932**	**100%**	**100%**

2.3 The Leeds population down by age in addition to IMD decile is shown here. If we consider only those aged 70 and over (82% of the deaths within LCH) then we see a slightly different pattern in the deprivation breakdown. Whilst only 16% of those over 70 live in IMD 1 areas, over 20% of LCH mortality

occurs in these areas. Whilst this is an interesting pattern the reason for it is unclear. Interpretation may be aided by using other data sets to build up a more comprehensive picture of mortality within each decile (i.e. to see the IMD breakdown of overall caseloads and risk of mortality in each IMD decile).

2.4 Age at time of death

IMD Decile	2018/19	2019/20	2020/21
1	79	82	81
2	81	81	81
3	82	81	83
4	78	80	83
5	83	81	83
6	83	85	83
7	86	85	85
8	82.5	83	82
9	81	80	83
10	82	81	82

2.5 Median age at time of death by IMD decile is shown in the table above. Slight variation can be seen across the deciles but without further analysis it is not clear whether this variation is significant.

2.6 **Ethnicity**

2.7 Overall mortality

Ethnicity LCH	18/19		19/20		20/21		Leeds Population
	Count		Count		Count		
White British	2473	83.9%	2569	86.7%	3067	86.5%	81.1%
Pakistani	38	1.3%	33	1.1%	47	1.3%	3.0%
Any other White background	76	2.6%	65	2.2%	53	1.5%	2.9%
Indian	27	0.9%	29	1.0%	36	1.0%	2.1%
Black African	4	0.1%	8	0.3%	15	0.4%	2.0%
Any other Asian background	8	0.3%	3	0.1%	8	0.2%	1.2%
White and Black Caribbean	4	0.1%	7	0.2%	15	0.4%	1.2%
Black Caribbean	26	0.9%	31	1.0%	30	0.8%	0.9%
Irish	27	0.9%	33	1.1%	25	0.7%	0.9%
Chinese	3	0.1%	4	0.1%	5	0.1%	0.8%
White and Asian	2	0.1%	2	0.1%	2	0.1%	0.7%
Bangladeshi	4	0.1%	0	0.0%	2	0.1%	0.6%
Any other Black background	0	0.0%	3	0.1%	1	0.0%	0.6%
Any other ethnic group	11	0.4%	9	0.3%	12	0.3%	0.6%

Any other mixed background	1	0.0%	1	0.0%	1	0.0%	0.5%
White and Black African	2	0.1%	4	0.1%	6	0.2%	0.3%
Not known	154	5.2%	102	3.4%	127	3.6%	
Not stated	89	3.0%	59	2.0%	92	2.6%	
Grand Total	**2949**		**2962**		**3544**		

2.8 Analysis of ethnicity data highlights several interesting patterns. Whilst 81% of the Leeds population are White British, over 86% of those who died in 2020/21 were in this group. Ethnic minority groups were frequently under-represented in the LCH mortality data. Whilst 3% of the Leeds population are Pakistani, only 1.3% of those who died within LCH in 2020/21 were Pakistani. There is also a large disparity in those of Black African ethnicity who make up 2% of the Leeds population but only 0.4% of the LCH mortality sample. Similar patterns are seen across several other ethnic minority groups.

2.9 Interpretation of these findings is difficult as there may be several reasons why these groups are under-represented. One explanation is that the 'not known' and 'not stated' ethnic groups might contain a disproportion number of individuals from ethnic minority groups. There is some national evidence that this commonly the case[1]. In the current year there has been an effort to reduce the 'not knowns' although this reduction has not altered the under-representation of ethnic minorities. Another possible explanation is that certain groups within the Leeds population find it more difficult to access LCH services. A third possible explanation is that certain groups actively choose not to use the services of LCH for whatever reason. Cultural differences in expectations of health and care services may differ between patients of different ethnicities. Importantly, from the data presented here it cannot be ruled out that certain ethnic minority groups have worse access to services than those from a White British background or that LCH services are not as well suited to individuals from ethnic minority backgrounds. It may be that the offer is perceived differently in different communities. Further analysis of neighbourhood team caseload data alongside improvements in the capture of ethnicity data would enable a more thorough assessment of access and experience of the service by ethnic group.

2.10 <u>Age at time of death</u>

2.11 Small numbers of deaths in some ethnic groups mean it is difficult to get meaningful information from the analysis of age at death by ethnicity. For example, across the 3 years, there were only 6 deaths in those from the Bangladeshi ethnic group. This is far lower than the number of deaths we may have expected based on relative population sizes (0.6% of the population are Bangladeshi which would equate to an expected 57 deaths over the 3-year period reported above). It is unclear whether this under-representation is due to poor ethnicity recording, whether deaths are occurring in other settings such as hospitals, or whether there is another explanation.

3.0 Potential for further developments for mortality reporting

3.1 It is proposed that consideration is given to the potential for framing mortality in terms of access, experience and outcome

3.1.1 Access
Access within the LCH strategy is broadly defined as the ease with which patients or communities can use appropriate services. The analysis and narrative above focus largely on access to services (i.e., where do our patients that die in LCH services come from).

3.1.2 Experience
The inclusion of experience measures would be a useful addition to the mortality report. Experience is loosely defined as what the process of receiving care feels like for the patient, their family, and carers. Examples of experience measures include compliments, complaints, significant events, and patient reported experience measures. Identifying experience measures related to mortality may be challenging but measures related to the wider scope of NT functions may help identify inequalities in experiences of care in the lead up to death.

3.1.3 Outcomes
3.1.4 Similarly, it would add value to consider relevant outcomes related to mortality to identify inequalities. Whilst all patients in this analysis ultimately had the same outcome, other relevant outcomes related to mortality may be important. The NICE Quality Standard QS13 provides detail on a range of possible outcome markers for the end-of-life period. Preferred place of dying (PPOD) is an important outcome which could potentially be analysed to identify inequalities in care although it should be noted that PPOD is part of the EPaCCS data so doesn't include all deaths.

4.0 Reference

4.1 [1] Ethnicity coding in English health service datasets, Scobie et al, Nuffield Trust June 2021

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Title: Health and Safety Compliance Report

Category of paper: for assurance

History: Business Committee 28 July 2021

Responsible director: Executive Director of Finance and Resources

Report author: Risk and Safety Manager

Executive Summary

This report provides information on the current level of compliance with health and safety legislation and policies. It also provides an update on the developments and effectiveness of the Trust's health and safety management system. It informs the Board that developments are being made towards addressing the missing elements of the health and safety management system as identified by the Health and Safety Group and by the Health and Safety Executive's inspection in August 2019.

The Board is particularly asked to note:

- There have been four work-related injuries reported to the Health and Safety Executive under Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 2003 (RIDDOR)
- New Violence Prevention and Reduction Standards were published in December 2020; the Risk and Safety Team will undertake a gap analysis on behalf of the Trust and create an action plan to address findings
- A Legal Compliance Register has been developed; the Risk and Safety Team have progressed auditing against legal requirements.
- Health and safety training requirements are being reviewed per job role; it is anticipated that additional mandatory training is required
- There are 32 Safety Champions representing the services across the Trust who will be coordinating health and safety improvements within their service, including the documenting of risk assessments, procedures, dissemination of lessons learned and escalating any issues.

Recommendations

Trust Board is recommended to:

- Note the progress made with implementing the health and safety management system and arrangements

1. Introduction

'Looking after the health and wellbeing of staff is far more than supporting staff to develop health lifestyles: there is a legal duty to protect as detailed in the NHS Constitution'. NHS Workplace Health and Safety Standards

The report provides the Trust Board with a summary of the principle activities and outcomes relating to the promotion and management of health and safety within Leeds Community Healthcare NHS Trust (LCH), since the last report was received in August 2020.

It provides a review of the management arrangements, legal compliance, accident performance data and health and safety activities and describes further planned activities which are required to strengthen the health and safety management system (appendix one) in order to fulfil the Trust's health and safety obligations.

2. Background

The Trust is required to monitor and review its arrangements for managing occupational health and safety, to ensure legal compliance and demonstrate that continuous improvements are being made to protect the workforce, visitors and third parties who may be affected by its work activities (Health and Safety at Work etc Act 1974).

The Health and Safety Executive (HSE) advises that a formal boardroom review of health and safety performance is essential. It allows the Board to establish whether the essential health and safety principles – strong and active leadership, worker involvement, and assessment and review – have been embedded in the organisation. It tells a Board whether its system is effective in managing risk and protecting people.

It is Leeds Community Healthcare NHS Trust's (LCH) staff who deliver the organisational goals and objectives and therefore it is important to ensure the continued health, safety, welfare and development of the workforce and to minimise the distress and disruption caused by any injuries or work related illnesses which may occur.

LCH's aim is to provide and maintain a safe and healthy environment for all who use its services. This can only be achieved through effective leadership by senior management, participation of all staff and open and responsive communication channels.

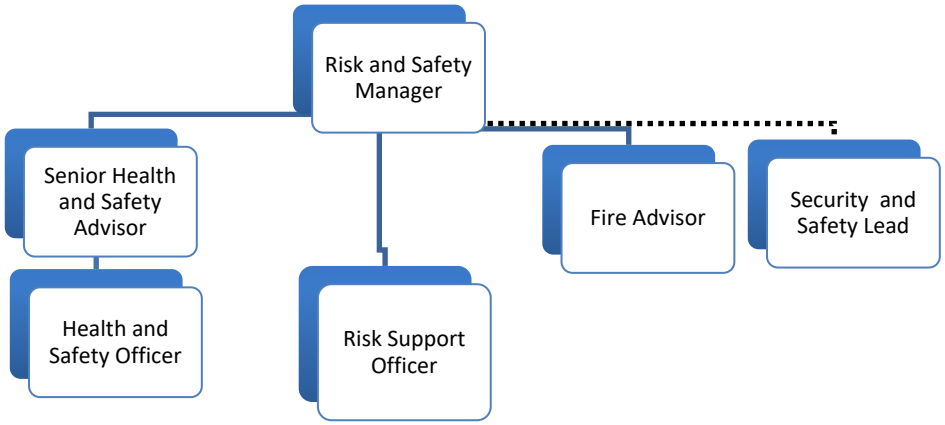
3. The Risk and Safety Team

The Management of Health and Safety at Work Regulations 1999 requires the Trust to appoint one or more competent persons to implement the measures it needs to comply with legal requirements.

The functions of Risk, Fire, Health and Safety and Security were brought together to form the Risk and Safety Team in December 2019. This team is led by the Risk and

Safety Manager, who is a qualified health and safety practitioner. The current structure is as follows:

Risk and Safety Team structure



The Risk and Safety Manager is supported by a team of health, safety, and fire safety specialists who provide advice and support to managers and staff, and measure compliance with health and safety policies and procedures.

The Health and Safety Executive (HSE) advised that the Security and Safety Lead role should be reviewed as some functions within the personal safety role were not being implemented because the scope of the role was too broad. A revised job description and a transition period have been agreed for the Security and Safety Lead to report directly to the Risk and Safety Manager and to commence their revised duties in accordance with the HSE's recommendation.

3.1 Risk and Safety Team Training and Development

Two members of the Risk and Safety Team have attended a virtual Display Screen Equipment Assessor course to ensure that they are providing the workforce with the most current information on the prevention of health risks associated with poorly designed work stations and/or work environments.

Selected team members will be attending an investigation course, ensuring that staff safety incidents are thoroughly investigated so that lessons learned, corrective and preventative actions can be taken to prevent similar incidents occurring.

The Risk Support Officer is to enrol onto the NEBOSH National General Certificate in Occupational Health and Safety course; this will ensure that all members of the Risk and Safety Team have the competency to fully support the organisation and its staff.

4. Progress against the Risk and Safety Action Plan

The Risk and Safety Team action plan details a number of developments that are required to ensure that the Trust has a comprehensive health and safety management system in place prior to some work activities commencing.

These include the following:

- Review of existing health and safety policies to ensure that they are suitable and sufficient
- The development of new health, safety and fire procedures to standardise processes and document additional functions which have not been addressed previously
- Configuring and implementing risk assessment and inspection/audit software to ensure these elements are managed effectively, including the outstanding non-conformances
- The development of a Risk and Safety communications strategy to ensure that the Trust is kept informed of legal updates, lessons learned from events, alerts, bulletins, and an overview of health and safety performance
- Reviewing and identifying training requirements for LCH staff members to ensure that they meet the needs of the organisation and legal requirements

5. Legal Compliance

5.1 Health and Safety Policy

LCH are legally required to have a written health and safety policy that is relevant, current, and meets all legal regulations to help keep staff safe and prevent accidents from happening. Most organisations set out their policy in three sections:

- **The statement of general policy on health and safety** at work sets out our commitment to managing health and safety effectively and what we want to achieve.
- **The responsibility section** sets out who is responsible for specific actions
- **The arrangements section** contains the detail of what you are to do in practice to achieve the aims set out in the statement of health and safety policy. This arrangements section could include risk assessment, training, consultation, evacuation.

The health and safety policy document must be brought to the attention of all employees, including when any changes are made. It is intended to be a 'live' document that all staff work towards. The policy statement (Appendix Two) was reviewed and signed by the Chief Executive in June 2021 and has been circulated via the midday brief and published on the staff internet.

5.2 Health and Safety Legislation Register

A register of legal compliance has been developed and references 49 relevant Health and Safety Acts, Regulations and Codes of Practice.

Compliance against all the identified legal requirements is not fully understood however the Risk and Safety Team have commenced auditing services against these requirements and the relevant policies and procedures. As further monitoring is undertaken, the status against each legal requirement will be reviewed, and an action plan developed and implemented to address the non-conformities and corrective actions.

Compliance against the legal requirements is now monitored bi-annually by the Health and Safety Group.

5.3 New Requirements

5.3.1 Violence prevention and reduction standards December 2020

The new national violence, prevention and reduction standards have been published by NHS England/Improvement. They complement existing health and safety legislation, reinforcing the general duty of care that employers have to protect their staff from threats and violence at work.

The standards deliver a risk based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

The Trust is required to review its current status against the standards, develop a prevention and reduction strategy, identify objectives, develop risk assessments, review performance and continuously improve. The Security and Safety Lead will be responsible for progressing this work in their enhanced role.

5.4 Policy and Procedure developments

The following policies/procedures have been reviewed and submitted to the Clinical and Non-clinical Policies group:

- Safe Management of Contractors
- Control of Substances Hazardous to Health Policy and Procedure
- Display Screen Assessment Policy and Procedure
- Driving at Work Policy
- Fire Safety Policy

The following policies are currently under review and development:

- Security Policy
- Slips, Trips and Falls Policy
- Working at Height

The following procedures have been developed and approved by Health and Safety Group for approval:

- Health and Safety Policy Statement
- Health and Safety Risk Assessment Procedure
- Health and Safety Audit Procedure
- Health, Safety, Security and Fire Inspection and Building Risk Assessment Procedure
- Integrated Management System Non-conformance, Corrective and Preventive Actions Procedure

The following procedures still require development before being approved by the Health and Safety Group:

- Fire Risk Assessment Procedure
- Risk and Safety - Management of change procedure

- Health and safety incident reporting, investigation and RIDDOR (staff)
- Health and Safety Communications Strategy

5.5 Risk Assessment

The completion and review of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999 and was a weak area identified by the HSE's inspection of the Trust. A software system called Assure has been purchased for audit, inspection and risk assessments. This software solution will allow staff members to:

- Produce and share risk assessments; allowing their contents to be checked, audited
- develop templates for audits and inspections
- carry out inspections and audits in real time (reducing the need for writing up reports)
- effectively monitor non-conformances and corrective actions
- automatically remind owners that reviews and updates are required, and escalating as required
- reduce time spent on carrying out and chasing actions, increasing productivity

COSHH, CAMHS Ligature and Lone Working risk assessments are currently being added to the Assure system. These will be published to a portal, allowing staff to reference as necessary without the need to log into a system.

6. Health and Safety Performance

Performance information is based on reactive and proactive performance monitoring (also known as leading and lagging indicators). Reactive monitoring reviews incidents and events that have occurred whilst proactive monitoring identifies what is in place to prevent injury and ill health.

6.1 Reactive safety performance

6.1.1 Staff Accidents and Incidents

LCH's incident reporting system is Datix and it is used to report and record accidents. Incident reports are forwarded to the Risk and Safety Team to review the contents of the report and determine the severity of the incident.

Work has been undertaken to re-classify the non-clinical reporting categories of accidents, incidents and near miss occurrences. These changes took effect on 1 April 2021. It is anticipated that future reports for accident, incident and near miss trend analysis will not be comparable to previous years' reports, but the data will be more accurate and useful in determining actions for reducing these occurrences within the Trust.

Where a serious near miss or harm has occurred, the Risk and Safety Team carry out an independent investigation of the event, ensuring that root causes are identified, remedial actions are taken to prevent reoccurrence, and where relevant, lessons are shared throughout the Trust.

The Risk and Safety Team is the Trust's statutory reporter of accidents that are required to be reported to the Health and Safety Executive (HSE) under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). This is to ensure that accurate information is submitted to the HSE and if further information is required, the Risk and Safety Team is the first point of contact. The Risk and Safety Team will further reinforce this communication to ensure that all managers are aware as two services have incorrectly reported incidents directly to the HSE.

The following injuries are reportable under RIDDOR when they result from a work accident:

- The death of any persons
- Specified injuries to workers
- Injuries to workers which result in their incapacitation for more than seven days
- Injuries to non-workers which result in them being taken directly to hospital

The number of reportable incidents made to the HSE for employees during 2020/2021 was five. For this year to date (2021/2022) LCH have reported four in total; two of which were not work related accidents and were therefore incorrectly reported directly to the HSE by services.

Incident One: The first incident involved a staff member who was bandaging a patient's bilateral legs. The staff member chose to sit on the floor rather than a stool. As the staff member was bandaging the patient's legs, the staff member felt a sharp pain in their lower back and was unable to stand up. The patient assisted them to their feet. This injury resulted in the staff member being absent from work for more than seven consecutive days.

Early investigation findings identify that there are a number of different stools available, none of which are recommended by Work Fit. Manual handling training for bandaging legs has limited effectiveness within the general manual handling training session as it is not relevant to some attendees; bespoke targeted training has been recommended.

Incident Two: The second incident involved a staff member who was assisting a patient from a lying position to sitting by supporting their hand and back; during the manoeuvre the patient jolted backwards. This caused pain to the staff member's neck and upper back. The staff member was absent from work for more than seven consecutive days.

Early investigation findings have identified that a mattress variator (a device that is attached to the mattress that lifts patients to a sitting position) was located next to the patient's bed, but had not been fitted by an Occupational Therapist due to a lack of staff resource. Had the mattress variator been fitted, this event may have been avoided

There has been one serious violent and aggression incident that resulted in two members of staff having replica guns pointed at them during their visit to a patient's home.

As a result of this incident:

- The staff involved were offered ongoing counselling and support.
- All subsequent visits were made by two members of staff
- The safety app has been rolled out across the team
- Ongoing care was guided by the patient in terms of the level of support he wanted to receive
- Plans for challenging patients are to be scheduled in advance for the leadership team to review.

A summary of staff accidents and incidents is provided twice per year in the Performance Brief.

6.1.2 Occupational Health

Occupational health data can be used to identify themes and problems which are occurring within the Trust. A six monthly report is provided to the Health and Safety Group for information, although currently this has been lacking in detail.

Human Resources are in discussion with the current service provider to identify any additional information that can be provided to assist the Trust in identifying areas of weakness.

6.2 Proactive Safety Performance

6.2.1 Health, Safety and Fire Inspections

The Trust's health and safety inspections focus on hazards in the work environment; they are a check on workplaces and work activities to ensure that they are healthy and safe. Inspections can help prevent incident, injuries and illnesses by addressing identified hazards.

Within the Trust, building inspections are carried an annual basis for health and safety and every two years for fire. The health and safety inspections have been completed for all LCH owned and known lease buildings. The Fire risk assessments continue to be reviewed.

A new risk and safety inspection procedure has been developed to combine the inspection focus of health and safety, fire and security arrangements. This inspection will not replace the fire risk assessment inspections, but is intended to compliment them. The inspection has been added to the ASSURE software; questions are due to be weighted so that buildings can be given an overall compliance score.

6.2.2 Health and Safety Audits

a. Internal Audits (TIIA)

TIIA undertook an audit on health and safety in January 2021 The audit covered key health and safety arrangements across the Trust and focused on the following:

- Arrangements for managing staff accidents, slips, trips and falls and COSHH
- An overview of the effectiveness of COVID arrangements.

The findings identified that:

- Staff had not been made fully aware of their health and safety responsibilities, managers were not fully confident of competent in delivering aspects of health and safety and require specific training to support them
- Serious accident outcomes did not consistently identify root causes or translate into learning
- Staff were confused about COVID arrangements due to multiple sources of information and updates

An action plan was developed to address these above findings; progress to achieving the action plan is monitored by the Audit Committee.

b. **Risk and Safety Team Audits**

The Risk and Safety Team have developed a schedule of audits based on risk. These audits consider the working practices within services, ensuring that the Trust is compliant with current health and safety regulations, and assesses the extent to which staff are following health and safety policies and procedures.

The Risk and Safety Team provide an independent review of the services' performance. The results will allow the Trust to identify areas of weakness, draw up plans for corrective actions and update the legal compliance register.

An audit on the Control of Substances Hazardous to Health (COSHH) was carried out in March 2021. The services involved were Domestic Services, Leeds Community Equipment Services and Leeds Sexual Health; The Dental and Podiatry services had been reviewed by TIIA in February 2021, identifying a lack of COSHH assessments as a non-conformance.

Nine non-conformances were identified, three of which were a direct breach of the legislation. Findings included:-

- A lack of COSHH assessments for all hazardous substances being used
- Incorrect information being detailed in the COSHH assessment
- No alternative (less hazardous) substances had been considered
- Incorrect personal protective equipment being worn
- Safety precautions were not outlined in some operating procedures
- Limited evidence that there were robust emergency/spillages procedures in place
- Lack of COSHH training for those staff who undertaken COSHH assessments
- Incorrect safety data sheets being used to inform COSHH assessments
- High amounts of flammable materials were being stored at any one time

Services have been provided with a targeted action plan and the Risk and Safety Team are assisting those services to review their COSHH assessments. Training is to be developed; it is recommended that this becomes a mandatory course for staff who undertake COSHH assessments.

Leeds Community Equipment Service have made excellent progress towards completing their action plan, including the development of procedures, completing COSHH assessments for all hazardous substances, reviewing the use hazardous substances and seeking alternative products that are less hazardous.

The next audit will focus on first aid provision and training at owned and occupied buildings, alongside provision for lone-working and mobile staff.

6.2.3 Health and Safety Training

Completion of mandatory health and safety training is monitored via ESR. A new e-learning package providing a high level overview of health and safety legal requirements was added to ESR in February 2021.

The Risk and Safety Team developed a health and safety training for managers to provide them with the understanding of their roles and responsibilities. This course is included in the Essential Management training programme (a voluntary three day course for managers). This programme has been paused during the pandemic.

Display Screen Equipment drop-in sessions have added to the events within My LCH to allow staff to discuss any problems they are having with their workstations and ensure that staff do not suffer upper limb disorders, eye sight problems and/or mental stress.

Training for clinical and operational leads on lone working and developing risk assessment took place in October 2020 and in June 2021. Once completed, lone working risk assessments are expected to be carried out, ensuring legal compliance within this area.

A review of staff training needs per job role is being undertaken to identify skills and knowledge gaps which are required to ensure that the Trust is legally compliant.

A further Leading Health and Safety session was held in February 2021 for the second cohort of directors and assistant directors.

6.3 Safety Champions

To assist with legal compliance, communications and awareness, 31 Safety Champions have been identified across the Trust, representing all services. Their role is to:

- Be a conduit for the Risk and Safety Group
- Receive and coordinate ‘bite-size’ action plans to ensure the continuous improvement of health and safety performance.
- Assist with the review of policies and procedures
- Be a point of contact for audits, ensuring action plans are completed
- Receive and disseminate communications, such as lessons learned

All Safety Champions will be invited to attend an IOSH Working Safely course during September 2021. Attendance is expected to raise their awareness of the importance of health and safety, allowing attendees to understand more about the elements of a successful health and safety management, including competence, key responsibilities, safe systems of work, emergency procedures, competence, health surveillance, work inspections, reporting and investigating incidents.

7. The Health and Safety Group

The Health and Safety Group, chaired by the Executive Director of Finance and Resources, provides a structured approach to communication and consultation. It provides a forum where Business Unit representatives, Staff-side, the Risk and Safety Team, Human Resources, Facilities and Estates can work together to resolve health and safety issues.

The Group approves the health and safety policies and procedures, reviews health and safety performance, serious incidents and helps to develop health and safety standards, rules and processes.

A revised work plan was agreed by the Health and Safety Group in January 2021. This considers all elements of the health and safety management system, from legislation to performance and review. The frequency of meetings has now increased from quarterly to bi-monthly to allow sufficient time for in-depth discussions. Issues which require escalation are forwarded to the Business Committee.

8. Fire Safety Group

The Fire Safety Group is a sub-group to the Health and Safety Group. It is attended by representatives from the Risk and Safety Team, Estates, Facilities, and FES Group (an estates and facilities management company) and aims to improve the communications between management, staff, contractors and partnership organisations to ensure that a suitable fire safety culture is in place for all employees. The Group ensures that the Trust is meeting its fire safety legal obligations and that a suitable fire safety management system is in place.

9. Lone Working Group

The Lone Working Group was established to address the findings relating to violence, aggression and lone working as identified by the Health and Safety Executive during their inspection of the Trust in 2019.

The Risk and Safety Team have supported services by writing the combined lone working, violence and aggression risk assessments, reviewing the lone working risk assessments developed by Services, and the development of lone working scenarios which services are currently adapting to their own circumstances.

10. Safe Working Environment Group

The Risk and Safety Group have played a key role in the Safe Working Environment Group that was established as a result of the COVID pandemic, ensuring the development and completion of COVID risk assessments for buildings, reviewing the safety arrangements where vaccinations were being undertaken and ensuring staff could work safely at home.

11. GP Confederation

In November 2020, the Risk and Safety Team agreed to support the GP Confederation and to:

- Act as the 'competent person' for Health and Safety
- Review the relevant working practices with GP practices to ensure they are compliant
- Provide Health and Safety advice and guidance to all extended access staff
- Identify gaps and develop the GP Confederation Health and Safety Management System to ensure continuous improvement of Health and Safety performance.

12. Next steps

A number of developments are planned to ensure that the Trust continues to develop a robust health and safety management system:

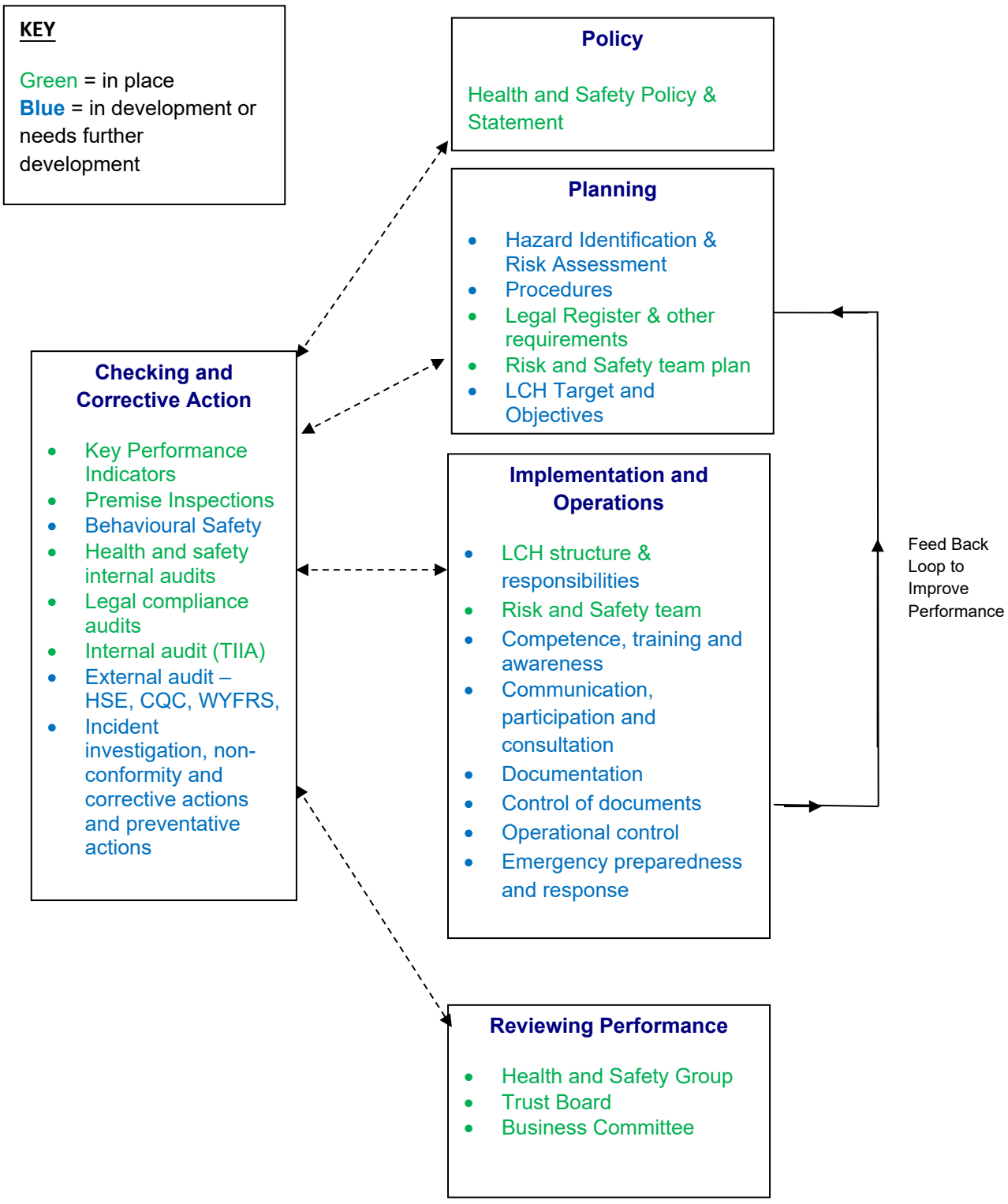
- The continued development of health and safety policies and procedures, prioritising the audit procedure and schedule, building inspections and risk assessments.
- Documenting the Risk and Safety Team communication strategy and schedule, and publish articles, bulletins and latest news relating to health and safety
- Documenting of the health and safety training requirements per job role
- Auditing first aid arrangements
- Training the Safety Champions to enable them to confidently assist in the completion of the work required to ensure legal compliance
- Review the Violence Prevention and Reduction Standards, identify and address gaps
- The further development the GP Confederation's health and safety management system

13. Recommendations

Trust Board is recommended to:

- Note the progress made with implementing the health and safety management system and arrangements

Appendix One LCH Health and Safety Management System



Health and Safety Policy Statement

At Leeds Community Healthcare, we are committed to ensuring the health, safety and welfare of all our employees and anyone else who may be affected by our work activities.
We know that high standards of health and safety are good for our employees, good for our organisation and good for the communities we serve.

We will comply with the requirements of health and safety legislation, find solutions and deliver improvements in order to promote the continual improvement of our health and safety management system and reduce occurrences of occupational injury or ill health.

This policy statement applies to our employees, the contractors who work for us and anyone else who may be affected by our work activities or use our services. To support our health and safety objectives we will:

Leadership

- Provide visible leadership, lead by example and promote health and safety as a priority.
- Work together to develop and maintain a positive health and safety culture based on fairness, trust and cooperation, where all safety incidents are reported and investigated in order to share lessons learned and prevent reoccurrence.
- Ensure that arrangements are in place to engage with our employees and others in accordance with the principles of partnership working.

Employees

- Provide suitable and sufficient information, advice, statutory and mandatory training and supervision to ensure that our employees are fully aware of their responsibilities and competent to undertake their work activities.
- Empower all our employees to embrace safe working behaviours, looking after themselves and others
- Encourage employees to report all accidents, incidents and near misses.

Performance

- Strive to achieve our targets for improvement, develop appropriate action plans and utilise robust measures to monitor performance.
- Establish channels of communication and consultation which encourage and permit our employees, and as appropriate their representatives, to contribute to improvement in our health and safety performance.
- Undertake audits and inspections to identify areas of weakness and ensure corrective actions are taken.

Responsibilities

- Provide our employees safe working environments, the right equipment, all necessary safety devices, and standard operating procedures, in order for them to be able to work safely.
- Ensure that the level of risk from all significant hazards is assessed, eliminated, reduced or controlled as far as reasonably practicable.
- Provide adequate resources to successfully manage health and safety at work.

The Trust Board has ultimate responsibility for ensuring that risks arising from our work activities are understood and mitigated as so far as reasonably practicable. We will make the best decisions to ensure that health and safety is integrated into our strategic plans and working practices.

Signed: _____ Date: _____

Thea Stein, Chief Executive
Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (59)

Title: Safe Staffing Report

Category of paper: For assurance

History: Quality Committee 26 July 2021 and Business Committee 28 July 2021

Responsible director: Executive Director of Nursing and AHP's

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Report author: Clinical Leads for the Business Units and Assistant Director of Nursing.

Executive summary

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

The paper sets out progress in relation to maintaining safe staffing over the last six months (January 2021 – June 2021). It covers the range of services provided in the Trust as requested by the Board previously. The statutory requirements and data is contained in an appendix with the main body of the paper being used to provide assurance to the Quality Committee and Board in relation to the effect of staffing pressures on services, including the continued impact of the COVID-19 pandemic, and how these are being mitigated.

The paper also triangulates elements of patient safety data to the staffing numbers where this is possible.

Recommendations

The Trust Board is recommended to:

Note the contents of the report and the progress being made.

Safe Staffing Report

1 Introduction

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

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

2 Background

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

In addition to reporting on the in-patient areas the paper also provides information on all the Trusts services as requested by Board. It is to be noted for this reporting period that the Community Neurological Rehabilitation Unit (CNRU) has remained closed and Little Woodhouse Hall transferred to LYPFT on 1 April 2021 so is included for the period of Jan 2021-March 2021.

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

3 Current position/main body of the report

3a) Specialist Business Unit (SBU):

SBU has seen many changes in the senior leadership structure with positions having been covered using secondments and temporary positions prior to permanent posts being filled. It is anticipated that all newly appointed post holders will be in place by the end of July 2021 which will provide some leadership stability across SBU.

Services continue to deliver care using new ways of working adopted during the pandemic which now incorporates a significant digital offer. Services regularly review and adapt, as appropriate, to ensure care is delivered in a way which meets the needs of the patients. This includes more face to face consultations being made available where required. Services have also submitted plans identifying the resource and staff requirements to address the waiting list backlogs within the Trust's wider piece of recovery work.

Within the Specialist Business unit the staffing issues to note are as follows:

Podiatry

The service **c**ontinue to mitigate unfilled vacancies with the use of agency staff and are now looking at creative short term contracts to attract a more dependable workforce. Staff who have left the service are being asked to join the internal bank (ClaSS) in addition to staff being invited to work extra hours to mitigate the staffing gap. In addition, the service is working with commissioners to explore how patients who are of low clinical risk will be managed in the future. This work has commenced with submission of an options paper.

Dental
The absence of a Paediatric Dentist within the service continues, as does work with the Leeds Dental Institute, Commissioners and regional providers to address this. In addition, the imminent departure of the specialist Dentist is being considered through a review of the skill mix of the service.

Leeds Mental Wellbeing Service (LMWS)
Previously raised staff turnover has been discussed with commissioners and short term additional investment has been agreed to help with these pressures. Review of the leadership structure is also taking place as one of the work streams in the wider project to ensure the LMWS model remains sustainable.

Speech & Language Therapy (SLT)
Heads of service are reporting issues in the recruitment to temporary posts, especially given the national picture of shortages of SLT staff, and this is being considered. An increase in the number of training places has been agreed to improve this. The service continues to appraise capacity and demand in reviewing how the service is delivered.

Policy Custody Suites
Recent recruitment drives have had limited success to fill vacancies and the service is reviewing a more creative approach to recruitment advertising. Staff continue to undertake additional shifts via CLaSS to ensure shifts are covered.

WYOI and Adel Beck
The challenge of cross-site working as a result of the Covid-19 pandemic has continued to have an impact however the service are working closely with Infection Prevention & Control (IPC) and will re-commence this when safe to do so. Maternity leave of CAMHS staff, employed by SWYPT, is imminent and the Trusts are working together to review cover and how to report staffing levels in both CAMHS and physical health to ensure consistency.

Cardiac Team / Respiratory Team
Capacity and demand work is ongoing and a number of staff are being recruited to address the backlogs within the services. Discussions are taking place with commissioners to attain a sustainable workforce.

Sexual Health and Gynae
Two additional doctor sessions per week have been commenced to address the back log.

3b) Children's Business Unit:

Hannah House
As a C1 service Hannah House has remained open to support vulnerable children and families with respite. A number of families chose to keep their children at home during this period which has resulted in reduced bed occupancy rates. The numbers of children accessing care at Hannah House increased when shielding ended and restrictions were stepped down. The service continues to provide 24/7 care for a long term ventilated child in the "step-down bed". Regular liaison has continued with social care and commissioners regarding a foster care placement and this is now being progressed.

Hannah House has maintained safe staffing levels throughout the reporting period; this has included use of Clinical and Support Service (CLaSS) staff at times. The safe staffing data, including use of CLaSS staff can be seen in Appendix 3. There has been 3 nights (1 child – 2 nights and another child – 1 night) cancelled by the service in the reporting period due to low staffing. A meeting has been arranged with the Service Manager, Team Manager, workforce and Children's Business Unit Clinical Lead to review the eRostering data process. All incidents within the unit have been in the category of no injury or minimal harm and none related to staffing issues. There have been three compliments recorded and no complaints.

Inclusion Nursing

Inclusion Nursing support children who attend a Leeds Specialist Inclusive Learning Centres (SILCs), and the children with complex health needs in partnership sites. The service is a C1 service to ensure healthcare provision for vulnerable children and families, where children are attending school. The service extended by also providing a service during school holidays as SILCs remained open. With a slight reduction in workload in the SILC sites as some children remained at home, the nursing team have kept in contact with families digitally, ensuring assessments and care plans were meeting the child's needs. If clinically indicated children have been visited at home. There have been a number of staff who have been shielding due to recognised health issues, and they have been supported to work from home undertaking activities for the service as a whole. A number of staff had to isolate due to track and trace during this period. As part of Covid-19 planning 0-19 practitioners and other community nursing colleagues have been redeployed to work in the service. Appropriate staffing levels have been maintained during this period. There have not been any moderate or major harm incidents reported by the service. There have been no complaints received.

Continuing Care and Health Short Breaks Team

The service continues to provide care to children in the family home. There has continued to be a high level of both long and short term staff sickness and staff vacancies, the remaining staff have worked flexibly alongside support from Hannah House staff, CLaSS and agency to prioritise providing night time cover. Carers who access the service have reported finding this particularly helpful at night. All essential nights have continued to be covered during this reporting period, although some nights (12 nights over 3 months) for children have had to be cancelled due to staffing capacity, this is only done following a clinical risk assessment. The service have provided training to education staff for ventilated children to enable them to access school. They also supported private providers delivering care to children with complex needs, by providing advice and where necessary training for staff. There have not been any moderate or major harm incidents.

Children's Community Nursing

The team provides a domiciliary service for children and young people with a wide range of nursing needs, providing advice and training for families and nursing assessments and interventions. During the reporting period there has been an increase in staff sickness leading to the need for some reorganisation and the introduction of new ways of working. This includes having a coordinator for the service working in the office ensuring clinical calls are handled promptly and appropriately. The workload has increased due to the pausing of other LCH services, non-attendance at school and a reduction of clinic attendance at acute based outpatient services. There have been no moderate or major harm incidents received by the service. There have been no complaints received.

Child and Adolescent Mental Health (CAMHS)

General Adolescent Inpatient Unit

CAMHS Adolescent Tier 4 Inpatient Service (AIS) is based at Little Woodhouse Hall and categorised as a C1 service. The service transferred to Leeds and York Partnership Foundation Trust (LYPFT) on 1st April 2021 so the reporting period is for January to March 2021. Staffing levels were monitored on a daily basis by the Operational Manager and Shift Coordinator who liaised with CLaSS and other agencies, and escalated staffing concerns as necessary. The safe staffing data, including use of CLaSS and agency staff can be seen in Appendix 4.

Prevention and Management of Violence and Aggression (PMVA) training which had not been possible to complete during Covid-19 was completed during this 3 month period. All temporary staff completed the required training. Temporary staff were either from LCH CLaSS, Leeds and York Partnership Foundation Trust bank or from a single agency where assurance is given that staff have completed required training to work in an inpatient CAMHS service. There was an improvement in managing safe staffing levels at this time with more efficient use of e-rostering and working closely with CLaSS to proactively manage the shifts that needed to be filled. Health and wellbeing of the team was prioritised at this time and staff sickness rates improved. There were 3 registered nurse vacancies during this time and an increase in annual leave during February and March.

In the previous 6 months there had been concern at the levels of self-harm incidents on the unit, this continued to decrease during this period. There were no moderate or major harm incidents related to staffing issues and no complaints or concerns reported.

Community CAMHS

The teams have continued to deliver care using a digital first approach where possible. There are vacancies across the whole of CAMHS and overall there has been an increase in referrals to all areas of the service. As of 31st May 2021, new external referrals are 32.3% above the Commissioner expectation for the year to date (1st April 2021 to 31st May 2021). The number of young people open to CAMHS at the end of May 2021 was 3704. This has increased by over 600 in the last 12 months, mostly due to high referral rates.

Crisis

Crisis referrals (08:00-24:00) are above the 2020-21 monthly average of 45 referrals, with 72 referrals received. This follows the trend in previous months where the lifting of Covid-19 restrictions and the re-opening of schools has resulted in much higher rates of Crisis referrals. There is a hope to develop a new Crisis Care line, however recruitment to the posts for Band 6 staff is proving difficult.

Eating Disorder Services

There are current vacancies across the multi-disciplinary team which are out to advert and there is commissioner funding for new posts in the team. Overall referral rates continue to be higher than previous years, in the 6-month period December 2020 to May 2021 the team received an average of 18 referrals per month, compared to 10 per month in the same period in 2019-20.

0-19 Public Health Integrated Nursing Service (PHINS)
The 0-19 PHINS is contracted to provide 145 Specialist Public Health Nurses (125 Health Visitors and 20 School Nurses).

The first 6 months of this year has been challenging regarding Band 6 staffing levels as an outcome of the Covid-19 pandemic has resulted in a significant number of staff either retiring or leaving the service. This, compounded with a lack of applicants for advertised posts, has resulted in the service having to temporarily pause part of the service offer with agreement from the Trust.

The table below shows the number of WTE Health Visitors and School Nurses employed with LCH from January 21 to June 21, however the number of staff delivering care has been lower due to annual leave, sickness, emergency leave and COVID19 isolation.

	January	February	March	April	May	June
Health Visitors	115.65	113.25	112.49	110.77	104.13	103.56
School Nurses	11.80	11.80	12.40	11.29	10.29	10.29

The service has maintained a daily capacity tool which has supported the movement of staff when required. Additional hours have also been offered and some support has also been available via CLaSS. The service has developed a recruitment and retention strategy and continues to work closely with corporate colleagues from the recruitment team. Commissioners are supportive of this recruitment and marketing strategy given the national and regional shortage of Health Visitors and School Nurses.

A rolling programme of recruitment has successfully appointed 1.0 WTE Health Visitor starting in July and 8.95 WTE Health Visitor's and 4.80 WTE School Nurse's starting in September.

In terms of future workforce planning the service has over recruited to Band 5 Staff Nurses and will support future Specialist Community Public Health Nursing (SCPHN) training applications. The service has also agreed to host 17 SCPHN students starting their training in September as well as supporting more Band 6 practitioners to do the Differing Fields training.

Children's Speech and Language Therapy Service
The Children's Speech and Language Therapy Service has a significant Covid-19 backlog which accumulated during the 1st lockdown and has been exacerbated by face to face reduced contacts in clinics and schools due to PPE use.
Despite best efforts it has not yet been possible to acquire additional staffing to address the backlogs either through temporary staffing or agency. Consideration needs to be given to recruitment of permanent staff above the establishment with a view to mitigating this risk against natural turnover and/or new traded school business.

3c) Adult Business Unit:

Neighbourhood Teams

As previously stated there are no nationally agreed staffing levels or evidence based tools for community teams. The Trust continues to develop the work to set safe staffing levels in community teams including involvement, as a test site, for the community registered nurse safer staffing tool. During June 2021 Seacroft Neighbourhood Team piloted the tool and data has been submitted to the national team at NHS England.

The Neighbourhood Model Transformation Programme has commenced and is providing an opportunity to revisit and refresh the Neighbourhood Model, including a number of work streams specifically focussed on staffing issues. There is a focus on staff engagement as part of the programme, with many staff contributing their suggestions for improvement. Whilst recognising that staff engagement will be key to enabling successful change, this also adds to the challenges of capacity and demand in the immediate term. A wide range of engagement approaches to maximise opportunities for staff to contribute to the programme are being employed.

Information is provided in Appendix 5 in relation to staff turnover and sickness rates. Also included is the breakdown of temporary staff used through the LCH CLaSS system.

Staffing is monitored and managed on a twice daily basis through the Capacity and Demand reporting tool with senior clinical and operational oversight seven days a week. Actions are initiated to ensure patient and staff safety is maintained. Staffing levels are monitored within the Adult Business Unit monthly performance process and any additional actions required considered by the Adult Business Unit senior leadership team. In addition a quarterly update report reviewing key indicators for Neighbourhood Team quality and workforce is provided to Quality Committee and Business Committee.

The Patient Complexity Tool (PCI) has been successfully trialled in West 2 Neighbourhood Teams providing helpful qualitative detail to consider alongside other capacity and demand information. In time, this will add detail about the complexity of individual staff and team caseloads as well as size of caseload and will further support safe practice. This information will also inform the skills and training needs within the teams. Planned rollout to other Neighbourhood Teams has been delayed due to ongoing capacity and demand pressures but rollout will continue as soon as possible. A gap in the information provided by the tool relates specifically to End of Life Care and ways to overcome this are being explored. Virtual consultations are being tested in Meanwood (therapy assessment) and Morley (staff to staff consultation) Neighbourhood Teams with a view to wider rollout, using a service improvement approach.

The main recruitment challenge in Neighbourhood Teams continues to be in recruitment of registered nurses reflecting the national shortage in these roles. Despite an ongoing national shortfall in therapists, there has been a recent increase in the number of appointable applicants for registered therapy roles in Neighbourhood Teams, reflecting the establishment of new clinical roles and career development opportunities. Whilst core staffing levels have improved, the next challenge for Neighbourhood Teams is to recruit in response to additional investment in community services (Physiotherapy, Occupational Therapy,

Neighbourhood Nights Service, Pharmacy Technicians and Neighbourhood Clinical Assistants) with some encouraging progress already made in Neighbourhood Clinical Assistant recruitment with a cohort of new recruits having started in late January 2021.

In addition to the ongoing recruitment issues teams are experiencing reduced capacity due to the ongoing impact of COVID-19, particularly the Track and Trace isolation requirements and impact on school bubbles. Staff continue to be supported to work from home where appropriate in these situations. Close working with CLaSS ensures that available bank and agency staff are targeted at teams with the greatest staffing challenges. The Trust wide resourcing group chaired by the Director of Workforce coordinates actions to support recruitment across the Trust including Neighbourhood Teams. In addition the contract continues with a local provider to support capacity in a number of teams with particular staffing challenges from a combination of vacancies and sickness.

Work is underway to ensure that additional staffing contingency is available to be deployed to maintain essential service delivery should this be required, building on the learning and feedback from staff about their redeployment experience.

Although the implementation of the new District Nursing training approach was paused due to COVID-19, progress with Advanced Practice training for 15 staff has continued. 14 further staff have confirmed places on the District Nursing training programme and started in September, with 9 people completing the course in September due to move into District Nursing roles within NTs. 3 Band 7 District Nurses have been recruited from within the existing workforce. Internally support has continued for Band 5 nurses with a development programme to enable them to progress to the next steps in their careers. This programme is now being offered to ensure equality of access to this development opportunity for part time staff. Investing in staff in this way supports staff recruitment and retention, and enables the development of services in response to the NHS Long Term Plan. Supporting the development of Advanced Clinical Practice (ACP) clinicians has enabled a response to the skills and competency requirements of the Enhanced Health in Care Homes and Urgent Same Day Response work streams, along with the effective and safe management of deteriorating patients within the Virtual Ward and the enhanced Neighbourhood Team offer. New approaches to joint working with primary care are being tested to support residents in care homes in two Neighbourhood Teams. The development of District Nurses and ACPs takes a minimum of 2 years and requires detailed forward planning for release and support of staff along with targeted recruitment and retention of LCH trained staff.

Staff experience remains variable and is influenced by a number of factors. Staff engagement is ongoing in all teams and a range of local initiatives continue to be implemented to improve staff experience and engagement in context of COVID-19. During COVID-19 the use of virtual technology has opened up new ways of maintaining contact within and between teams and senior leadership however staff report that they miss the face to face opportunities for more informal support and connection. The Trust has implemented a wide range of additional support mechanisms for staff health and wellbeing during the COVID-19 period, with ongoing efforts to ensure that these measures are responding to staff feedback, for example additional support in relation to End of Life care (EOL) delivery.

Monitoring patient safety incidents that are related to staffing issues or concerns constitutes a key area for review. This will be monitored very carefully within ABU

incident investigations, mortality reviews and any complaints raised by patients, families and staff, as always, and any issues related to staffing levels will be escalated to the senior management team (SMT).

There are a number of routes for staff to share their feedback and discuss solutions to local and citywide issues including:

- Regular team meetings
- Neighbourhood Model Transformation Programme engagement activities
- Additional staff support sessions related to COVID-19 and EOL care (virtual and face to face where required)
- Executive Director of Nursing and AHPs and other Board Member visits/engagement sessions (including virtual) e.g. Team LCH meetings
- Regular time with and focussed support from ABU Leadership Team when required
- Maintaining individual staff 1:1s with their supervisor or line manager
- Appraisal and reported clinical supervision rates have reduced during COVID escalation. A recovery plan is now in progress to ensure that all staff have an up to date appraisal and that clinical supervision is reported accurately for all teams
- Monthly quality and performance panel
- Presentations at Quality Committee e.g. End of Life
- Clinical drop ins
- Specific drop ins for the CMs, ACMs and DNs / senior nurses, Leadership Team members with support from the ODI team as required

There have been a total of 10 complaints and 226 compliments logged in the reporting period January to June 2021 (compared to 17 complaints and 399 compliments in the previous 6 months). No new themes have emerged. As previously reported the audit of cancelled and rescheduled visits continued during this period. This daily review of all Neighbourhood Team rescheduled and cancelled visits showed that due to capacity and demand issues there continues to be a number of registered nurse visits that were rescheduled or undertaken by a non-registered member of staff. There was senior clinical oversight of decision making and clinical risk. This will continue to be monitored closely with involvement of the Director of Nursing and AHPs who reports to the Senior Management Team regarding any areas of escalation from this audit work.

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

- All essential work is completed on the day
- Daily handovers
- Safety huddles
- Quality Board - incidents, complaints, patient FFT returns
- Caseload reviews (this remains an area where there is on-going work to embed)
- Clinical supervision and safeguarding supervision
- Review meetings post incidents
- Sharing patients safety memos

Some of the routine work associated with monitoring and understanding impact has been disrupted over the last 6 months in response to the ongoing absence in the Neighbourhood Team leadership.

4. Impact:

Quality

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

Resources

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

Risk and assurance

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

5. Conclusion

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

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

4 Recommendations

The Trust Board is recommended to note the contents of the report and the progress being made.

Appendix 1

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

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

Appendix 2
National Guidance

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

Appendix 3: Hannah House

Safe staffing data from eRoster

	Day	Day	Night	Night
Average fill rate	Registered Nurse	Non-registered	Registered Nurse	Non-registered
Jan 21	76%	56%	82%	61%
Feb 21	70%	51%	77%	51%
March 21	79%	35%	68%	53%
April 21	82%	43%	66%	56%
May 21	98%	36%	86%	54%
June 21	93%	29%	82%	44%

Use of CLASS and Agency staff in Hannah House

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

Hannah House	Day	Day	Night	Night
	Registered Nurses	Non-registered	Registered Nurses	Non-registered
Jan 21	1	0	1	1
Feb 21	0	0	0	0
March 21	0	5	1	2
April 21	0	1	1	0
May 21	1	0	2	1
June 21	0	3	0	2

Use of CLASS and Agency staff in Hannah House: Unfilled Shifts

Hannah House	Day	Day	Night	Night
	Registered Nurses	Non-registered	Registered Nurses	Non-registered
Jan 21	0	5	0	1
Feb 21	0	2	0	2
March 21	0	4	0	1
April 21	0	2	0	0
May 21	0	2	0	1
June 21	0	0	0	4

Appendix 4: Little Woodhouse Hall

Safe staffing data from eRoster

	Day	Day	Night	Night
Average fill rate	Registered Nurse	Non-registered	Registered Nurse	Non-registered
Jan 21	75%	98%	69%	138%
Feb 21	86%	86%	48%	145%
March 21	71%	92%	53%	148%

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

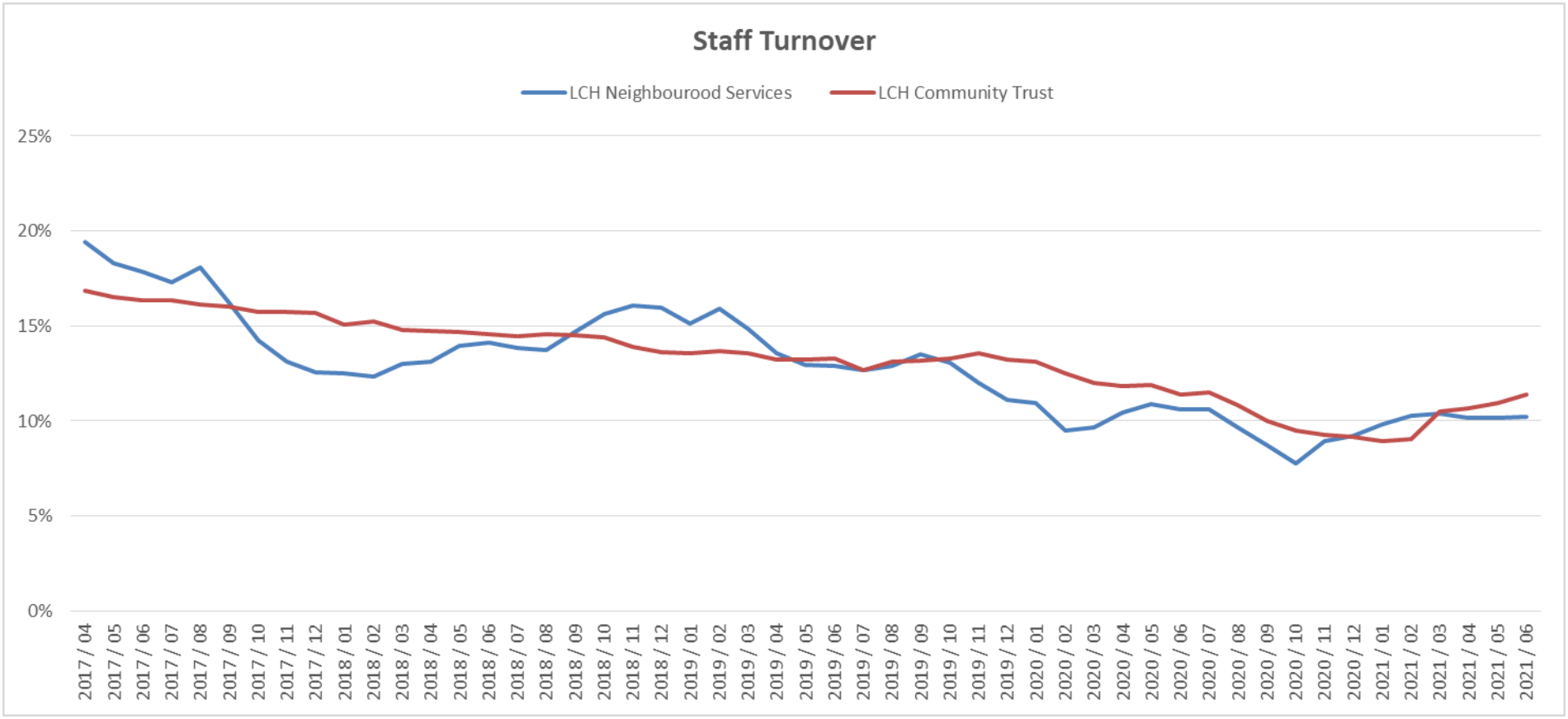
	Number of registered nurses	Number of non-registered staff
Jan 21	19	138
Feb 21	37	123
March 21	25	147

Appendix 5

Neighbourhood Teams

Staff Turnover

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

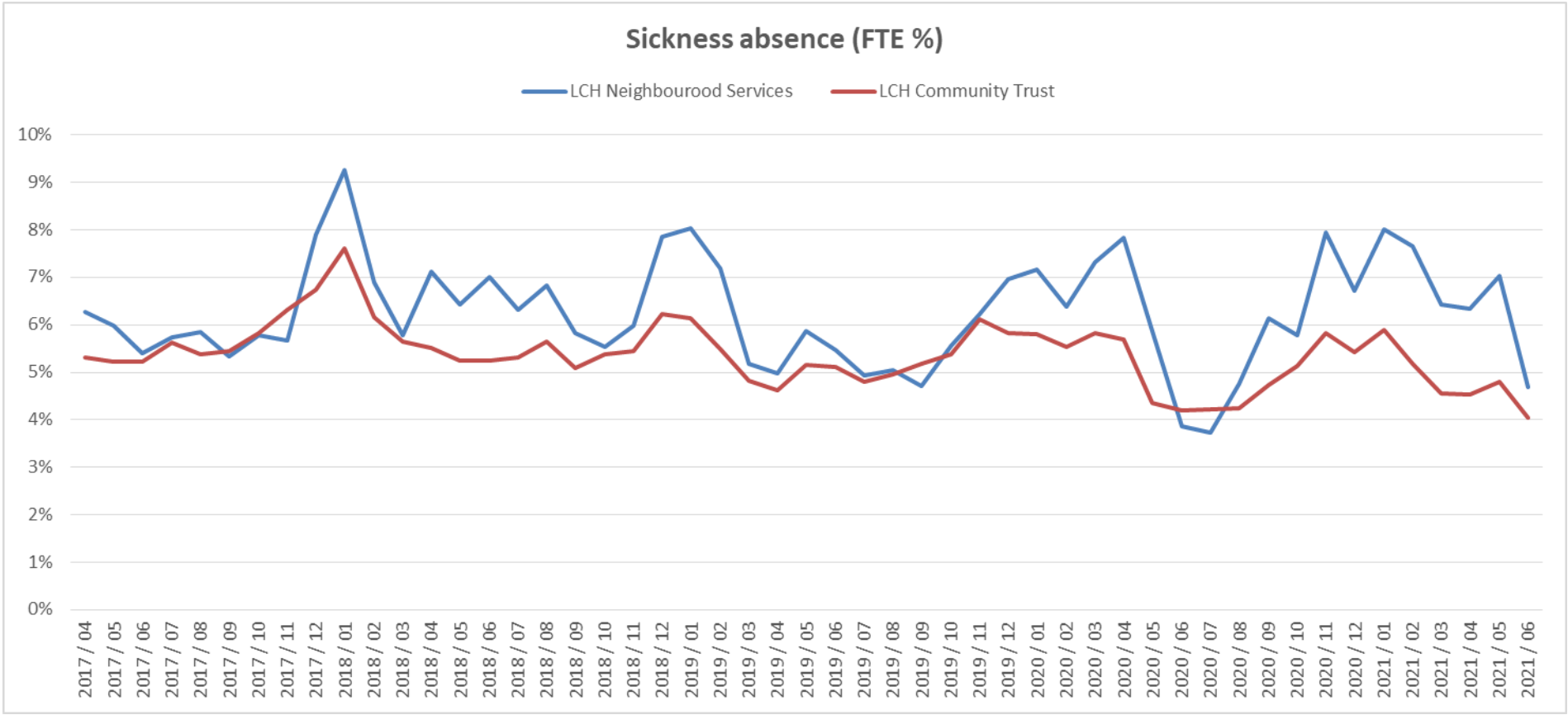


Number of leavers <12 months

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

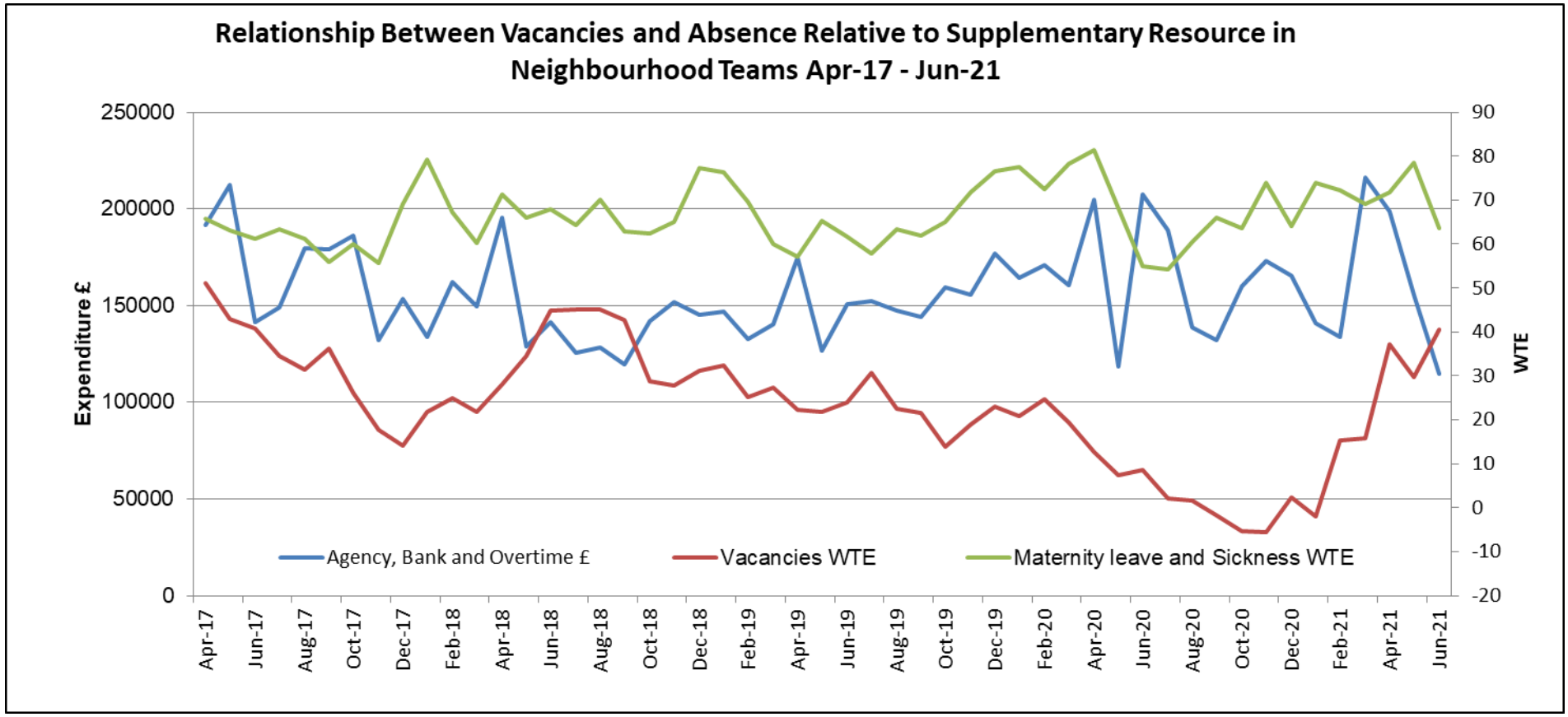
Sickness Absence

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



Supplementary staffing

This chart shows that Neighbourhood Team vacancies have started to increase over the last period, whilst maternity leave and sick leave has remained relatively consistent. Supplementary staff via bank and agency has varied during the period, based on staffing availability through these routes. This trend will continue to be monitored.



Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (60)

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Category of paper: For Assurance
History: SMT 21 July 2021, Quality Committee 26 July 2021 & Business Committee 28 July 2021.

Responsible director: Executive Director of Nursing and Allied Health Professionals and Executive Director of Finance and Resources
Report author: Business & Planning Manager and Clinical Governance Manager

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Executive summary

This report provides a progress update against the Trust priorities at the end of Q1 2021/22.

Our Five Trust priorities were agreed by SMT in 2021/22 to drive achievement of the Trust's four strategic goals and support delivery of system priorities. These Trust Priorities were developed during our response to the international COVID 19 pandemic that has been a major focus of our work during 2020/2021.

At the end of quarter one, progress has been made against all five priorities as LCH continues to support its staff, patients and the wider health and care system in Leeds and West Yorkshire and manage the impact of the ongoing pandemic. This is an amazing achievement considering the pandemic and continued extreme pressure across the health and care system.

The five Trust priorities are:

- Priority 1 - Build our services back better.
- Priority 2 - Play a full part in #TeamLeeds' ongoing response to Covid-19, standing ready for further surges, supporting the vaccination programme, supporting system resilience and patient flow.
- Priority 3 - Promote and support the health and wellbeing of our workforce.
- Priority 4 - Develop integrated provision with a stronger focus on prevention, self-management and pro-active care.
- Priority 5 - Work pro-actively across the organisation and with #TeamLeeds to understand and improve health equity.

Recommendations

The Board is asked to agree that, in the most challenging of circumstances, staff have continued to go above and beyond during the ongoing pandemic, delivering high quality care to patients whilst delivering against the Trust priorities. They have significantly contributed to the Trust being a better provider of care, a better employer and a better partner.

Trust Priorities 2021/22 - Q1 Update

1 Introduction

This report provides a progress update against the Trust priorities at the end of Q1 2021/22.

Our Five Trust priorities were agreed by SMT in 2021/22 to drive achievement of the Trust's four strategic goals and support delivery of system priorities. These Trust Priorities were developed during our response to the international COVID 19 pandemic that has been a major focus of our work during 2020/2021.

The last 12 months has seen an unprecedented change in how services have been delivered to meet the challenges of the COVID-19 pandemic. The Trust has fundamentally changed the way we work to maximise our ability to meet the evolving needs or our communities, and to optimise the health and wellbeing of our patients, families, carers and staff. The way we have innovated and developed our services to continue to deliver high quality care with a focus on improvement will continue into 2021/2022 and beyond.

The Trust Priorities we have developed are underpinned by our learning and experience during 2020/2021. The Trust Priorities also reflect our challenge to ourselves as we seek to continuously learn and improve on our approach to the provision of high quality care. Our aim being to drive the quality of our care delivery forward through the progress against those Priorities.

There will be a qualitative focus on measuring the success of our Trust Priorities this year. We will demonstrate progress and success during 2021/2022 through the alignment with our overarching Trust Vision 'to provide the best possible care to every community we serve'. Taking a qualitative approach means we can capture how our Priorities are making a difference where they matter most: in our communities.

At the end of quarter one, progress has been made against all five priorities as LCH continues to support its staff, patients and the wider health and care system in Leeds and West Yorkshire and manage the impact of the ongoing pandemic. This is an amazing achievement considering the pandemic and continued extreme pressure across the health and care system.

2 Priorities

2.1 Priority 1 - Build our services back better

Key focus 1: Reducing covid related backlogs as part of a wider programme of work to develop and embed standardised sustainable approaches to measuring, recording, reporting and managing waiting lists led by clinical assessment of need.

Improving Patient Flow and Prioritisation Programme (IPFP Programme) was fully established in Q1, led by Adam Glass. The aim of the programme is to ensure robust operational and clinical processes and capabilities to enable effective management of patient pathways and flow, leading to a sustainable and safe way of managing waiters.

The programme has four distinct projects, each with its own objectives. These are:

- Reducing COVID-created back logs
- Improving Clinical Prioritisation
- Improving Waiting List Management (IWLM)
- Developing Capacity & Demand Capabilities

Work in Q1 focussed on scoping the work for the above projects, a stocktake of the work that has already happened, establishing a robust governance framework to oversee the programme. Backlog reduction plans and associated funding requests from Business Units have been approved and will continue to be implemented in Q2. Modelling services' plans to quantify what impact they may have on the successful reduction of backlogs will continue in Q2 along with waiting list management gap analysis sessions with services.

Key focus 2: Developing and embedding new ways of working that offer different means of accessing and experiencing our services dependent on need and suitability for the patient: Digital & Self-Management.

The Digital Clinical Enablers Steering Group was established in April 2021 to drive forward the agenda around digital clinical tools to improve both the patient and clinician experience alongside improvements to the city-wide system.

Pathology/Radiology Requesting and Results (ICE) - An ICE Pathology Toolkit has been drafted to guide services through the process of using ICE to request and receive Pathology investigations electronically through SystmOne. The toolkit will sit on a MY LCH landing page along with comprehensive process maps, guides and links to training videos. A central budget has been agreed for the provision of licences.

Electronic Prescribing (EPS) - Building on the exploratory work undertaken by ICAN during 2020, a service e-Prescribing readiness checklist has been drafted. Development of the ICAN e-Prescribing formulary continues, with additional templates for the management of epilepsy and gastro-oesophageal disease underway. During May and June 2021, the Cardiac Service have established their e-Prescribing formulary, enabled quick link buttons within SystmOne and expect to go live during Q2. In June, the Virtual Ward (Frailty) became the third service to embark on their e-Prescribing journey, with the identification of service champions and initiating scoping work to develop their e-Prescribing formulary. Services have expressed a wish to implement electronic prescribing at pace, however, it has been agreed that a programmed approach is preferred, with the creation of templates, provision of staff training and agreement on the necessary safety checks and balances prior to 'go live'.

Digital Dictation - ICAN Digital Dictation roll out was completed in June 2021. A post evaluation survey will be conducted in Aug/Sept 2021. The second phase of the Digital Dictation rollout is now commencing with Gynae, Dental and CAMHS.

Voice/Speech Recognition - A Toolkit approach plan is being planned.

Self-Management - The aims of the self-management project are:

- Enhance patient experience by providing greater choice, and timely information.
- Augment treatment options available to patients through the provision of self-management materials.
- Increase service delivery capacity through enabling appropriate self-management of conditions by patients.
- Improve waiting list management for services by increasing efficiency of patient flow from point of referral to treatment.

In Q1, an external video supplier was procured to assist services in the development of patient self -management materials and information guides to support development of self-management material has been finalised and launched. The only outstanding objective of the project is the 'procurement of a Learning Management System to host content'. This has been scaled back due to a lack of financial resource. In Q2, the project team will focus on the feasibility of using the Leeds Healthcare Academy system to host some structured education content.

Key focus 3: Embedding use of Quality Impact Assessments to assess the impact of new ways of working / changes on health inequalities and ensure that mitigations are in place.

The Quality Impact Assessment process has been reviewed and revised in full and equity has been included to ensure changes in practice also consider health equity as a priority. The EQIA is now in use and monthly Executive/Assistant Director led meetings are secured in diaries for 2021. Training workshops have been held monthly across quarter one with quarterly updates being planned for new starters, those new to EQIA and for refresher if required.

The governance process has been established, all EQIA templates are recorded in the Datix Management System with a supporting administration function in the Clinical Governance Team. Quarterly reports will be initiated from July 2021 to the Quarterly Assurance and Improvement Group for oversight for all EQIA presented and reviewed in the previous quarter. EQIA panel meetings are secured in diaries every month for 2021.

2.2 Priority 2 - Play a full part in #TeamLeeds' ongoing response to Covid-19, standing ready for further surges, supporting the vaccination programme, supporting system resilience and patient flow

Key focus 1: Maintaining leadership and support for the vaccination programme.

In addition to the existing project team that includes the Senior Responsible Officer and the Programme Lead, LCH has now recruited two dedicated Project Managers and a Project Support Officer as well as an interim Programme Lead to ensure timely delivery of the vaccination programme. The next phase, phase 3, will include the booster programme. The most recent guidance specifies hard to reach cohorts and all health and social care staff will be required to have received the booster between 5 September 2021 and 15 December 2021, a fifteen-week period. Phase 3 will then be applied to the remaining cohorts with a view that the covid vaccination programme will become business as usual and potentially aligned to the annual flu campaign.

Leeds numbers:

- Vaccinated **971,852** in Leeds – Aiming to hit 1,000,000 by the end of July
- Over 533k people have had a 1st vaccination
- 87.8% of Clinical Extremely Vulnerable people (CEV) and 83.3% of 'at-risk' people have been vaccinated
- Over half of the **18-29 group (52.2%)** have now been vaccinated
- Over 438k people have now had a **2nd vaccination**
- 83.8% of CEV and 78.7% of 'at-risk' have had a 2nd vaccination

Key focus 2: Maintaining 'mutual aid' staffing arrangements that support provision of essential LCH and partner services.

A workshop was held last month with key stakeholders (including GMs, clinical leads, Workforce, Comms and BCDS representatives) to develop a culture and engagement plan to help staff be more accepting of mutual support as an approach across the organisation to bolster our resilience. This will be launched properly at Leaders Network at the end of July. The Resourcing Team's focus continues to be on maximising capacity, working closely with managers across our supply routes.

Key focus 3: Working with partners to develop / further develop and implement service developments and initiatives in the city plan that prevent admission and improve discharge from LTHT.

It's important to acknowledge that the system remains extremely pressured. LCH continues to work with and support partners across the city as outlined below to prevent hospital admission and improve discharge flow.

LCH's ODI team helped to facilitate a week-long rapid improvement workshop in June to look at the discharge pathway across the city. This is a highly complex pathway involving LCH, Leeds Teaching Hospitals NHS Trust (LTHT), Adult Social Care and third sector organisations. The workshop, which was based on lean methodology, has highlighted several PDSA cycles which will now be taken forward to help improve discharge flow and function. LCH will be specifically focussing on the referral process through SPUR and the role of Leeds Integrated Discharge Service (LIDS).

CIVAS continues to build relationships and promote integration with OPAT. A visioning day is planned for July 2021 to bring the teams together and consider learning and new ways of working from the pandemic.

During the past year, CIVAS has:

- Cared for over 200 neighbourhood team line cares and chemotherapy disconnect patients (since February). This is over 200 home visits normally allocated to Neighbourhood team.
- Seen Zolendronic Acid patients in the community, who usually go to hospital as a day case. A total of 50 vulnerable patients received this treatment in their home.
- Carried out dressings, tinzaparin administration, as well as other tasks usually carried out by the neighbourhood teams.

- Supported LTHT with the administration of antibiotic devices, as the nurses have been unable to use them. This has also reduced wasting expensive antibiotic devices.
- The team have gone above and beyond to be flexible and deliver work outside of their current pathway if they have had capacity to do so and it contributed to hospital avoidance. This includes a patient they had referred from VFW that needed IV diuretics, who would have otherwise needed to be an inpatient. This was a vulnerable person with dementia and this approach not only improved her symptoms but ensured she was safe and cared for at home.

Following a successful CCG/LCC led bid to NHSE, **HHIT** are a partner (alongside Bevan, LCC, CCG, Pathway and LYPFT) in delivering the new enhanced out of hospital care model for homeless people. Liz Keat from LCH has been appointed as the Integration Lead across the whole partnership.

Virtual Ward Respiratory – Continued integration with LTHT is resulting in more appropriate referrals and the ward now consistently reaching maximum capacity.

- In Q1 21/22, we received 128 referrals compared to 45 in the same quarter last year and received only 1 inappropriate referral.
- 16 referrals received in Q1 related to Covid O2.
- Since April 2021, we have received and accepted 27 referrals for hospital avoidance and 55 to facilitate hospital discharge and of these only 9 were admitted/readmitted to LTHT.

Virtual Ward Frailty (VWF), a collaboration between LCH, LTHT, Adult Social Care and third sector, is now embedded citywide to reduce missed opportunities for referrals. The team consists of Consultant Geriatrician, Community Matrons, Pharmacists, Nurses, therapists and support staff who provide coordinated rapid care to people in their home who are experiencing an acute medical episode[1] 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. The VWF began accepting patients in one neighbourhood in November 2019. By September 2020 it had rolled out to all neighbourhoods.

- Since the start we have received 961 referrals and accepted 758 (79%) onto the caseload.
- Patients stay on the ward on average for 4.6 days.
- The main referrers are GPs, Neighbourhood Teams, LTHT and YAS.

[1] Acute medical episode associated with falls, immobility, incontinence, side effects of medication or increased confusion e.g. infection, breathlessness

- We have met the 2-hour response target 74% of the time and estimate that we have saved 3696 bed days.
- We hold an average caseload of 28 (it has been as high as 37).

The next phase to develop more integrated enhanced community offer involving respiratory, cardiac and frailty pathways and a bid for recurrent funding has been submitted, pending sign off by Ageing Well Board at end July.

Night Care Home Pilot - Our Nights service working in partnership with Age UK Home Comfort Service to provide registered nursing support to the Age UK team working in the evening and night times. The aim is to improve patient and staff experience in evening and night time hours, promote effective joint working to make the best use of skills available to meet people's needs and ensure more people are supported in evenings and overnight including people with End of Life care and support needs, and people on Virtual Ward caseloads. A bid for recurrent funding has been submitted, pending sign off by Ageing Well Board at the end of July.

Therapy Supported Discharge - The TSD team, made up of therapists and therapy assistant practitioners, aim to facilitate patients to return home from hospital as soon and as safely as possible, and with the appropriate level of support in place, reducing the length of stay and optimising patient outcomes. The pilot continues to use a quality improvement approach of PDSA cycles to enhance learning and further development, and involves joint working between Leeds Community Healthcare (Neighbourhood Teams & LIDS), Leeds Teaching Hospitals and Leeds City Council (Adult Social Care). Previous PDSA cycles have demonstrated the following:

- A reduction in the average time from a referral being received by the Neighbourhood Team from the hospital, to the patient being discharged into the Neighbourhood Team (from 3.75 days to 0.5 days)
- A reduction in the average time between hospital discharge to therapist input (from 10.4 days to 1.3 days)
- A reduction in the average length of time a patient is on an NT case load for OT/PT input (from 86.8 days to 31.5 days)
- An increase in personalised care plans, OT functional assessment and ADL reviews to 100% of patients

The next 30-day PDSA cycle has recently commenced in July 2021, in line with recent rapid improvement work that has taken place across the system. This will test therapy supported discharge in ED at St James's, working closely with LIDS to further develop the integrated discharge function. Capacity of the TSD team is expanding following recruitment in Q1. A bid for recurrent funding has been submitted, pending sign off by Ageing Well Board at the end of July.

Stroke – Since April 2020, the Community Stroke Rehabilitation Team (CSRT) has received 843 referrals for patients that may have otherwise remained in hospital to have their rehabilitation needs met.

Once patients are accepted into the service for specialist rehabilitation, a personalised programme of inter-disciplinary treatment is developed to maximize rehabilitation potential and improve quality of life for people following a stroke and support their carers. This equates to an average of 1,051 follow up appointments per month, delivered by a variety of disciplines including Physiotherapy, Occupational Health, Speech and Language Therapy and Psychology.

During 2020/21, as part of the pandemic response, an agreement was made with the Stroke Association to increase the number of patients they would see. The criteria were widened so that all 6-month reviews and all Priority 3 patients were seen by the Stroke Association. This resulted in 275 patients accessing support through the Stroke Association in a timelier manner whilst also creating additional capacity for Priority 1 and 2 patients in CNRS.

Like many services in LCH, the Stroke Association quickly adapted and found new and innovative ways to support stroke survivors and carers and the cohort of patients that was new to them. Crucially they ensured that they continue to get the information and support they need to rebuild their lives, including:

- New resources, ‘getting online for people with Aphasia’, to help people stay connected at this time.
- New videos to help people who have had a stroke be more active at home.
- A virtual UK Stroke Assembly.
- A Here for You volunteer telephone service which provides peer support and social
- connection.
- WhatsApp peer support for carers and hosting communication support groups, exercise classes and Choir practice over Zoom.

Continuing this arrangement for the remainder of 2021/22 will allow further time to evaluate the impact this has on releasing clinical capacity and to develop a business case for 2022/23.

2.3 Priority 3 - Promote and support the health and wellbeing of our workforce

Key focus 1: Explore the health & wellbeing needs of diverse communities and groups within LCH.

During 2020/2021 there was a decrease in sickness absence levels from 5.9% to 4.7%. The most recent staff survey results, released in February 2021, highlight a reduction of over 7% in staff coming to work when feeling ill. LCH has continued to remain within sickness absence tolerance levels during Q1, with sickness rates of between 4.7% and 5.1% during the quarter, against a maximum threshold target of 5.8%.

We continue to build on the increasing segmentation and targeting of our organisational Health & Wellbeing offer, to best meet the need of our communities and groups in LCH. These measures are designed to support and understand the needs of our colleagues beyond the pandemic.

Ongoing engagement with forums including the Race Equality Network, the Shielding Group and our Podiatry staff champions; as well as the LCH Health & Wellbeing Engagement Forum itself, is assisting us in aligning our offer to the needs of specific groups.

We continue to develop our work on psychological support for staff, securing substantive employment of a clinical psychologist during Q1 as a result of the success of clinical psychology interventions during 2020/21.

Models with Clinical Psychology support as a key component of staff wellbeing programmes have been evidenced to improve staff wellbeing, sickness rates and patient care. We are working to identify and monitor impact measures of our own group and individual clinical psychology interventions, which already receive superlative qualitative feedback.

Key focus 2: Provide and expand a comprehensive Health and Well-Being offer to our staff.

Over 40 different types of emotional, psychological, physical and social interventions have been designed, developed and implemented in response to the health and wellbeing need of our LCH colleagues and create a more compassionate culture. LCH has targeted support to individuals and delivered over 60 sessions as well as working with a range of teams experiencing significant trauma such as End of Life Care and the Sudden Unexpected Death in Childhood Team.

Other interventions include:

- Space to support staff who were shielding, which led to the establishment of the shielding staff reference group.
- Continuation of a fortnightly Men's Health forum which started in July 2020.
- Introduction of clinical support to staff after serious incidents and psychological trauma.
- Establishment of a Working Parents group to deal with challenges during lockdown which was attended by over 200 parents.
- Weekly clinical drop-in sessions which supported staff and created space to talk about work pressures and emotional challenges.
- Our Freedom to Speak up Guardian and Clinical Psychologist supported staff suffering from domestic abuse and violence. Some aspects delivered by our Clinical Psychologist were supported through face-to-face visits with staff working in the community and this aided a more tailored response to those staff.
- Development of educational resources to support staff. These included Mindfulness bite-sized sessions and Acceptance and Commitment Training/Therapy. Sessions were designed and delivered to staff facing significant challenges on stress and burnout with sign posting to further support as required.
- Development of a Facebook page dedicated to Health and wellbeing with over 500 members. This continues to move from strength to strength as more staff hear about it and access the materials, resources, and signposting.

Key focus 3: Equip leaders with the appropriate skills, knowledge and confidence to hold effective health & wellbeing conversations.

Support for leaders across the organisation included creating space to talk about the challenges of managers leading staff during Covid. Children services were particularly affected with safeguarding issues, and this was supported with space to listen to and support staff. Wellbeing conversations have become integral to the appraisal process and the ongoing support of staff and teams, including during supervision.

Our LCH Leadership Programme has been developing new modules during Q1, for launch in Q2. The Programme will include modules focusing on the qualities of compassionate, inclusive leadership and the art of sensitive, curious conversations, which support effective health & wellbeing conversations.

2.4 Priority 4 - Develop integrated provision with a stronger focus on prevention, self-management and pro-active care

Please see priority 1 for an update on LCH's self-management project.

Key focus 1: Playing a full part in Leeds Integrated Care Partnership, develop collaborative governance structures and priority programmes that support our ambitions for better, more integrated care in the city

Steered by the ICP Development Board, of which the LCH Chief Executive is an active member, the Trust is involved in several workstreams to support the formation of the Integrated Care Partnership (ICP).

Membership models and governance structures are currently being shaped to adapt existing arrangements to meet the requirements of NHS Legislation. A paper is expected at LCH Trust Board in October 2021 with details of the ICP partnership agreement and proposed governance structure.

Key focus 2: Developing community offers that support people to keep well / stay at home or in the community maximising partnership working with primary care, the 3rd sector and other healthcare partners

A wide array of work continues under this overall ambition, with a clear link to the current Neighbourhood Model Transformation programme. SBU colleagues and wider stakeholders are involved in the Neighbourhood Model Transformation Programme.

- Work has been undertaken to align the Virtual Ward (Frailty) with the urgent community 2-hour crisis response service.
- Virtual Ward development continues e.g. aligning/sharing processes between frailty and respiratory wards and a future model for a cardiac pathway is in development.
- Phase 2 of the Night Care Home Response Pilot with Age UK has commenced which aims to reduce the risk of failed discharges, avoid unnecessary hospital admissions, and promote better care at home. Extension of hours for transport and settle has enabled a return home for delayed discharges and also had a positive impact for liaison and enabling transfer of care for Virtual Ward Frailty patients.
- A service position paper for the Community Cancer Support Service (CCSS) was presented to the Leeds Integrated Cancer Services Group which received positive feedback and recognition of the service impact and the need to develop a business case for wider expansion; CCSS now rolled out to 4 areas of Leeds with early learning re collaborative working with partners across the cancer care pathway and greater understanding and responding to population needs in local areas.
- Work commenced in Q1 with system partners on the next phase to develop sustainable primary care / community integrated wound clinics that drive a

consistent approach to wound care city-wide, improve quality, outcomes and resource utilisation. Integrated Wound Clinics expected to provide a blueprint for other integrated clinics e.g. catheter and line care. Initial focus has been on developing a single template for use initially across primary care and LCH, and subsequently wider partners. System digital leads have agreed to focus on the project in the next stage of work to develop information sharing across providers. To test the template in clinics in quarter 2.

- We are in the early stages of exploring innovative integrated nursing models with Morley and West Leeds PCNs and working with system partners to develop and test a MDT approach in Care Homes (e.g. a community matron working for primary care in Morley, a B6 nurse working in HATCH) to support the EHCH agenda.
- Work has continued to develop the citywide falls offer with close working between LCH and LTHT, including the development of a virtual MDT clinic and refresh of acceptance criteria.

Key focus 3: Develop more integrated working and pathways between services within and across BUs and with partners.

In Q1, LCH's Director of Nursing and AHPs has engaged extensively with GP Confed, PCN Clinical Directors and other primary care stakeholders about a draft Integrated Care proposal. The proposal sets out a shared commitment to progressing and accelerating our vision of a single community registered and non-registered workforce, across Nursing and Allied Health Professionals, and defines how we will shift to ensure we are working as one team to serve the population of the ICP. SBU General Manager attended the first ICP Mental Health Board this month. The delivery plan is currently focussed on adults but will be extended to incorporate children's. IAPT is a key programme.

ICP Priority Programmes:

- Frailty is an ICP priority regarding testing governance and has involvement from LCH/ABU colleagues to develop the approach over the coming year. LCH adopting joint approach with commissioners to develop Ageing Well implementation plan including draw down of SDF funds to invest in community services and delivery LTP priority for 21/22 – Urgent Community Response within 2 hours 7 days a week.
- End of Life care also selected as an ICP priority regarding developing an integrated community offer. ABU colleagues involved in this.
- With regards to transition, the focus for this year is the Transitions from CAMHS to Adult Mental Health Services, and the Business Unit is working with Commissioners to develop proposals for an enhanced offer and improved process within CAMHS.

First Contact Physiotherapy: LCH are currently delivering MSK FCP services in 7 PCNs. The vast majority continues to be delivered virtually, with a small number of face to face appointments available in each PCN. However, we have been approached by one PCN to increase our face to face provision and we anticipate this will be a trend across other PCNs in the coming months. The FCP network is now fully established. Work, supported by the ODI Team, in Q4 of last year has established clear principles in ways we work and provided a helpful foundation to the network. All providers are experiencing similar issues and the network is taking a collective approach to address them rather than each provider having individual conversation at PCN level. The main issues continue to be the requirements of the MSK FCP Roadmap and achieving these standards. Although the timescale has been removed, which is beneficial, we believe that without a joint strategy for the city it is unlikely providers will be able to meet the requirements without impacting the other areas of business e.g. core MSK for LCH. A paper has been developed outlining the issues and the support required from the PCNs. Conversations about the best forum to take this paper are being supported by LCH's Director of Workforce, OD & System Development.

Development of **CBU 'Communications'** and **'Behaviour' Offers** recommenced with the aim of the communications offer being launch in Q3 and behaviour offer in Q4.

Leeds Long COVID Community Rehab Service – Amazing teamwork in Leeds has been achieved in response to the rehabilitation needs of people recovering from COVID-19. Ignoring organisational barriers, a cross city, multi-organisation, multi-disciplinary team researched, created and developed a unique, integrated rehabilitation pathway focussed on and responsive to patient's needs. Team members include Primary Care, LCH, LTHT University of Leeds and Leeds City Council, providing specialist, multidisciplinary rehabilitation, assessment and intervention with support from an in-house research team. Strong multi-disciplinary leadership ensures that the service remains at the national and international cutting edge of the evolving story of Long Covid, shaping National guidance and International policy.

A business case has been submitted to the CCG requesting additional funding to enable LCH to increase capacity to meet the growing demand for this service. This would fund an increase in clinical WTEs and the introduction of new clinical (clinical fellow, CBT therapist) and operational roles.

2.5 Priority 5 - Work pro-actively across the organisation and with #TeamLeeds to understand and improve health equity

The Health Equity Strategy was approved at Board in May 2021 and will focus our efforts to work pro-actively to improve health equity.

Key focus 1. Develop focus and competencies in all services and corporate functions to understand, mitigate and reduce health inequalities in existing delivery and service change, including the robust use and review of EQIA processes

Equity will be embedded in proactive approaches within our services and corporate functions of quality, including research, evidence-based guidance and outcomes. It will be part of the review of incidents and within patient experience to understand any inequalities affecting particular communities or communities we are not hearing from and why, and act to address these.

The implementation of our new combined Equity and Quality Impact Assessment process has been completed and is now in use. This included a series of dedicated equity training workshops to ensure our teams had appropriate competency to develop the equity element of the EQIA in addition to the overarching training for the process.

Each EQIA is reviewed by a monthly Panel to ensure risks and opportunities are identified and action taken. This includes a strong focus on equity to ensure change in practice do not cause any inadvertent disadvantage. Each EQIA is considered for a review, the reviews include the use of relevant health equity data, where appropriate, to inform and reduce any potential impact and ensure appropriate mitigation is in place.

Key focus 2. Improve access to and understanding of new and emerging data to better understand, mitigate and reduce impact of service changes on health inequalities

As our Health Equity Strategy progresses, we will develop systems to routinely assess and monitor our health equity data to better understand how to utilise the information to support our communities.

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.

Population equity data is being considered within our governance reports and includes mortality review and reporting and patient safety incident review and reporting. The use of equity data in governance reports will be strengthened over the year.

Key focus 3. Improve communication and access to services through implementation of Accessible Information Standards

The communication template update as part of the Accessible Information Standard implementation is live in SystmOne. This is mandatory and will enable us to understand, flag and share people's communication needs and put actions in place to address those needs. By doing this, we will improve access, experience and outcomes for people with additional communication needs. Other clinical systems will follow.

The Patient Experience Team are supporting services across the organisation to implement the Standards and consider easy read options and support communication in different languages. Our CAMHS Team have developed east read literature to support their assessments.

There are resources available organisationally to support services develop accessible literature and posters and to support communication through interpretation services and resources.

Key focus 4. Test new partnership approaches with the 3rd Sector that drive reduction of health inequalities

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 our Specialist Business Unit with an emphasis on health equity.

We are working with the third sector more widely, utilising our third sector strategy, to improve health equity and explore new ways of working with our diverse communities. This includes working in Local Care Partnerships and school clusters to improve health equity, promoting partnership working.

Partner reviews of our progress are a key element of our partnership approach, 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.

The strategic objectives supporting this priority also include:

- Increasing our understanding of health equity in our services through improving the recording, access to and analysis of demographic data.

- Work in partnerships, including the 3rd sector and system partnerships including ICS, THIG and Synergi.
- Development and delivery of tools and resources to increase awareness and skills in identifying and addressing inequity.
- Focus on equity in quality and safety.
- Addressing inequity through person-centred care including digital access and self-management
- Testing different ways of working
- Sharing successes and progress
- Understanding the difference we are making

While not explicitly part of the Health Equity Strategy, there is also significant crossover with:

- EQIA which was rolled out in April 2020, with monthly delivery of EQIA and specific EIA information sessions delivered to staff. The EQIA review panel reviews these for assurance and to agree specific actions to mitigate risk of impact.
- The communication template update as part of the Accessible Information Standard implementation goes live on SystmOne on 19th July. This is mandatory and will enable us to understand, flag and share people's communication needs and put actions in place to address those needs. By doing this, we will improve access, experience and outcomes for people with additional communication needs. Other clinical systems will follow.
- Learning from existing third sector partnerships with Basis, Mesmac, Leeds GATE and Touchstone and others that support services to improve equity in service provision.
- Implementation of the third sector strategy. Impact on health equity is central to the four workstreams: co-production, self-management, inclusive accessible services and connecting better across LCH, and there will be a clear focus on assessing impact. The draft implementation plan is being submitted to July Business Committee for approval.

3 Recommendations

The Board is asked to agree that, in the most challenging of circumstances, staff have continued to go above and beyond during the ongoing pandemic, delivering high quality care to patients whilst delivering against the Trust priorities. They have significantly contributed to the Trust being a better provider of care, a better employer and a better partner.

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (61ai)

Title: Approved Audit Committee minutes: 16 April 2021

Category of paper: for noting
History: Audit Committee 7 June 2021

Attendance

Present:	Khalil Rehman	Chair of the Committee, Non-Executive Director
	Richard Gladman	Non-Executive Director
	Ian Lewis	Non-Executive Director
In Attendance:	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Company Secretary
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	David Robinson	Internal Audit Manager (TIAA Limited)
	Beric Dawson	Counter Fraud Specialist (TIAA Limited)
	Mark Dalton	Director for the Public Sector (Mazars)
Apologies:	Louise Stables	Assistant Manager (Mazars)
Minutes:	Liz Thornton	Board Administrator

Item: 2021-22 (1)

Discussion points:
Welcome, introductions, apologies and preliminary business

The Chair of the Committee, Non-Executive Director (KR) welcomed everyone to the meeting.

a) Apologies
All members were present.

b) Declarations of interest
The Chair of the Committee reminded the Committee that Mazars was the external auditor for East Lancashire Hospitals NHS Trust where he was also a Non-Executive Director. The Executive Director of Finance and Resources informed the Committee that Mazars was the external auditors for St Anne's Community Services where he was a Trustee.

There were no new declarations of interest made in relation to any items on the agenda for this meeting.

c) Minutes of the meeting held on 12 March 2021
The minutes of the meeting were agreed as a correct record.

d) Matters arising and review of the action log
Item 2020-21 (50c) – Head of internal audit opinion: covered by minute 3.b. **Action closed**

*Item 2020-*21 (50d) –SICA report: Senior Management Team (SMT) to be reminded about ensuring that the clinical aspects and risks are addressed when setting the scope of audits. The Executive of Finance and Resources confirmed that this had been done. **Action closed**

*Item 2020-*21 (53) – non-attendance of Clinical Governance Advisor/Clinical Safety Officer at Information Governance Group meetings: the Executive Director of Finance and Resources confirmed that steps had been taken to ensure that invitations were issued for future meetings. **Action closed.**

Item 2021-22 (2)

Discussion points:

Annual report and accounts 2020/21: progress report

The Executive Director of Finance and Resources said that all aspects were being progressed to the revised timescales for completion of the annual report and accounts and there were no significant issues to report to the Committee.

Non-Executive Director (RG) queried when the annual report and accounts would be publically available.

The Company Secretary said that these would be published on the Trust's website by the end of July 2021 and a date for the Trust Annual General Meeting had been set for the 14 September 2021 and the annual report and accounts would be presented at that meeting and available on the Trust's website.

Item 2021-22 (3)

Discussion points:
Internal Audit

a) Summary internal controls assurance report
The Internal Audit Manager introduced the report.

Completed audits
The Committee discussed the executive summary and strategic findings for the three audits completed since the last Committee meeting.

Waiting Lists
The Committee noted that this was an operational rather than an assurance review therefore no assurance assessment was required. The review had focussed on the appropriateness of the actions included within the revised procedures in place during the pandemic and the actions taken in order for a consistent approach to be employed in managing patient data and service waiting lists across the Trust. The status of the Audit had been changed from assurance to advisory in the light of the pandemic.

The Committee reviewed the findings from the review and agreed that it did not provided sufficient information or assurance that the Trust was managing waiting lists diligently enough to mitigate the risks to patients. It was suggested the Business Committee should review the audit findings and reflect on how further assurance on waiting list management could be achieved, including the value of undertaking a further audit later in 2021-22.

The Internal Audit Manager confirmed that the findings identified in the advisory review had been accepted in the management response.

Payroll
This 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 Chair of the Committee sought assurance that the core functions of the payroll system were being undertaken effectively.

The Internal Audit Manager confirmed that this was the case and he was comfortable that overall the payroll output was accurate. He added that the findings from the audit were common to audits conducted in many NHS trusts.

The Chair of the Committee suggested that in addition to a robust reminder to managers about the importance of completing forms in a timely manner they should be reminded about the potential for and quantum of overpayments which occurred as a result of the late submission of the forms.

Patient engagement
This audit had been determined **substantial assurance** with two routine recommendations related to information published on the Trust's website and promoting news of improvements following feedback from service users.

Non-Executive Director (IL) said that the audit had been reviewed in detail by the Quality Committee where the findings were welcomed as positive, noting that the implementation of the new engagement strategy had led to significant improvements. He added that the Quality Committee had raised concerns that the audit had reviewed a limited number of services and as a result the findings may not accurately reflect the position across the whole Trust.

Internal audit plan 2020-21
The Committee reviewed progress against the plan.

The Internal Audit Manager said that TIAA were committed to having all the outstanding audits completed and presented to the Committee by 7 June 2021.

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) Head of Internal Audit opinion

The Head of Internal Audit reminded the Committee that he had presented a draft end of year report at the last meeting on 12 March 2021 and the reasonable assurance opinion included as part of that report was not expected to change in light of the findings from the outstanding audits. He confirmed that the final Head of Internal Audit opinion would be presented to the Committee on 7 June 2021.

Outcome:

- the Committee noted the verbal update from the Head of Internal Audit.

c) Internal audit recommendations update

The Committee reviewed the recommendations update paper and noted that the five recommendations due for completion by the end of March 2021 had been implemented. The Committee had received an update on the three overdue recommendations relating to statutory and mandatory training at the meeting on 16 March 2021 and noted the revised completion date of 30 June 2021.

Non-Executive Director (RG) advised that the Business Committee would receive an update on the three overdue recommendations at its next meeting on 28 April 2021.

Outcome: the Committee:

- noted the update reports.

Item 2021-22 (4)

Discussion points: External audit

a) External audit progress report 2020/21 audit

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.

Outcome: the Committee

- noted the audit progress report and the assurance that work to complete the end of year audit was on track.

Item 2021-22 (5)

Discussion points: Counter fraud

a) Risk assessment and annual work plan 2021/22

The Counter Fraud Specialist presented the report which summarised counter fraud activity to be undertaken across the organisation in 2021/22 and the high level outcome of the Fraud Risk Assessment (FRA) which had been scored and RAG rated against the Trust's risk process.

The Committee reviewed the FRA outcomes noting that the assessment was that the Trust was in a good position in most risk areas. The work plan was risk-based but was also aligned to the Government functional standard, which replaced the NHS Standards for Providers from April 2021. The assessment did not identify any high risks to the Trust.

The Committee discussed that medium (amber) assessment against Covid specific risks. It was noted that the tender and waiver reports presented to the Committee at every meeting had demonstrated that the procurement rules and practices within the Trust had not been relaxed significantly during Covid but it was agreed that the potential risk of fraud in this area still existed therefore the amber rating was appropriate.

Outcome: the Committee

- noted the Fraud Risk Assessment and approved the counter fraud annual workplan for 2021/22.

Item 2021-22 (6)

Discussion points:
Governance

a) **Annual governance statement – first draft to review**

The Company Secretary presented the first draft of the annual governance statement. She explained that it was required to record the effectiveness of the stewardship of the organisation to supplement the annual report and accounts. The draft statement had been reviewed by the Senior Management Team and reflected the matters to be finalised closer to the end of the year.

Outcome: the Committee

- received and noted the first draft of the annual governance statement.

b) Audit Committee annual report 2020-21 and review of terms of reference

The Chair referred to the report prepared by the Company Secretary. This item contained the Audit Committee's annual report, the annual review of committee effectiveness, areas for future development and a review of the terms of reference.

The Committee reviewed the report and the terms of reference noting the proposed change to the terms of reference to include reference to the Committee's duties in relation to the responsibility for data security assurance.

Outcome: the Committee

- approved the Audit Committee annual report for submission to the Trust Board and endorsed the amended terms of reference for approval by the Trust Board.

c) Board and sub-committees' annual reports 2020/21

The Committee reviewed the reports for each sub-committee noting that the reports had also been reviewed by the relevant committee.

Outcome: the Committee

- noted the annual reports from the other committees and the assurances they contained, noted that any changes to the terms of reference for each committee would be approved by the Trust Board on 28 May 2021.

d) Board Assurance Framework (BAF) Strategic Risks 2021/22

The Company Secretary presented the report and explained that the content of the BAF required an annual review to ensure the strategic risks remained relevant. At its meeting on the 26 March 2021, the Trust Board had reviewed and agreed its priorities and objectives for the coming year and approved the proposed amendments to the strategic risks.

Outcome: the Committee

- noted the amendments to the strategic risks within the Board Assurance Framework..

e) Audit Committee directors' interest disclosures 2020-21

The Committee reviewed and noted the register.

Outcome:

- the directors who were members of the Audit Committee confirmed that they were content with the declarations contained in the register as presented. Only new declarations would need to be made at future meetings.

Item 2021-22 (7)

Discussion points:
Financial controls

a) Losses and special payments report

The Executive Director of Finance and Resources presented the report which covered payments made during March 2021.

He drew attention to loss 2021 -21: £88,972.09 which required Trust Board approval given the value and the Committee noted that a full report had been made to the Board meeting held on 26 March 2021 where it had been approved. The External auditors had also received a full report.

Loss 2021-22: £7,000 was a compensation payment to an employee and had been made following consultation with the Trust's lawyers.

Outcome: the Committee

- received and noted the report.

b) Tender quotations and waiver report

The Executive 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 waivers completed since the last audit committee meeting.

Outcome: the Committee:

- received and noted the report and the extract from the 2020/21 register.

Item 2021-22 (8)

Discussion points:
Sub-group minutes for noting

a) Information Governance Group minutes : 14 January 2021

The Committee reviewed the minutes.

The Committee noted the discussion about the EU Exit and the implications for the continued flow of personal data to/from EU countries after the 30 June 2021 and asked for a further update to be made available to the Committee when more clarity was available.

Action: The Committee to receive an update on the implications of EU Exit for the continued flow of personal data to/from EU countries after the 30 June 2021 when more clarity was available.

Responsible officer: Executive Director of Finance and Resources

Item 2021-22 (9)

Discussion points:
Committee's work plan

It was noted that as the Counter Fraud Risk Assessment and annual work plan had been presented at this meeting it should be removed from the meeting scheduled for 23 July 2021.

Item 2021-22 (10)

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
- Annual report and accounts 2020/21
- Board sub-committees' annual reports 2020/21
- Counter fraud risk assessment and annual work plan
- Information Governance Group – EU Exit implications for data flow post 30 June 2021

Item 2021-22 (11)

Discussion points: **Any other business**
None raised.
Date and time of next meeting 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

Trust Board Meeting held in Public: 6 August 2021

Agenda item number: 2021-22 (61aii)

Title: Approved Audit Committee minutes: 7 June 2021

Category of paper: for noting
History: Audit Committee 23 July 2021

Attendance

Present:	Khalil Rehman	Chair of the Committee, Non-Executive Director
	Richard Gladman	Non-Executive Director
	Ian Lewis	Non-Executive Director
In Attendance:	Thea Stein	Chief Executive (for Item 12)
	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Company Secretary
	Cherrine Hawkins	Deputy Director of Finance and Resources
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	David Robinson	Internal Audit Manager (TIAA Limited)
	Mark Dalton	Director Public Services (Mazars)
	Louise Stables	Assistant Manager (Mazars)
Apologies:		
Minutes:	Liz Thornton	Board Administrator

Item: 2021-22 (12)

Discussion points:

Presentation by the Chief Executive

The Chair welcomed members and attendees, particularly the Chief Executive who was attending to give her perspective on the Trust's activities and performance in the 2020/21 financial year.

In introducing her presentation, the Chief Executive said that 2020/21 had been an 'unprecedented' year in terms of the complexity; the emotion; the risk and the astounding levels of commitment towards keeping the community safe.

She began by expressing enormous thanks to each and every member of the staff across the Trust who had worked in a flexible, committed and focussed way to maintain the delivery of high quality healthcare to the community in Leeds. Whilst often dealing with personal disruption, they had individually contributed enormously to the successful delivery of community healthcare within a fast and ever-changing context. She added that the Trust had done a significant amount to support the health and wellbeing of its workforce but it was important to acknowledge that many staff were now suffering chronic fatigue and were emotionally drained. She also commended the dedication and commitment of the Senior Management Team and the work with partners across the city including local hospitals, GPs, Leeds City Council and the Clinical Commissioning Group.

She said that the Infection Control work had been an important key to community healthcare and had provided support across the whole city; the work with children had been unremitting and the commitment to a rapidly accelerating community 'end of life' service had increased by 40 per cent during the pandemic and has been both devastating and outstanding.

The Trust had worked with a wide range of partners which was best exemplified in the mobilising of vaccination clinics at the Thackray Medical Museum and Elland Road stadium and across all other areas of the city.

The work of shaping a new design for service delivery within a strong city and Integrated Care System framework was also important and the Trust had a strong and proven foundation to build from. One example was the creation of a Virtual Frailty Ward, which was 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 homes who were experiencing an acute medical episode and are living with moderate or severe frailty. As the service rolled out further the benefits to patients in terms of allowing them to remain at home and financially by reducing admissions to hospital would be significant.

Equally important were the issues of health inequalities and diversity and inclusion for the community and the workforce. These priorities, along with the emerging safeguarding demand; the deepening mental health challenge and the developing 'long Covid' priority would take centre stage in what she expected to be a challenging 2021-22.

The Chair of the Committee thanked the Chief Executive for her presentation and asked the members for their comments or questions. Both internal and external auditors indicated that the Chief Executive's presentation and the contents of the annual report showed a consistent picture with their own findings and observations of the Trust.

The Chief Executive left the meeting.

Item 2021-22 (13)

Discussion points:

Welcome, introductions, apologies and preliminary business

The Chair of the Committee, Non-Executive Director (KR) welcomed everyone to the meeting.

a) Apologies
All members were present.

b) Declarations of interest
Prior to the Committee meeting, the 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.

There were no **new** declarations of interest made in relation to any items on the Agenda for this meeting.

c) Minutes of the meeting held on 16 April 2021
The minutes of the meeting were agreed as a correct record.

d) Matters arising and review of the actions' log
There were no actions due for review at this meeting. One action remained on the log which was due for review at the meeting on 23 July 2021.

Item 2021-22 (14) – the discussion points under this Item were taken as set out in these minutes.

Discussion points:
Internal Audit

a) <u>Summary internal controls assurance (SICA) report (o/s audits 2020/21)</u>
The Internal Audit Manager introduced the report and advised that since the Committee's last formal meeting on 16 April 2021, the two remaining audits for 2020-21 for Performance Data Quality and Covid Financial Governance had been completed and the final reports issued. Both audits indicated **Substantial Assurance** opinions. The status update report on the Data Security Protection Toolkit Part One would be discussed under Item 14c.

The Committee discussed the executive summary and management action plans for the two completed audits within the report.

Performance data quality
This audit had been determined **substantial assurance** with no recommendations. Committee members asked for more clarity on the scope of the audit in relation to the key strategic findings in the report and expressed surprise about the overall substantial assurance conclusion.

The Internal Audit Manager explained that the scope of the audit had been narrow and focussed on Workforce Information performance data which fed into the Trust's integrated performance report and not the process and supporting data for all the Key Performance Indicators across the Trust.

The Committee asked the Internal Auditors to ensure that in future the scope of all audits were clearly defined to ensure that the outcomes could be clearly understood.

The Committee reviewed the audit report.

Non–Executive Director (IL) referred to the finding that it had not been possible to verify the data on staff absence. He said that as this was one of the most important KPIs for workforce then why had no recommendations resulted from it and he queried how the Committee could take substantial assurance that improvements would be made to the data production and audit trail process if there was no recommendation to follow up.

The Internal Audit Manager said that the issue related to accessing data on a 'live system' but agreed to reflect on the comments made by the Committee and provide more detail on the rationale underpinning their **substantial assurance** conclusion at the next meeting.

Action: More detail to be provided by the Workforce Directors on how they are assured of the accuracy of staff absence information and in particular on the processes the Workforce Information Team go through to verify and input data into the integrated performance brief.

Responsible officer: Executive Director of Finance and Resources

Covid financial governance
This audit had been determined **substantial assurance** with one routine recommendation that the Trust's Standing Financial Instructions (SFIs) be amended to state who may approve procurement waivers below £30K

The Executive of Finance and Resources confirmed that this recommendation had been agreed and this would be updated when the annual review of the SFIs was undertaken in July 2021.

Item 14c on the Agenda*: Data security and protection toolkit part one review*
The Internal Audit Manager explained that the report presented to the Committee was part one of a two part audit. He reported that part two of the review had been concluded since the SICA report had been drafted and subject to the inclusion of some outstanding information requested from an external provider the report was expected to conclude **Substantial Assurance**.

The Executive Director of Finance and Resources said subject to the conclusion of the report he intended to submit the return to NHS Digital to confirm that the Trust was compliant against all the standards to meet the submission deadline of 30 June 2021.

Action: Executive Director of Finance and Resources to confirm the submission to NHS Digital by email to Committee members.

Responsible Officer: Executive Director of Finance and Resources

Internal audit plan 2020/21
The Committee noted that subject to the final completion of the Data security and protection Toolkit part 2 review, all the audits had been completed and issued.

The Chair of the Committee thanked the auditors for completing their work in a timely manner despite the challenges they had faced during the year.

Outcome: the Committee:

- noted the contents of the summary internal controls assurance report and the completion of the 2020/21 plan.

b) Annual report including Head of Internal Audit opinion
The Head of Internal Audit introduced the draft annual report, he confirmed that the opinion was that based on the work undertaken in 2020/21 **reasonable assurance** could be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives. No emerging risks were identified which could have an impact on the overall effectiveness of the governance, risk and internal control framework of the organisation.

The Head of Internal Audit explained that the conclusion was based on the completion of the audit plan for 2020/21 and there were no matters to bring to the attention of the Committee.

Outcome: the Committee:

- the Head of Internal Audit opinion was noted.

Item 2021-22 (15)

Discussion points: Annual report and accounts 2020/21

a) Audit completion report ISA 260 external audit opinion (including draft letter of representation)

The Director Public Services (Mazars) presented the report which summarised the audit conclusions for year ending 31 March 2021 and he led members through the detail. He advised that the audit work had been substantially completed in respect of the financial statements for the year ended 31 March 2021. He drew attention to matters which remained outstanding which were set out in section 2 of the report and advised that an update on the outstanding issues would be provided through a follow up letter prior to signing the auditors' report. He confirmed that he expected to issue an unqualified opinion without modification on the financial statements following the Board adopting them.

In respect of the Value for Money (VFM) commentary he explained that this had not yet been included in the auditors' annual report but they anticipated having no significant weaknesses to report in relation to the arrangements that the Trust has in place to secure economy, efficiency and effectiveness in its use of resources. A further update on the VFM commentary would be made to the Committee at the next meeting on 23 July 2021.

Action: A further update on the VFM commentary to be provided to the Committee on 23 July 2021.

Responsible Officer: Director Public Services (Mazars)

The Director Public Services drew the Committee's attention to section 6 of the report which outlined the misstatements identified during the course of the audit which were above the trivial threshold for adjustment of £105k. He explained that the auditors did not agree with the management assessment and accounting treatment of the £1,124k redundancy provision for GP pharmacists which the auditors believed did not meet the requirement of IAS37 and should therefore be disclosed as a contingent liability only.

The Executive Director of Finance and Resources provided the rationale underpinning the accounting treatment of the redundancy provision and confirmed that the management view was that the effects of any uncorrected misstatements were immaterial, both individually and in aggregate, to the financial statements as a whole and did not plan to adjust in the accounts for 2020-21.

He acknowledged that the financial risk related to the redundancy provision could change during 2021-22 and provided assurance that this would be kept under review. He asked the Committee to support the management decision for 2020/21.

Outcome: the Committee

- supported the management assessment and approach to the accounting treatment of the £1,124k redundancy provision for GP pharmacist noting that this would be reviewed during 2021/22.

The Director Public Services reported that there were no other unadjusted audit differences and confirmed that the annual governance statement and the annual report had been reviewed.

The External Auditors thanked the Trust's finance team for their co-operation to complete and progress the audit work within the allocated timeframe.

The Chair of the Committee said that he was pleased and reassured to receive the satisfactory report and that this evidenced continued robust financial management during the course of the year. On behalf of the committee, the Chair thanked the new External Auditors for their hard work during the Pandemic and approach and insight into some of the issues discussed.

b) Trust's annual report 2020/21

The Executive Director of Finance and Resources introduced the draft annual report for 2020/21, and advised that the report presented at the meeting reflected the actions taken in response to the comments made by the Committee's members at the informal meeting held on 12 May 2021.

The Chair of the Committee invited the auditors to comment on the annual report.
None were made.

Non-Executive Director (IL) suggested that more information should be included about improving outcomes resulting from the development of the Virtual Frailty Ward and its benefits for patients and the city particularly in savings around hospital admissions.

The Executive Director of Finance and Resources agreed to draft a short paragraph to be included in the annual report and the external auditors agreed that they could accommodate the further change to the draft.

Action: Executive Director of Finance and Resources to draft a paragraph on the benefits due to development of the Virtual Frailty Ward for inclusion in the Trust's annual report.

Responsible officer: Executive Director of Finance and Resources.

The Chair of the Committee thanked officers for their work in drafting the annual report and noted and recognised the good work done by the Trust on the sustainability and green agenda as set out in the annual report.

Outcome: the Committee:

- noted the draft annual report, including the annual governance statement
- received assurance from external auditors that the draft annual report was compliant with guidance as set out in the manual for accounts
- recommended the draft annual report for adoption by the Board at its meeting on 11 June 2021.

c) Trust's annual accounts 2020/21

The Deputy Director of Finance and Resources introduced the annual accounts for 2020/21 and led the Committee through some of the presentational changes which had been made since the last review at the informal meeting on 12 May 2021. She explained that the annual accounts would be made available to the public as part of the Trust's annual report; the content of the report and the accounts being prescribed in the Government Accounting Manual, relevant legislation and International Financial Reporting Standards. She added that the accounts were to be presented to the Board and subsequently submitted to NHS England/ Improvement.

The Executive Director of Finance and Resources also reported that the external auditors had undertaken a detailed examination of the annual accounts and reviewed the mandatory disclosures in the annual report; their findings being contained in the Draft ISA 260 audit memorandum to Mazars audit of the 2020/21 financial statements. The report from Mazars had contained no significant issues.

The Chair of the Committee agreed that the informal meeting on 12 May 2021 had proved very helpful and thanked the Executive Director of Finance and Resources and his team for their work in producing the accounts and supporting analysis.

Outcome: the Committee

- received the annual accounts and recommended the adoption of the accounts by the Board at its meeting 11 June 2021 and the signing of the letter of representation

Item 2021-22 (16)

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:

- the annual report and accounts would appear as substantive items on the Board agenda for the meeting on Friday 11 June 2021
- external auditors confirmation that in terms of value for money, the Trust had made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2021.
- no recommendations had been made in respect of management actions.
- completion of the 2020/21 Internal Audit Plan

Item 2021-22 (17)

Discussion points:
Any other business

None raised.

Date and time of next meeting

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

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (61bi)

Title: Quality Committee minutes 24 May 2021

Category of paper: for noting

Attendance

Present:	Ian Lewis (IL)	Chair, Non-Executive Director (Chair for Items 11 to 15)
	Alison Lowe (AL)	Non-Executive Director
	Steph Lawrence	Executive Director of Nursing and AHPs (Chair for Items 16 to 20)
	Sam Prince	Executive Director of Operations
	Ruth Burnett	Executive Medical Director
	Rachel Booth (RBo)	Non-Executive Director
In Attendance:	Diane Allison	Company Secretary
	Thea Stein	Chief Executive (Items 11 to 14a)
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Brodie Clarke	Trust Chair
	Bryan Machin	Director of Finance & Resources (Item 12d)
	Hannah Beal	Clinical Lead, Children's Business Unit (Item 13a)
	Debra Gill	0-19 Head of Service, (Item 13a)
	Sarah Cooke	0-19 Clinical Change Lead (Item 13a)
Apologies:	Helen Thomson (HT)	Non-Executive Director
	Stuart Murdoch	Deputy Medical Director
Minutes:	Lisa Rollitt	PA to Executive Medical Director

Item: 2021-22 (11)

Discussion points:

(a) Welcome and introductions

The Chair welcomed members and attendees.

Apologies were noted from a Non-Executive Director (HT)

(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 26 April 2021

The minutes of the meeting held on 26 April 2021 were reviewed and agreed as an accurate record.

(d) Matters arising and review of action log

Item 2020-21(85e) Quality Account – first draft

It was noted that the item was on the agenda and the action was agreed as closed.

Item 2021-22 (2d) 0-19 Service: Immunisation programme update

It was noted that the action was included in agenda item (13a) and the action was agreed as complete.

Item 2021-22 (2e) WYOI/Adel Beck update

The update was scheduled on the agenda and the action was agreed as complete.

Item 2021-22 (2f) 0-19 PHINS offer

It was noted that the action was included in agenda item (13a) and the action was agreed as complete.

2021-22 (12)

Key issues

a) Covid-19 update

The Executive Director of Nursing and AHPs confirmed that there had been no further Covid-19 outbreaks in care homes since the update at the meeting in April 2021.

The Executive Director of Operations spoke about the current challenges in the vaccine programme. It was noted that usage of some of the venues were due to be discontinued and alternative venues were being sought in order to continue to provide vaccinations. Preparations were being put in place for surge vaccinations in the event

of cases of a new variant. It was noted that the uptake of second doses was reported to be less than the first and this was being addressed pro-actively to optimise uptake.

b) Reset and recovery update from previous month

The Executive Director of Operations gave a verbal update from the previous month, noting that a programme of work was now in place around waiting lists across the whole Trust, with a dedicated project manager to support this. There was a discussion about projections on waiting lists and the risks to people's health. It was noted that there were long waits in the Children's Business Unit (CBU) in Children's Audiology, Paediatric Neurodisability and Speech and Language Therapy services. It was expected that the recovery plan would be complete in Autumn 2021.

The Committee heard that greater assurance was expected next month around Podiatry and Dental services in the Specialist Business Unit (SBU) and the specific therapy waits in the Adults Business Unit (ABU) were to be addressed within the transformation project.

c) QAIG assurance report 20.04.2021

The Executive Medical Director presented the report and stated that, as requested by Quality Committee, analysis on the previous month's data identified that 50% of medicines incidents attributable to LCH reached the patient. This would continue to be monitored.

The committee found the more detailed narrative report helpful and it was agreed that similar reports from future meetings could be presented to Quality Committee in place of meeting minutes to ensure key issues were raised in a timely manner. It was requested that future reports should also include more specific information to provide further assurance to the Committee. The Executive Medical Director suggested that it would be helpful if at least one Non-Executive Director from Quality Committee could attend future QAIG business meetings to assist with the work to ensure the Committee received the most informative and meaningful reports to provide assurance.

It was noted that in the last QAIG workshop a deep dive was completed exploring the difference between Trust level data compared to business unit/service level data across the Specialist Business Unit. Consideration of different levels of data will be explored within QAIG work stream reports at future business meetings to ensure better conversations, triangulation, learning and quality improvement.

d) CAMHS Provider Collaborative (draft)

The Director of Finance and Resources presented the paper and described the business case to move from the current New Care Model arrangement to a Provider Collaborative led by Leeds and York Partnership Foundation Trust (LYPFT). The Committee was requested to consider the business case from the perspective of sections 2 & 3 and the model going forward. There was a discussion around the financial and quality risks and it was noted that increasing investment in to CAMHS services was expected and the financial risk was quantified in the document.

The Committee raised concerns regarding the impact of an increasing demand for in-patient beds in addition to the out of hospital pathways to maintain young people at home safely.

The Quality Committee agreed to support the Business Case for a provider collaborative.

e) Adel Beck – Ofsted/CQC Outcomes

The Executive Director of Nursing and AHPs provided an update regarding the delayed transfers of care. It was noted that this was acknowledged as a nationally challenging position. A further national conversation had taken place and plans were in place for either transfers of care or more comprehensive packages of wrap around care at home for the young people previously impacted.

It was also reported that Adel Beck had received an unannounced CQC / Ofsted inspection and had been rated overall as Outstanding, with Good for healthcare. It was noted that this had been recognised directly to the team by the Chief Executive and Trust Chair.

2020-21 (13)

Update / Spotlight : Children's Business Unit

a) 0-19 outcome update

The Executive Director of Nursing & AHPs introduced Debra Gill, 0-19 Head of Service, Sarah Cooke, 0-19 Clinical Change Lead and Hannah Beal, Clinical Lead, CBU.

The 0-19 Clinical Change Lead introduced the presentation. The Committee heard that the service was awarded a new contract in April 2019, combining three services and delivering care to over 190,000 children with an extensive public health focus.

The 0-19 Clinical Change Lead spoke about the challenges faced by the service through the pandemic with redeployment of staff whilst maintaining a service to the most vulnerable families. It was noted that the service re-set in September 2020 with catch-up contacts resulting in an extra 800 contacts whilst maintaining achievement of key performance indicators.

It was reported that 20% of children in Leeds live in poverty and strategies were employed in the delivery of projects to improve development and health outcomes.

In relation to Quality during the Covid-19 pandemic, it was noted that audits were performed to ensure vulnerable families received essential care at critical touch points; workforce development continued; pathway developments continued and the school vaccination regimes were supported.

The Executive Director of Nursing and AHPs asked the Committee to acknowledge the national workforce shortage as the above progress had taken place regardless of these challenges.

The Executive Director of Nursing and AHPs also acknowledged the work of the staff who had witnessed incredibly distressing situations in the past year, noting that specific psychological support was in place and the support from the management team was recognised.

A Non-Executive Director (RBo) commended how the service had maintained critical touch points during the Covid-19 pandemic and asked what was expected in the next 6-12 months and how it was prepared to meet the challenge. The 0-19 Clinical Change Lead stated that they expected there would be a legacy of parents who were unsure about parenting due to the lack of social contact over the last 12 months, and that it was important for the service to maintain visible contact, giving consideration to how levels of social support could be increased and working with partner agencies to deliver this.

It was also acknowledged that many families had been exposed to trauma such as bereavement, domestic violence and poverty due to loss of employment. It was also noted that the service was looking to develop the 0-7 practitioners, ensuring they would be well supported. The 0-19 Head of Service stated that staff health and wellbeing was a priority and this was being taken into consideration when planning for the future.

A Non-Executive Director (AL) spoke about children who had English as their second language and asked if there were plans to do anything differently to meet their needs in terms of heath equity. The 0-19 Clinical Change Lead confirmed that an equity appraisal had been undertaken before the reset in September 2020 to ensure that nobody was excluded. It was noted that practitioners in the areas where families were most in need had a lower caseload to ensure that more time could be given to deliver a higher level of care. It was also noted that the media (radio stations) had been used to advertise the service and open access baby hubs were being developed in the areas with families most in need, to ensure access was available without stigma.

The Executive Director of Operations stated that there was a significant challenge in that the workforce doesn't represent the people it served and there was a case for positive discrimination to ensure the workforce was more representative of the

population demographic. It was noted that the workforce plan would need to consider this.

The Executive Director of Nursing and AHPs stated that work was ongoing in the City to ensure recruitment represented all cultures, offering alternatives such as apprenticeships.

The Committee Chair stated that he would be interested to hear about the impact of this year in terms of broader public health outcomes in young people such as perinatal mortality and breastfeeding.

It was agreed that a further update would be given to the Committee in 12 months' time.

2020-21 (14)

For discussion: Quality governance and safety

a) Performance Brief and Domain reports

The Executive Director of Nursing & AHPs introduced the paper and highlighted the main issues for consideration.

A Non-Executive Director (RBo) spoke about the commentary on missed opportunities to prevent patient safety incidents and asked if this was reflective of the pressures on the services. The Executive Director of Nursing and AHPs stated that work continued to identify true root causes of missed opportunities and therefore meaningful learning from these investigations.

The Committee Chair referred to hospital discharge related incidents and asked about the learning. The Executive Director of Nursing and AHPs stated that engagement had improved with the hospital around discharge communication and actions being taken to improve care around recurring themes.

The Committee Chair asked about communication issues in the Morley Neighbourhood Team. The Executive Director of Nursing and AHPs confirmed that feedback had been shared with the Business Unit Quality Lead and the relevant teams, stating that an update on action/learning would be shared in the next Performance Brief report.

Action: Update on action/learning regarding communication issues in the Morley Neighbourhood Team to be shared in the Performance Brief report.

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 & AHPs presented the report and highlighted the updates on the actions from the overdue Serious Incidents which had not been cross referenced to Datix, and the Local Safety Standards for Invasive Procedures (LocSSIP) which arose from the previous MSK Never Event, including the development of an action plan to be embedded going forward.

It was noted that a Patient Safety Strategy Working Group had been established and are working on the implementation plan to progress the principles of the national Patient Safety Strategy and ensure the organisation is prepared for a proposed launch date of April 2022.

Clinical Leads' reports

Adult Business Unit
The Executive Director of Nursing and AHPs highlighted the work of the Neighbourhood Team Transformation Programme. The Trust Chair asked about the alignment of Neighbourhood Teams and PCNs and the benefit it would give to both. The Executive Director of Nursing and AHPs stated that the alignment was essential to look after the health of the population. The vision was for there to be one team to provide the right care. It was noted that work was underway with PCN clinical directors to ensure alignment was done in a managed way.

The Committee heard that the Virtual Frailty Ward continued to regularly support approximately 30+ patients at any one time to prevent hospital admissions. It was also noted that extended hours was now open until 8pm. The Executive Director of Operations spoke about national funding which had become available via the Ageing Well Programme. The Trust Chair asked about further development of the virtual ward proposition. The Executive Director of Nursing and AHPs stated that conversations were taking place around cardiac service. The Executive Director of Operations stated that the Trust would like to see the skills in the virtual wards embedded in the comprehensive Neighbourhood Team offer.

The Trust Chair referred to self-management and asked about the scope for this to continue the positive work so far. The Executive Director of Nursing and AHPs stated that a particular focus on embedding the ethos of self-management was needed.

Children's Business Unit
The Executive Director of Nursing and AHPs highlighted the update around schools and the work which was taking place now that they had reopened.

It was noted that several members of clinical staff had to attend court proceedings and the extensive support from the Safeguarding Team was acknowledged.

It was also noted that 0-19 PHINS held a celebration event to mark the success of the pilot "Facemums", which had received great feedback from both practitioners and families.

Specialist Business Unit
The Executive Director of Nursing and AHPs spoke about the changes to the Operational and Clinical Leadership in the business unit.

The Executive Director of Nursing and AHPs highlighted positive patient feedback which had been received by Podiatry and Wetherby YOI.

c) Neighbourhood Team Triangulation report

The paper was presented by the Executive Director of Nursing & AHPs and Executive Director of Operations.

The Committee Chair commented that the report reflected the impact of the Covid-19 pandemic.

The Executive Director of Operations spoke about the waterfall data, which showed a very small gap in funded versus utilised staffing levels, and the referral data which was beginning to show an upward trend which may reflect the lived experience reported by staff.

It was noted that conversations were ongoing with Commissioners in relation to preparations for Winter 2021 and what would need to be put in place now to ensure an effective community response. The Trust has been asked to create a business case to identify how it could extend capacity in the community.

It was noted that the complexity tool was being trialled in the Trust and the involvement in a national pilot of a community safer staffing tool would help to better understand patient dependency.

The Trust Chair referred to the increase in the number of incidents per 1000 face to face contacts for all Neighbourhood Teams in the last two quarters and asked if this was concerning. The Executive Director of Nursing and AHPs stated that these were the no and low harm incidents, and the reporting of these would lead to learning, preventing escalation to more serious harm. It was also identified that the analysis of the data was able to provide information on low reporting teams. It was agreed that identification of low and no harm incidents on the chart would be helpful.

The Trust Chair spoke about delayed appraisals and asked if there was a Trust solution to manage this. The Executive Director of Nursing and AHPs stated that work was ongoing to address the issue.

The Trust Chair commented that it would be helpful to review the key indicators, suggesting that heat mapping would be helpful. The Executive Director of Operations stated that the Business Intelligence team were working on this and would pick up more indicators than were included in this report.

A Non-Executive Director (RBo) asked about the drop in training levels, particularly Health and Safety training. The Executive Director of Nursing and AHPs stated that work was ongoing to ensure the training would be completed.

d) Quality Priorities & Quality Account update

The Executive Director of Nursing and AHPs presented the update and it was noted that the bringing forward of a revised timeframe for completion of the 2020-21 Quality Account, at short notice, had resulted in the Account being reviewed offline by Committee members. It was noted that feedback had been provided to the author specifically in relation to setting the Account in the context of Covid-19. It was also noted that given the impact of the pandemic, an annual summary of the Quality priorities would also be included in the Quality Account and presented to Board in June 2021.

e) Quality Improvement Plan

The paper was presented by the Executive Director of Nursing and AHPs.

The Committee Chair asked about the action relating to the ratification of the revised ligature policy. It was noted that in light of the ongoing review of the CQC ligature guidance, it had been agreed to ratify the policy in June 2021, acknowledging amendments may be required once the CQC guidance was updated and re-published. The approach was agreed by the Quality Committee, acknowledging that the Trust was following current guidance and had plans to review this once the CQC had re-published the updated guidance. The Committee agreed to the closing of the 'should do' action, which was noted as complete.

f) Risk Register

The paper was presented by the Company Secretary highlighting one extreme risk related to delayed transfers of care in Adel Beck/WYOI. It was noted that this was under review in view of additional mitigation and the score was to reduce before the next Quality Committee meeting.

The Company Secretary also commented on one new operational risk which had clinical implications and was being assessed and added to the risk register regarding the Leeds Community Equipment Service budget limitations and the impact on patients in the community receiving equipment, noting that this was being worked through.

g) Mortality Report (Q4 and annual)

The Executive Medical Director presented the QAIG Quarter 4 report, proposing that this would be the format for quarterly reports going forward.

The Executive Medical Director presented the Trust annual summary, noting the volume of workload on NTs above and beyond the pressures of the pandemic and commended the Adult Business Unit for maintaining the high level of preferred place of death.

It was highlighted that there were no lapses of care identified. The Committee Chair questioned this and the Executive Medical Director clarified that learning was available

through the reviews, for example, communication, but there were no fundamental clinical lapses in care that caused the death of our patients.

There was a discussion about the level of assurance provided through mortality reviews which looked at end of life care only. The Assistant Director of Nursing and Clinical Governance stated that there had been an increase in the number of unexpected deaths being reviewed in the 72 hour review process. Mortality cases were being scrutinised by this process outside of the mortality review process where there was any concerns in relation to the broader care delivered.

It was recognised that differences in BME and deprivation were evident in the mortality data and it acknowledged that there was more work to do to generate meaningful analysis.

h) Internal audit: Children's Safeguarding
The report was presented by the Executive Director of Nursing & AHPs demonstrating substantial assurance with no recommendations. The report was positively received by the Committee.

2020-21 (15)

For approval: Clinical Effectiveness

a) Patient Group Directions
The Committee received and ratified the Patient Group Directions.

b) NICE Guidance compliance update
The Executive Medical Director presented the paper and informed the Committee that responsibility had passed to the Clinical Governance Team from Medicines Management.

The Executive Medical Director asked the Committee to note that whilst assessment of compliance with the guidance had been completed at the point of publication, robust embedding of improvements and assurance of compliance had been delayed by the pandemic, but this was being progressed. The Committee Chair commented that progress by service was not included as had been in previous reports. The Executive Medical Director agreed to discuss this with the author of the report to ensure this was added going forwards.

Action: Future reports to include progress by service to provide position of non-compliance by 2 years

Actionee: Executive Medical Director

c) Outcome measures update and forward plan
The paper was presented by the Executive Medical Director alongside a proposal that this would be the last separate report to Quality Committee as Outcomes were embedded in to ongoing business as usual.

The significant progress was recognised. There was a discussion about how QAIG reports Outcomes information to Quality Committee. It was agreed that the Committee would receive the QAIG quarterly assurance reports going forwards and there would be further conversations / workshop to ensure appropriate assurance around Outcomes.

Action: Consideration to be given to how Outcomes data, which is now business as usual, is reported to Quality Committee

Actionee: Executive Medical Director

2020-21 (16)

For noting and any questions: Sub Group minutes

a) QAIG minutes: 20.04.2021
The Committee received the minutes.

b) Safeguarding Children's and Adults Group minutes: 22.04.2021
The Committee received the minutes. The Executive Director of Nursing and AHPs highlighted the following items for escalation to Quality Committee:

- Front Door and capacity of the 0-19 Service to support that
- Conversation around Domestic Violence and men
- LMWS PCMISS issue to be raised on risk register
- PREVENT update

c) Mental Health Act Governance Group minutes: 23.04.2021
The Committee received the minutes.

The Executive Director of Nursing & AHPs stated that these would be the last minutes from this group as it had now been handed over to LYPFT with the move of Little Woodhouse Hall. It was reported that any Community CAMHS issues would be fed in to the Safeguarding Committee for escalation to Quality Committee as required.

d) CCG Clinical Quality Review Group minutes: 08.03.2021
The Committee received the minutes.

The Executive Director of Nursing and AHPs reported that this was the last meeting in this format at conversations continued throughout the City to improve this for the future.

2021-22 (17)

Quality Committee work plan

a) Work plan
The Committee received the up to date work plan.

2021-22 (18)

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, with substantial assurance noted for the following items:

- Internal audit: Children's Safeguarding
- 0-19 Outcome update
- Self-management
- Virtual Ward Frailty

2021-22 (19)

Reflections on Committee meeting

The Trust Chair asked for feedback on the meeting. It was agree that the Committee was content with the progress through the issues and papers.

2020-21 (20)

Any other business

There was no further business discussed.

Date and time of next meeting

Monday 21 June 2021 9.30am – 12.30pm (Via MS Teams)

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 6 August 2021

Agenda item number: 2021-22 (61bii)

Title: Approved Quality Committee minutes 21 June 2021

Category of paper: for noting

Attendance

Present:	Helen Thomson (HT)	Chair, Non-Executive Director
	Ian Lewis (IL)	Non-Executive Director
	Steph Lawrence	Executive Director of Nursing and AHPs
	Sam Prince	Executive Director of Operations
	Ruth Burnett	Executive Medical Director
	Rachel Booth (RBo)	Non-Executive Director
In Attendance:	Diane Allison	Company Secretary
	Thea Stein	Chief Executive (Items 11 to 14a)
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Kim Taylor	Team Co-ordinator, Adult Speech and Language Therapy (Item 23a)
	Dorothy Wilson	Clinical Lead, Adult Speech and Language Therapy (Item 23a)
Observing:	Nicola Copley	Interim Head of Portfolio 2, SBU
Apologies:	Alison Lowe (AL)	Non-Executive Director
	Stuart Murdoch	Deputy Medical Director
Minutes:	Lisa Rollitt	PA to Executive Medical Director

Item: 2021-22 (21)

Discussion points:

(a) Welcome and introductions

The Chair welcomed members and attendees.

Apologies were noted from the Trust Chair.

(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 24 May 2021

The minutes of the meeting held on 24 May 2021 were reviewed and agreed as an accurate record.

(d) Matters arising and review of action log

2021/22 (15b) NICE Guidance compliance update

The Executive Medical Director updated that work was underway to give a more detailed update in regards to services who had not met full compliance. A paper would be presented to the next QAIG business meeting, including updates by business unit to identify trends.

The action was agreed as complete.

2021/22 (15c) Outcome measures update and forward plan

The Executive Medical Director updated the Committee, stating that it had been agreed to continue to report Outcome measures as a separate paper.

The action was agreed as complete.

Board required action from 28/05/2021

The Executive Director of Nursing and AHPs stated that the number of major amputations had decreased, and the number of minor amputations had slightly increased. A full presentation of detailed findings would be presented to the Committee in September 2021. It was suggested that partners from LTHT could be involved in the presentation.

The deadline for the action was amended from July to September 2021.

2021-22 (22)

Key issues

a) Escalation of key issues from QAIG

The Executive Director of Nursing and AHPs gave a verbal update on the most recent workshop which focussed on learning and development. The primary area being progressed was around how the Trust could get more students (Nursing, AHPs and Medical) in to its services through new and creative approaches to placements across LCH and Primary Care.

b) Closed culture progress

A verbal update was provided by the Executive Director of Nursing and AHPs around ongoing work to identify and address closed cultures across the Trust to prevent it becoming an issue.

This work would include some slight amendments to the Quality Walk questions, ensuring that staff are given an opportunity to speak without a manager present as well as speaking to managers. There would also be changes to the performance and workforce dashboard to support triangulation of data to raise early indicators.

A Non-Executive Director (RBo) asked if staff grievances had been considered. The Executive Director of Nursing and AHPs replied that this had been considered and would be included in the work, ensuring that this information would be treated as confidential.

It was noted that there was an anticipated timeframe for 2-3 months for the updated dashboard to be completed and it was agreed that an update would be provided to the Committee in September 2021.

It was agreed that involvement with Non-Executive Directors would be beneficial.

There was a discussion about collection of data, and the importance of ensuring that it is qualitative.

A Non-Executive Director (RBo) asked if the work on leadership would be picked up in the workstreams, the Executive Director of Nursing and AHPs confirmed that this was the case.

Action: Update on closed culture progress to be provided to the Committee in September 2021.

Actionee: Executive Director of Nursing and AHPs

c) Covid-19 update including Delta variant update

The Executive Director of Operations stated that transmission rates were increasing in Leeds, with some areas of concern reporting over 600 cases per 100k. It was noted that in these areas, there had been an enhanced testing and vaccination approach, with walk in vaccination centres. The Committee heard that 40k of those not yet vaccinated were in the most vulnerable cohorts. It was also noted that the biggest

growth of positive cases was being reported in 18-24 year olds which would, in turn, pose a danger to the vulnerable groups.

It was noted that there was currently no significant impact on hospital admissions with evidence showing that the second vaccine was fundamental in preventing admissions.

The Committee Chair referred to the 40k people not yet vaccinated and asked if this was concentrated in Leeds, or was more widespread. The Executive Director of Operations stated that they were identified as being in areas of higher deprivation and work was underway to consider how these groups could be given confidence to come forward for vaccination.

The Chief Executive asked how the programme was managing with the vaccination of over 18 year olds. The Executive Director of Operations commented that although the Elland Road vaccination centre would be closing on 31st July 2021, this would be replaced with a marquee in the grounds and satellite centres would be opened to replace the PCN sites that were due to close.

A Non-Executive Director (Rbo) asked about the possibility of children receiving the vaccination. The Executive Director of Operations stated that the Autumn programme (October 2021 to January 2022) was still being worked through and a decision had not been made as to whether it was appropriate to vaccinate 12-18 year olds However, if this was the case, it was assumed that it would be included in the school vaccinations programme.

d) Reset and recovery update from last month

The Executive Director of Operations asked the Committee to note that an extended performance panel was scheduled for 9 July 2021 to focus on each service's backlog position. It was also noted that the Trust had set an ambition to have all backlogs cleared by September 2021 if possible, before heading in to winter, but definitely by the end of the calendar year. A more detailed update would be provided to the Committee in July 2021.

Action: Update on work to address service backlogs to be provided to the Committee in July 2021

Actionee: Executive Director of Operations.

2020-21 (23)

Spotlight : Specialist Business Unit

a) Adult Speech and Language Therapy (SALT): urgent referral pathway

The Executive Director of Nursing & AHPs introduced the presentation by the Adult Speech & Swallowing Team.

The Team Co-ordinator, SALT presented an overview of the citywide service, including current staffing and the nature of referrals. The Committee heard that not all referrals were accepted, noting that rejection of referrals had increased from 10% in 2019/20 to 20% in 2020/21, highlighting a need for accurate marketing of the service. Referrals are triaged through a clinical prioritisation tool into urgent or routine categories, defined by medical risk.

It was noted that therapists from the service were often the first contact with patients resulting in slightly longer and complicated consultations which had impacted on clinical admin time.

The Team Co-ordinator spoke about the concerns identified in the service, noting that urgent referrals had increased in 2020/21, and on review of capacity and demand, shortfalls in relation to the 2 week response time for urgent patients and 6 weeks for routine had been identified. Collaboration with Business Intelligence had enabled a detailed exploration of data to support a successful response to urgent referrals.

The Clinical Lead, SALT spoke about the ongoing challenges in relation to referrals and the capacity to meet the routine demand. Initiatives included re-referral for patients who had deteriorated so they were seen on an urgent pathway, and a duty line for care homes had been implemented.

The Clinical Lead, SALT expressed concern that the service was working at OPEL Level 3, which had resulted in an impact on response times and a lack of service development.

It was highlighted that vacancies for temporary staff were not attracting applications for Band 6 posts. The Executive Director of Operations asked about the availability of staff if the posts were permanent; stating that she wished to receive assurance that everything had been done from a housekeeping point of view to ensure that that an additional permanent member of staff would meet the demand. It was noted that a business case was being produced which would address this.

In response to a question from a Non-Executive Director (RBo), it was noted that data had evidenced an increase in urgent referrals before the Covid-19 pandemic.

The Executive Director of Operations referred to a comment about patients waiting over 52 weeks and queried this, stating that it should be reported as a never event. It was agreed that further conversations would be taken forward with the Executive Director of Operations in relation to the 52 week waits, productivity and efficiency in the service. Feedback would be provided to the next Committee.

Action: Further conversations to be taken forward in relation to the 52 week waits, productivity and efficiency in the service, with feedback to be provided to the next Committee meeting.

Actionee: Executive Director of Operations

2020-21 (24)

For discussion: Quality governance and safety

a) Risk Register

The paper was presented by the Company Secretary highlighting that there were three new risks, two escalated and two de-escalated risks.

Risk 1047: Volume of Callers into the Leeds Sexual Health Appointment Line

The Executive Director of Operations commented that a way to look at unanswered calls had been identified. Although there were currently a limited number of lines, a new telephony system was due to be implemented which should mitigate the risk.

Risk 1041: PCMIS (patient information system) used by Leeds Mental Wellbeing Service (LMWS) does not have the functionality to run a system capture of all safeguarding cases.
In response to a query from a Non-Executive Director (RBo) the Executive Director of Nursing and AHPs, clarified that the cases were not captured in PCMIS, so the risk was due to the inability to safely share the data with clinicians. It was hoped that this would be resolved within 4-6 weeks.

Risk 954: Diabetes Service waiting times
The Committee Chair referred to the expected date to reach target as the end of the calendar year, and asked for comment. The Executive Director of Operations stated that this was a potential risk. The Executive Director of Nursing and AHPs agreed, stating that the risk was around a vacancy which would hopefully be filled. The Committee Chair commented that it was important to ensure that the wording was correct.

Risk 957: Increase in demand for the Adult Speech and Language Therapy Service
It was noted that an update documenting an action plan had been added to Datix; however the risk had been escalated as the action plan would need to be embedded before reducing the risk score. It was also noted that the expected date to reach the target or reduction score would be added.

A Non-Executive Director (IL) expressed concern about the risk score, suggesting that it was a risk that the Board should be aware of. The Company Secretary stated that the risk would be captured in the next Board report.

It was agreed that the language and whole process needed to be reviewed as to how it would be presented to Board.

Action: Risk 957 to be reviewed to ensure it is highlighted correctly to the Board

Actionee(s): Executive Director of Operations and Executive Director of Nursing and AHPs

There was a discussion around the scoring of risks. The Company Secretary reminded the Committee of the process of adding risks to the risk register, which had recently been reiterated. The Company Secretary stated that some of the new risks may not have been captured in the process, but was hopeful that the quality of risk scores, quality and controls would be improved.

Risk 1002: Coronavirus (Covid-19) increased spread of infection
It was noted that this risk would be reviewed, considering the Delta variant.

2020-21 (25): Policies and reports for approval or noting

a) Safeguarding strategy update

The Executive Director of Nursing and AHPs introduced Lynne Chambers, Head of Safeguarding who presented the Safeguarding strategy update.

The Chief Executive commented that it was a very positive paper, but asked the Head of Safeguarding what worried her. The Head of Safeguarding stated that currently the Trust had 22 people trained and able to offer safeguarding supervision training to adult services and this number of trainers would need to continue to increase, so a plan was required to address this.

The Executive Director of Nursing and AHPs stated that she was not worried about the internal Safeguarding team as it was excellently led and had adapted well during the Covid-19 pandemic. The main concerns were around capacity, the increased number of safeguarding incidents and the number of reviews asked to participate in.

A Non-Executive Director (RBo) asked about how duty of candour fitted in and what was hoped to be achieved in the next steps phase. The Head of Safeguarding stated that in terms of Duty of Candour, raising awareness of this in policies and procedures was important. The Committee heard that a large piece of work was underway looking at self-neglect, with the development of an exceptional risk forum.

A Non-Executive Director (IL) asked about the Children Looked After service area changes and the impact of this. It was noted that the geographical changes in service areas had had no detrimental effect on children, and service provision was maintained by the most appropriate geographically located service.

The Non-Executive Director (IL) asked about improving health outcomes for the children. The Executive Director of Nursing and AHPs stated that this was reported in performance panels, and agreed that there was work to be done to improve how it feeds back into safeguarding.

2021-22 (26)

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. Limited assurance was noted for the Adult SALT urgent referral pathway based on the evidence presented and substantial assurance was noted for the Safeguarding strategy update.

2021-22 (27)

Reflections on Committee meeting

The Trust Chair asked for feedback on the meeting.

A Non-Executive Director (IL) commented that the remaining time could have been used for an extra deep dive or workshop. The Executive Director of Nursing and AHPs stated that this was the first time a workshop had been undertaken virtually and going forwards, it should be possible to cover more services.

There was a discussion about the presentation of data from business units. It was noted that work was underway to provide succinct yet consistent data to the Committee.

2020-21 (28)
Any other business There was no further business discussed.
Date and time of next meeting Monday 26 July 2021 9.30am – 12.30pm (Via MS Teams)

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 26 May 2021 (9.00 am to 11.30 am)

Present:	Richard Gladman (Chair)	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman	Non-Executive Director (KR)
Attendance:	Laura Smith	Director of Workforce
	Diane Allison	Company Secretary
	Sara Clarke	Service Manager (CAMHS) – for item (11) only
	Catherine Chadwick	Senior Clinical Nurse Specialist (for item (11)
	Kate Burns	Service Manager (CAMHS)–for item (11) only
	Emma Bolton	Associate Director of Estates–for item (12b) only
Apologies:	Helen Thomson	Non-Executive Director (HT)
Note Taker:	Ranjit Lall	PA to the Exec Director of Finance & Resources

Item 2021/22 (10): 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. In addition the members reviewed the Committee's declaration report (item 6) and noted the declarations made for future reference.

c) Minutes of meeting dated 28 April 2021
The minutes of meeting dated 28 April 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 the updates.

Item 2021/22 (11): Service spotlight

Discussion point:

Child and Adolescent Mental Health Service (CAMHS)
Community transformation programme
The Committee Chair welcomed representatives from the CAMHS team to the meeting. A presentation had been circulated previously for information relating to today's service spotlight. The following is a summary of the progress made and key points noted.

The CAMHS transformation programme was set up over a year ago. The clinical engagement, clinical leadership and co-production had become the cornerstone and continue to guide other work in the service. The model focused mainly on co-produced services between clinical and operational and also engagement with patients and families influencing the development of care plan documents.

An emotions disorder pathway was the result of transformation workshops led and held by the clinicians, and understanding the service moving forward to meet the needs of young people and their families. Another option being considered was the rolling out of group therapy run by clinical staff. The Service Manager said that funding was being made available for children's mental health service therefore it was important to be prepared to apply for the funding.

The Executive Director of Operations said that she wanted to remind the Committee members about the challenges that remain in the CAMHS service about re-designing pathways for young people to access services quickly.

The Executive Director of Finance and Resources said that there was a further link to this service through the transformation programme and certainly a priority for the Provider Collaborative in order to prevent unnecessary admissions or unnecessarily long length of stay to manage beds at Red Kite View. He was concerned about the workforce constraints rather than funding over the next few years. It was noted that the recruitment campaign into Red Kite View was a priority and the aim was to make roles as attractive as possible, by working with universities on building those relationships and raising awareness but was advised that recruitment across the board into the Children's Business Unit was difficult. There was active support for newly qualified nurses, clear career progression and in-house management programmes.

The Chief Executive said that the service was harnessing the creativity of families and children and aiming for excellence in care which she felt was happening but noted it was challenging as demand was growing.

Work was focused on the care co-ordination across specialist clinicians, making care more efficient and meeting the immediate needs of those more complex young people presented with high risk.

In respond to the Chief Executives question about networking with other partners in the city, it was confirmed that work was in progress across the systems and other wider ICS work streams. The Chief Executive and the Executive Director of Operations offered their support if needed when working with partners.

The Director of Workforce (LS) was content with the progress being made, particularly about the aspirations of growing own workforce and supporting people into leadership roles. She said the new workforce strategy for the organisation was being launched in late autumn and she was happy to involve the CAMHS service in terms of leadership offer particularly to middle and new managers to make sure it fits with the needs of CAMHS.

In terms of co-production, there was involvement of patients, parents and then working with Commissioners on improvements. A number of families were invited into the original workshops to contribute to discussions, to create the care plan and then map the journey through the service. The Executive Director of Operations said that they had not experienced co-production with Commissioners yet. She said the offer going forward was very much based on co-production and a joint effort approach.

A Non-Executive Director (KR) asked how success would be measured and the Executive Director of Operations said that this would be through monitoring waiting times and outcomes. She said the service have had a very structured approach to outcomes as it was incorporated into the care plan, routinely right from the start so that the data could be extracted directly.

The Committee Chair thanked the CAMHS team for sharing their success story. The service was set for the future in terms of co-production and the availability of further funding. He said that other services could learn from how the clinicians had worked together with the operational people and had come up with creative ways of improving care.

Item 2021/22 (12): Strategy

Discussion points:

a) Review of planning priorities 2021/22

The Committee received a summary of the Trust's planning priorities which included a read across to national NHS priorities for 2021/22, West Yorkshire Integrated Care System priorities, and the Leeds 'Place' aims. The conclusion drawn was that there were no obvious alignment gaps in the Trust's priorities.

The Committee Chair said that in previous times the Trust would create an annual business plan with specific targets and objectives and then measure against those targets during the year, and asked whether previous targets and goals were to be refreshed. The Executive Director of Finance and Resources said that they would perhaps not be measured in the same way this year. There was going to be more narrative on progression and aligning key performance indicators to reset the recovery programme and half way through the year there would be a check on progress against the priorities to make sure things were on the right track.

Action:

The Senior Management Team would be monitoring and reporting back to the Committee in September 2021 on business planning and business reporting framework for this financial year.

Outcome:

The Committee noted the summary of plans presented and confirmed that no changes were required to the Trust's priorities for the year.

b) Estates strategy update

The Associate Director of Estates was welcomed to the meeting. The Committee received an overview of the key highlights in the estates strategy update. In terms of strategy refresh the original vision and aims were still appropriate and carrying on with business as usual.

Some of the work that was progressing was aligned to the Trust's service strategy in conjunction with clinical teams so that the estate provided met clinical and patient needs, and that the estate was located in the right place for patients. This would provide a better understanding of how services could be provided in the future, considering all the different models of care delivery over the pandemic period.

A key piece of work on the preferred operating model was being matched to the estate provision with a short, medium and long term plan. This piece of work was being completed by the end of July 2021 as part of the next phase of the strategy going forward.

The Committee Chair said that the work around services and their future requirements looked interesting and asked about the timeframe in order to be able to do the next iteration of the estate strategy including feed in from overall workforce policy on the combination of where people are working. The Associate Director of Estates said that this was a very much a service led piece of work and she envisaged completion by end of summer 2021 before producing the refreshed estate strategy. She said a lot of this information was in the old strategy which would be lifted out and included into the new refreshed strategy rather than a whole rewrite. The Workforce Director (LS) said that she was working with the Associate Director of Estates to take into account the inspiration towards hybrid working and blended model of home working.

The Committee was advised that part of co-production work with other partners in the city, the estate strategy was aligned to stakeholder meetings with the Clinical Commissioning Group, City Council and Leeds Teaching Hospitals NHS Trust.

Outcome:
The work was continuing to take in analysis and input from others for another few months before a draft estate strategy was to be brought back to the Committee in autumn.

c) Sustainability annual report
The Executive Director of Operations introduced the first annual report on sustainability. In 2020, during the height of the pandemic the Trust approved its first Sustainable Development Management Plan and the annual report demonstrated progress in establishing projects to begin to reduce carbon emissions. The metrics show that carbon emissions from travel and electricity reduced in 2020/21, probably linked to the increase in home working.

The Committee was advised that the size and ambition of the 2021/22 sustainability plan was still being finalised with stakeholders, but it was proposed that this was to be challenged and influenced by a Board workshop.

The Executive Director of Operations said the changes were small scale changes and going forward she expected that to grow. The Chief Executive said that as a health organisation the hybrid working policy, the estate policy, and the sustainability policy were all coming together.

The Committee recommended that expectations should be managed by determining actions that could reasonably be achieved in year.

Outcome:
The Committee received the annual report to note and was looking forward to seeing further updates in the future.

Item 2021/22 (13): Covid and Reset and Recovery

Discussion points:

a) Covid update
The Committee received an update on the infection rate in the city; currently at 38.7 per one hundred thousand and for the over 60's the rate was now 7.5 equating to 12 weekly cases. The Committee was advised that there were currently 10 people with Covid positive in hospital and less than 3 people in intensive care.

The Executive Director of Operations advised the Committee that the wider health system was under a lot of pressure at the moment. The Yorkshire Ambulance Service has had a

30% increase in calls, the primary care system was under pressure, and the Community Trust was at OPEL 3. Leeds Teaching Hospitals Trust was reporting higher than ever attendances at the accident and emergency and Leeds, York Partnership Foundation Trust were boarding a number of people in out of area placements. The Executive Director of Operations suggested this pressure may be the result of patients emerging from the pandemic period and actively seeking care or because of people going to A&E for face to face assurance as opposed to digital interactions.

In terms of the vaccination programme, 420k people had received their first dose and 300k have had both doses.

The booking system had now opened up to 30+ age group from today (26.05.22). The programme itself has had a number of challenges due to the pressure on the primary care network participating on top of already busy primary care system. Currently new venues for vaccinating were being sought. It was noted that there were no issues with vaccination supply.

b) (i) Reset and Recovery update
The Executive Director of Operations said that the reset and recovery update was part of a number of papers on today's agenda and the first one was the major change programme covering the work on waiting lists.

(ii) Neighbourhood teams transformation programme
This is a programme of work to ensure the neighbourhood model was effective, efficient and adaptable in order to provide high quality care for all patients and enable an outstanding and satisfying work experience for all staff

The presentation outlined the importance of working together with each work area having a Project Initiation Document with objectives, success measures, risks and mitigations that had been identified through the working groups and co-produced with staff. A number of priorities included the digital offer focusing on the EPR element of an electronic allocation tool to free up time to provide more care and the health and wellbeing of staff.

The Executive Director of Finance and Resources said it was good to see a number of areas broken down into priorities and potential finance costs for one of the allocation options. He said a lot of the input was from people already within the Trust and asked whether any different opinions on how things might work were sought from outside of the Trust. The Executive Director of Operations said that a number of virtual site visits took place to see how people used EPR allocation tools. She also said that a number of people had come from different organisations that had brought with them their knowledge and experience to the Trust.

A Non-Executive Director (KR) said that outside observations reinforce external best practice and its innovation. He said he would welcome any feedback on any inspiration taken or on reviewed models elsewhere. He also asked about ways of communicating success measures and failures so that the services do not lose sight of what can actually be achieved within the next 24 month period.

The Chief Executive said it was the right thing to do for both staff and patients. She said there should be something in the set up that demonstrated how the patient's voice was being listened to. The Chief Executive continued to say that Health Watch video was a good place to build on and can be powerful and interesting to see, including details of complaints and information over the last two years would be helpful.

The Committee Chair thanked the Executive Director of Operations for sharing her well planned work and was looking forward to receiving regular reporting as part of governance.

Item 2021/22 (14): Change Programme

Discussion points:

a) Major change projects

The focus of the meeting was on the transformational programmes of work including Community CAMHS, Neighbourhood Teams, Electronic Patient Records, and a suite of projects within the Reset and Recovery programme.

The Committee agreed that there was some encouraging co-produced, transformational work ongoing and it looked forward to receiving further updates on progress. The Committee also received an update on the Estate Strategy, which will be refreshed later in the year. Clinical teams were being consulted to ensure that the estate was fit for delivering the services needed in the future.

The Executive Director of Operations focused on improving flow and prioritisation of waiting list work. Funding had been identified to address significant scale areas of waiting list backlogs. A scoping document from children's business unit had been produced. However, there was a small element of backlog in adults around the Continence, Urology and Colorectal service and the waiting list in the specialist business unit was still being analysed. The Executive Director of Operations said that this was the immediate piece of work for the programme. The remaining work was to make sure that all foundations were right going forward.

The Executive Director of Operations explained how the programme was being managed with a good resource of support for all of this work. She said that during the pandemic a number of staff with expertise was brought together who had a project management or a business management aspect of in their roles into a one team. This substantive team was now called the Business Change and Development Service.

Further discussions were being held by the Senior Management Team about project governance and change associated with new business growth.

A Non-Executive Director (KR) said that the governance or programme management was useful for this journey but the other area of focus for him was the 'so what?' aspect of the project management, relating to transformation with demand and needs and capacity and linking back to finances and opportunities. How the transformation would essentially recognise scope for growth in some areas and not so much in other areas. He said that this was what he would be interested in beyond the project management methodology.

The Executive Director of Operations said that the transformation programme was about implementing the best practice for best outcomes and being as productive as possible. She said some of the work of the Business Development and Change Team was to focus on horizon scanning and looking for opportunities in growth and intelligence.

In his summary the Committee Chair said that it was helpful to see a one page snapshot of projects and that it would be helpful to have a strapline for each project that explained its aim. He said in terms of assurance perhaps there could be a deep dive at one of the Committee meetings in the future.

b) Electronic Patient Record (EPR)

The Executive Director of Operations introduced a brief presentation updating the Committee on four key schemes as follows:

- Neighbourhood Model Transformation Programme
- Work on the replacement of system in the Sexual Health Service, going live November 2021
- Integrated Children's Additional Needs work
- Future feasibility study in CAMHS

The Executive Director of Operations said that the optimisation project in EPR was a major overhaul of Systmone as there were currently too many unnecessary templates to complete.

Item 2021/22 (15): Business Case

Discussion points:

CAMHS Provider Collaborative
The Committee reviewed the draft CAMHS Provider Collaborative business case, which the Trust Board would receive on 11 June 2021. The Committee recognised that with service providers working more collaboratively there would be significant benefits to patients and was supportive of the ethos of the business case.

The Committee explored the implications of the risk share agreement and the proposed mitigations and asked for further clarity to be provided in the version that the Board would be asked to approve.

The business case described the challenges of growth in admissions and the growth of length of stay over the past year. The increase in demand for CAMHS was still unclear whether it was due to the pandemic or part of general pressures in society.

The business case suggested that any risk to the provider collaborative not being able to live within the resources could be satisfactorily mitigated into two ways; by the end of 2023/24 there was a surplus of £1.3m dependent on additional money from NHS England of £1.7m of non-recurrent medium term funding of a £1m and links to reduced length of stay and admissions as a result of community investment across West Yorkshire. The business case explained some of the opportunities and actions that were available to West Yorkshire CAMHS system to take in order to reduce admissions and length of stay.

The Executive Director of Finance and Resources said that it was the right thing to do for the West Yorkshire system to work together across providers and across commissioners to work out the best possible care for young people and children of West Yorkshire.

The business case suggested a deficit of £240k against available funding in 2022/23. Without risk share across West Yorkshire the risk of £240k would have to come from other services and may impact on individual financial positions.

Outcome:
The Business Committee considered the Business Case and assessed the financial risks and recommended approval to the Board, albeit with more information included in the Board version on the risk share agreement.

Item 2021/22 (16): Performance management

Discussion points:

a) **Performance brief and domain reports**

The Executive Director of Finance and Resources introduced the Performance Brief and Domain reports. It was noted that in the well-led domain, performance against appraisal rates continued to improve; retention and sickness remained at a reasonable level.

The Committee was provided with details of how waiting times were being tackled within the Reset and Recovery Programme item.

FINANCE
No formal summary of the financial report had been produced for April 2021, with it being month one. The Business Committee discussed the overall financial outlook for the first 6 months and this would be shared with the Trust Board.

The Committee heard that there was resource available to address waiting times in priority areas H1 and the Executive Director of Operations was constructing a spending plan.

b) **Appraisal recording & reporting update**
The Director of Workforce (LS) said that the appraisal recording method had been discussed at SMT and the recommendation was to support the proposal as set out in option 1 in the paper.

The Committee approved the recommendation to amend the way in which appraisal compliance reporting was conducted, i.e. to only include completion of the full annual appraisal, rather than including the 6-monthly reviews of staff that had sometimes been included in the data previously.

c) **Neighbourhood teams triangulation report**
The Executive Director of Operations presented the neighbourhood team's quarter 4 report providing a snapshot of detail on the breakdown of the position in March 2021. The Committee was referred to chart 2 in the pack demonstrating funded whole time equivalent and its utilisation being at a comfortable state.

The Executive Director of Operations also referred to chart 5 showing demand for neighbourhood team services being stable. The number of referrals initially dropped during the Covid-19 period, and then returned to more stable pattern with a normal range with an increase in referrals in the latter half of quarter 3 and into quarter 4.

d) **Partnership Traded Contract Performance 2020/21**
There were six services the Trust delivered in formal partnership with other providers: Leeds Sexual Health Service, the Leeds Mental Well-being Service, the Forensic Youth Service, the Humber Court Liaison and Diversion Service, the Tier 3 Weight Management Service, and the Community Care Beds Service (CCBS).

The Committee was advised that despite the impact of the interim financial regime for 2020/21, introduced nationally in response to the pandemic, all but two of the joint operation partnership contracts have made a surplus or are about to breakeven for 2020/21.

Outcome:
The Committee welcomed the insight into the financial performance of the contracts and agreed that partnership governance arrangements were robust.

e) **Operational and non-clinical risk report**
The Committee was advised of two new non-clinical risks scoring 8 or above and there were no new non-clinical risks scoring 15 or above (extreme).

There was one clinical risk scoring 15 or above: Delayed transfer of children/young people from WYOI who required medium secure CAMHS hospital beds. The Company Secretary said that this risk was discussed at the Quality Committee meeting on 24 May 2021 and it was noted that it was an improving situation and this risk would be reassessed and rescored.

The Committee Chair referred to digital related risks being operationally challenging. He said it would be useful to have a general conversation at a future Committee meeting about how the operations side of the business was being supported in this hybrid world. The Executive Director of Finance and Resources suggested meeting outside before further discussions took place at the Business Committee in two months' time.

Action: (Executive Director of Finance and Resources)
A discussion on digital capacity and support to be included on the July Business Committee meeting agenda

Outcome:
The Committee noted the contents of the risk register and assured the Board that non-clinical risks were being appropriately managed.

f) **Internal audit: Performance data quality**
The Committee was pleased to note substantial assurance for the audit of Performance Data Quality with no recommendations made.

The Committee Chair thanked the Business Intelligence Team for their hard work.

Item 2021/22 (17): Matters for the Board and other Committees

Discussion points:

Assurance levels
The Committee reviewed and discussed the levels of assurance for the strategic risks related to the agenda items and agreed there was reasonable assurance across all agenda items

The Chief Executive referred to the issue of a pressurised health system in Leeds, which would be brought to the Board's attention and assured the Committee that the Trust was already working to mitigate this during the next six months.

Item 2021/22 (18): Business Committee work plan

Discussion points:
The Committee reviewed and noted the work plan.

Item 2021/22 (19): Any other business

Discussion points:
None discussed.

NHS
Leeds Community Healthcare
NHS Trust

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 23 June 2021 (9.00 am to 11.30 am)

Present:	Richard Gladman (Chair)	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman	Non-Executive Director (KR)
Attendance:	Brodie Clark	Trust Chair
	Laura Smith	Director of Workforce
	Diane Allison	Company Secretary
	Emma Bolton	Associate Director of Estates – for item (21)
	Richard Slough	Assistant Director of BI, Clinical Systems and IT (22a)
Apologies:	Helen Thomson	Non-Executive Director (HT)
Note Taker:	Ranjit Lall	PA to the Exec Director of Finance & Resources

Item 2021/22 (20): Welcome and introductions

Discussion points:

a) Apology: Noted as 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. In addition the members reviewed the Committee's declaration report (item 6) and noted the declarations made for future reference.

c) Minutes of meeting dated 26 May 2021
The minutes of meeting dated 26 May 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 the updates.

Item 2021/22 (21): Estates

Discussion point:

a) Seacroft business case
The Committee Chair welcomed the Associated Director of Estates to the meeting.

The Executive Director of Finance and Resources introduced the Seacroft Clinic Business Case. The summarised details of the case were provided in the cover report. He said there

was an opportunity of refurbishing the building and creating a different space for primary care in the East of the City.

The Committee was asked to consider providing immediate approval to use of the allocated fees and survey budget to allow detailed design work and a tendering process to begin.

The Committee considered the business case to address condition and functional suitability issues at Seacroft Clinic, alongside a request from Leeds Clinical Commissioning Group that the Trust consider surrendering its lease of rooms at Park Edge Clinic.

It was noted that an application for planning permission had already been submitted. The detailed design and specification for the tendering process was also being worked up. The Committee would be asked to agree at a future meeting the final fund to put tender in place subject to the Board approving of the Business Case in its entirety. The Associate Director of Estates said that a detailed service decant plan would be drawn up to ensure service continuity whilst building works were underway. Further progress updates would be provided to the Business Committee as the scheme progressed over the next two years.

The Executive Director of Operations welcomed the opportunity of creating a good quality building aligned to the service strategy that would serve the population and its needs.

There were discussions about Park Edge in the future and noted that all service provision would be provided from Seacroft as a hub as part of future East Leeds extension proposition creating a much better environment at Seacroft for both the clinicians and patients and it would provide a good quality environment over the next decade. The Chief Executive said that she was committed to people in Seacroft and making the building better as a local base.

The Director of Workforce (LS) also welcomed the business case and acknowledged the implication of staff consultation about the decant plan. She said engagement with workforce was the key and offered her assistance from an HR perspective to navigate areas that linked into organisational change as things move forward and keeping positive momentum.

In response to a Non-Executive Director (KR) about finances, the Executive Director of Finance and Resources said that the cost was within the financial parameters and spending any more would compromise other capital requirements

A Non-Executive Director (KR) said that one of the risks was a significant construction price inflation already being seen and expected potentially to get even worse over the next 2 years both in terms of workforce and material cost; that would be something to bear in mind of the changes and the design framework. The Executive Director of Finance and Resources said that on the construction risk there was a reasonable contingency in the budget in terms of inflation.

The Trust Chair asked about the 32 week programme timeframe and whether the plan contingency to cover was enough under the current circumstances. He suggested more contingency should be considered in the current climate. The Associate Director of Estates said that she was confident with the 32 week programme and the contingency. The Quantity Surveyor report had recently been completed and the current construction market had been factored in.

The Committee Chair was concerned about the project progressing in advance of work on the new estate strategy related to service needs and future workforce models. He also asked about patient involvement and the impact of decanting on patient flow and the ability to have continuity of care. The Associate Director of Estates said that because of the proposed hybrid working office space, the Seacroft Clinic improvements would in effect act

as a pilot scheme for new ways of working for LCH. The impact on patients was still being considered and not fully modelled against the decant plan and the Committee was advised that it would be factored in. The two nearest bases, Park Edge and Holton Clinic would not be released until the decant programme was completed.

Outcome:
The Committee was supportive of the option for a full refurbishment of Seacroft Clinic with the clinical space reconfigured to increase its capacity and patient flow and gave its approval for spend on fees and surveys to allow detailed design work and tendering to proceed. It would also recommend to Trust Board that the remaining capital implications of the scheme be supported over 2 financial years as set out in the financial case. The Business Case would be presented to the Board in three months for full approval.

b) Premises Assurance Model (PAM)
The NHS Premises Assurance Model (PAM) is a governance tool that allows NHS organisations to better understand the efficiency, effectiveness and level of safety of estates and facilities (and related) services, including how that linked to patient experience. This year Trusts were required to complete the safety and patient experience elements of the model, with a deadline of 23 July 2021.

The Estates Team took the lead on collation of data and the scoring process and presented the current version to the Committee. It was noted that there were areas which still required responses as well as areas that required improvement. It was noted that the PAM was Acute Trust focussed and not all sections were completely relevant to this Trust. The Committee had some concerns about the gaps in evidence in the PAM, however the Committee was advised that more work was being done to remedy this situation and further information would be presented to the Committee in due course.

The Associate Director of Estates said that this had now become a contractual requirement and that patient safety related modules were to be formally submitted to NHS Improvement by 23 July 2021. The scoring had been based on evidence received and the report provided the exceptions for the areas not adequately evidenced and identified as need improvement.

The Trust Chair was concerned about the support and help needed, particularly from those failing to provide the evidence required to complete the work. He was also concerned about a number of issues not documented or not able to testify through the evidence received.

The Committee Chair noted some significant items that carried high risk and clearly needed to be prioritised. The Executive Directors were asked to identify people who could provide the necessary support to gather the remaining evidence. The Executive Director of Finance and Resources said there were a number of increased governance requirements across a whole range of facilities management covering risk areas and prioritisation and the Trust needed to ensure those responsibilities were discharged appropriately. The purpose of this report was clearly to provide a framework to identify gaps for assurance and then provide a work schedule to meet the deadline. The Committee was advised that the timeline for responses was the next stage of development.

The Committee Chair summarised the discussion. He said it was a good baseline and work was continuing over the course of next month to fill gaps and to embellish evidence and in terms of a target date, putting in place the people or assigning the responsibilities to fill those gaps. The Committee recognised that this was new and some elements of this were not tailored to Community Trusts and were supportive of completing the work and submitting by 23 July 2021.

c) Estates internal audit

The draft internal audit report was presented to the Committee. It was noted that the final report received on 22 June 2021 from Internal Auditors included management comments.

The purpose of the audit was to provide assurance that the organisation had robust controls in relation to the maintenance of its buildings. The concluding audit opinion was that assurance was limited with issues raised concerning documented compliance with water quality monitoring, gas safety, asbestos management, fire and electrical safety remedial actions, and evidence of leased properties' compliance.

The Executive Director of Finance and Resources provided the Committee with detailed actions that were to be taken to remedy the gaps highlighted in the estates audit. The Committee noted the short timescales allocated ensuring that this work was completed quickly.

The Associate Director of Estates said that she was confident about fire safety remedial action. The work was actually completed but lacking in evidence. The process for completed jobs in future was being reviewed and the Contractors were asked to make sure there was an audit trail in in place.

The Executive Director of Finance and Resources said that with regards to backlog of fire risk assessments it had been agreed to report to the Fire Safety Group on 5 August 2021 and subsequently to Health & Safety Group on the programme of fire risk assessments and estates would review any remedial action from previous fire risk assessments to ensure that it had been carried out.

The Executive Director of Finance and Resources agreed to circulate the final audit report with management responses to the Committee members at the end of today's meeting and any follow up actions would go through the normal process.

Action

Executive Director of Finance and Resources to circulate the final estates internal audit report which included management responses. **(Action closed)**

Item 2021/22 (22): Performance management

Discussion point:

a) Operational and non-clinical risk report

The Committee Chair welcomed the Assistant Director of Business Intelligence, Clinical Systems and IT to the meeting.

The Committee received the risk register report which had a particular focus on IT / Digital systems risks as this had been identified as a theme in the May 2021 Board and Business Committee risk register reports.

The Assistant Director of Business Intelligence, Clinical Systems and IT was in attendance to discuss the IT / Digital systems risks and the mitigation that was being put in place. The Committee was advised about the new telephony system that was being installed, which would have better functionality and would also be able to monitor demand and support callers. The Committee explored possible additional sources of assurance that could be provided once the new telephony system was in place.

There was an ongoing recruitment campaign for more IT helpdesk staff, laptops were now being advance-ordered so that they could be quickly allocated to new staff and improvements to smartcard processes were being introduced. There was also progress towards an arrangement with Leeds City Council to provide some out of hours IT support.

The Committee Chair asked about PCMIS (patient information system) that did not have the functionality to run a system capture of all safeguarding cases and there was a risk that it may be missed by clinicians which could result in clinicians not acting to prevent harm to vulnerable individuals. The Assistant Director of Business Intelligence, Clinical Systems and IT said that work was well underway, with the Solution Provider, to introduce the required enhancements this week for clinical staff to test out.

The Trust Chair noted that the Leeds Sexual Health appointment line were considering putting in a phone service for people to use to receive advice and make appointments as necessary. He was concerned about the phone service not fit for purpose and not able to take the capacity of calls coming into the service. The risk was when people could not get through and able to raise health concerns. The Chief Executive explained that the Sexual Health telephone system was operated by Leeds Teaching Hospitals NHS Trust (LTHT) and did not allow more than the number of people answering the phone. A new telephony system was being procured by Leeds Community Healthcare in September 2021 and the Leeds Sexual Health Service would be a high priority for the new system. This should have all the functionality expected from a modern telephony system. The Assistant Director of Business Intelligence, Clinical Systems and IT was working with the colleagues from LTHT and exploring if enhanced call management be added to the existing system in the interim.

The Assistant Director of Business Intelligence, Clinical Systems and IT was invited to discuss IT related issues recorded on the Trust's risk register. The discussions focused on the recognition that Covid and pandemic had created a great deal of extra demand on new ways of working. Remote ways of working had been adopted and which significantly increased pressures on the in-house IT team.

The Committee learnt how the IT team had been dealing with extra demand and about the key mitigations put in place in the short term. The plan was to put two additional whole time equivalent band 4 staff on the support desk to create a greater telephone support capacity. Through the recruitment exercise three months ago two people were appointed. Unfortunately one had since resigned but the second person was starting soon. The Committee was advised of further two vacancies due to staff turnover. In addition to this a band 6 administrative lead for the service had also been recruited.

The Committee Chair acknowledged the challenges with the helpdesk team and noted the short term mitigations that were in place. He asked how the Trust would need to adapt to a permanent shift in the level of support needed to staff who working to new service and workforce models. The Assistant Director of Business Intelligence, Clinical Systems and IT said that it was difficult to assess whether the capacity enhancements to the current model would be sufficient, or other measures may be needed. He highlighted there were opportunities for partnering with other organisations in the city. An example was given of the out of hours support by Leeds City Council to provide cover into the evenings and provide services on a Saturday and Sunday during the working hours.

The Committee Chair commented that continued focus on simplifying the use of technology, simplifying self-service and upskilling staff were key areas that many Trusts were pursuing as they adopted more remote and digital ways of working.

The Assistant Director of Business Intelligence, Clinical Systems and IT said that opportunities for further enhancements and extra user support capacity was being explored.

The Executive Director of Finance and Resources said that one of his objectives for this year was to explore further medium and long term enhancements to the model of service desk provision.

The Committee Chair said that the most important thing was to ensure that people had the right IT service that they needed in order to serve patients. The Committee was assured and recognised a new approach was needed to support digital models. A further update was to be provided in autumn when the medium and long term requirements would be considered.

The Committee Chair asked about ways of measuring and reporting on IT performance with a view to receiving more information at the Committee to better understand issues. The Assistant Director of Business Intelligence said that there was some very basic information available at the moment. The new phone system would be able to provide better reporting capability and help build a dashboard to monitor performance.

The Committee Chair thanked the Assistant Director of Business Intelligence, Clinical Systems and IT and his team for all the work being undertaken to improve the level of support offered to staff.

Action
Executive Director of Finance and Resources to provide an update on the short, medium and long term plans to enhance the IT support model, including the performance standards and monitoring in October 2021.

b) Internal audit schedule and scope
The Committee Chair had previously asked that the Business Committee was provided with an opportunity to assess and influence the scope of internal audits planned for the 2021/22 financial year.

The Committee received details of the audit scopes for this year's internal audit programme and how they aligned with the strategic risks on the Board Assurance Framework (BAF). The Committee asked that Directors and the Trust's internal auditors work together to ensure that there was consideration of the relevant strategic risks when setting the scope of each audit to support the Board Assurance Framework.

The Executive Director of Finance and Resources said that through his initial assessment of the scopes of the audits mapped to the BAF indicated that coverage was reasonable. He recognised that previously the scope of individual audit hadn't been specified well enough in order to provide sufficient value or the assurance the Committee required.

Outcome:
The Business Committee considered the scopes of the proposed audits.

Item 2021/22 (23): Strategy update

Discussion point:

Workforce Strategy 2021/25 update (slide presentation)
The Director of Workforce (LS) presented a set of slides to support the 2021 to 2025 Workforce Strategy discussion. She set the overall direction of travel and advised that this was an opportunity for the Committee to receive an overview of the next Workforce Strategy, which was currently being drafted as well as a looking back at the previous strategy (2019/21) and the measureable outcomes that had been achieved.

The Committee was keen to be involved in the shaping of the new strategy's priority areas. It also agreed that productivity and agility should also be key features of the Workforce Strategy, and the main focus should be on enabling staff to deliver high quality care.

The Committee was asked to consider and agree to the proposed plan against the six priorities in the 2021 to 2025 strategy and how to make step change for the organisation during the next strategy period.

In terms of content of the new strategy there were increased digital and artificial intelligence opportunities that would benefit the organisation. There was also a new theme called 'Foundation' specifically linked to the workforce department to maximise available technology and digital opportunities to automate workforce processes and for the first time the Workforce Strategy incorporated the Trusts Freedom To Speak Up strategy.

The Trust Chair was content with the themes described in the priorities and suggested that 'productivity' should also be included as it was a key feature of issues around staffing across the organisation. He also said that in the next stage of strategy development it would be important to see the different themes populated and the breakdown of each into priority areas and activities. The Director of Workforce (LS) supported the view that productivity should be included and said that both digital and technical data and evidence should help assess productivity.

The Executive Director of Operations observed that there was currently no reference made to patients or services and the very best employment experience for people creating the very best patient experience.

A Non-Executive Director (KR) said he was happy with the direction of travel but would like to know what had and hadn't worked over the last couple of years particularly around resourcing issues.

Outcome:
The Committee noted that the Workforce Strategy was on track and progressing well. A number of key areas highlighted were to be considered for the next update.

Item 2021/22 (24): Covid and Reset and Recovery update

Discussion points:

a) Covid update
The Committee received an update on the local situation including the current increased infection rate for Leeds, the number of patients locally in hospital with this disease, and the latest information on the vaccination programme.

The infection rate currently was 210 per 100,000 people with the increase being driven by the 18-25 years old age group and there were some very hot spots within the City. The current infection rate in Headingley/Hyde Park was 1092 per 100,000 people and 532 per 100,000 people in the Little London and Woodhouse area.

The Executive Director of Operations said that the City was running an enhanced response testing scheme by going door to door to test people. A local vaccination centre was opening soon at Woodhouse Community Centre for the local community to access.

There were currently 20 positive Covid patients in hospital and 2 in intensive care unit. 60% of the adult population had been vaccinated once and 52% twice. The Executive Director of Operations said that a new target had been set to vaccinate 90% of cohorts 1-10 by 19 July

2021 (the current vaccination rate for these groups in Leeds was 85%).

b) Reset and recovery update (waitlist data)
The Trust had allocated some non-recurrent funding in order to clear services' backlogs by the end of the year. All services had submitted a backlog management plan for achieving this. The backlog situation for the Podiatry service remained a particular concern particularly as there had been a recent commissioning decision on service scope and to decommission some elements of low risk foot care.

The Committee was advised that on 9 July 2021 the Executive Director of Finance and Resources and the Executive Director of Operations were hosting a 'confirm and challenge' process. Each business unit was presenting their plans to address their backlogs and these would be tested out to get a real understanding of the ongoing challenges.

A comprehensive heat map was being developed to share with the Business Committee on a regular basis. The first draft of that had been reviewed at the last performance panel. A dashboard of current waitlist information would be presented to the Business Committee meeting in July 2021.

c) Future oversight of reporting - change programmes
The Committee recognised the need for the move towards agreed governance structures and regular reporting for critical change programmes, to bring together information, including hotspots and about the various projects involved in these programmes.

The Committee discussed in general on how to move from the current style of reporting during the pandemic into more regularised pattern, giving assurance for waiting lists and progress of the big change programme and transformation programme.

The Executive Director of Finance and Resources agreed to have a 'Senior Management Team' type discussion about the oversight of work and the management of waiting lists and backlogs and timescales. He said the plan was to bring the dashboard that was referred to in the earlier discussion into the main performance report on a regular basis in terms of having a broader understanding of the responsiveness of all services.

The Executive Director of Finance and Resources said that he was still exploring ways of coherent reporting of major change projects and to learn more about how the Major Change Management Board worked in terms of bringing everything together post Covid for a more sustainable management system.

The Trust Chair understood the challenges for the Executive Directors. He said at this stage through briefings, the executives should be able to build some of that into the programme as well as around the shape of the business to come. The Trust Chair said that there was a cause for discussion with those key players in the Trust who were leading on particular aspect of the work.

Outcome:
The Committee to receive updates in the new section of the Performance Brief and Domain reports highlighting progress of key projects.

Item 2021/22 (25): Minutes to note:

Discussion point:

Health and Safety Group minutes (15 April 2021)

The Committee received the minutes for noting.
Item 2021/22 (26): Matters for the Board and other Committees
Discussion point: **Assurance levels** The Committee reviewed and discussed the levels of assurance for the strategic risks related to the following agenda items: • Estates update including Seacroft plans and approvals • IT risks and mitigations • Workforce Strategy • Reset and recovery update
Item: 2021/22 (27): Business Committee work plan (to note)
Discussion point: The Committee reviewed and noted the work plan.
Item 2021/22 (28): Any other business
None discussed.