Bundle Public Board Meeting 1 October 2021

Agenda

Final Agenda Public_Board_Meeting_1 October_2021- blue box - amended 28092021.docx

62 09:00 - Welcome, introductions and apologies:

63 Declarations of interest

64 Questions from members of the public

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

65 09:10 - Minutes of previous meeting and matters arising:

65.a Minutes of the meetings held on 6 August 2021

For Approval

Item 65a Draft Public Board minutes 6 August 2021.docx

65.b Actions' log

Item 65b Public Board 1 October 2021 actions' log.doc

66 09:15 - Patient's story

67 09:35 - Chief Executive's report: including Covid-19 update

Item 67 CEO report - Oct 2021.docx

68 10:05 - Committee Chairs' Assurance Reports:

68.a Charitable Funds Committee: 17 September 2021

Item 68a Charitable funds Committee Chair Assurance Report September 2021.docx

68.b Nominations and Remuneration Committee:17 September 2021

Item 68b Nom and Rem Committee September 2021 - Chair Assurance report.docx

68.c Quality Committee: verbal report

68.d Business Committee: verbal report

69 10:25 - Performance brief and domain reports: August 2021

Item 69i Performance Brief Cover Paper.docx

Item 69ii Performance Brief (Aug 2021) BCQCBoard.docx

70 10:35 - Significant Risks and Board Assurance Framework (BAF) Summary Report

Item 70 Significant risks and Board Assurance Framework (BAF) final.docx

71 10:45 - Provider Collaborative Application for Lead Provider Selection: Tier 4 CAMH Services, Business and Clinical Case – confirmation of funding – verbal report

72 10:55 - Workforce Strategy: 2021-2025 (reviewed by Business Committee 29 September 2021

Item 72i Draft Workforce Strategy for October Board cover paper V1.0.docx

Item 72ii Draft Workforce Strategy 2021 25 V1.0 BOARD.docx

73.a 11:10 - Workforce Disability Equality Standard annual report 2020-21 and action plan (reviewed by Business Committee 29 September 2021)

Item 73ai WDES annual report 2021 Trust Board 1 October 2021 Final.docx

Item 73aii WDES action plan 2021-22 Trust Board 1 October 2021 Final.docx

73.b Workforce Race and Equality Standard annual report 2020-21 and action plan (reviewed by Business Committee 29 September 2021)

Item 73bi WRES report 2021 Trust Board 1 October 2021 Final_.docx

Item 73bii WRES action plan 2021-22 Trust Board 1 October 2021 Final.docx

74 11:30 - Item removed

75 11:35 - Infection prevention and control: Annual Report 2020-21 (reviewed by Quality Committee on 27 September 2021

Item 75 Annual Report IPC 20-21.docx

76 11:45 - Board workplan

Item 76 Public Board workplan 2021-22 v3 23 09 2021.xlsx

77 Any other business

78 Close of the public section of the Board

79 Blue Box item: Engagement Strategy update - reviewed by Quality Committee 27 September 2021

Item 79 2021 09 16 Final Engagement Strategy Update Report Board.docx

80 Blue Box item: Digital Strategy update - reviewed by Business Committee 29 September 2021

Item 80 Digital Strategy Update Report TB Sep 2021.docx

81 Blue Box item: Infection prevention and control assurance framework - reviewed by Quality Committee September 2021

Item 81 IPC Assurance Framework.docx

Leeds Community Healthcare NHS Trust

Agenda Trust Board Meeting Held In Public

Virtual meeting and live streamed

Date 1 October 2021

Time 9:00 – 12.00noon

Chair Brodie Clark CBE, Trust Chair

All items listed (Blue Box) in blue text, are to be received for information/assurance, having previously been scrutinised by committees, and no discussion time has been allocated within the agenda. The Trust Chair will invite questions on any of these items under any other business.

AGENDA		
2021-22 62	9.00am	**Welcome, introductions and apologies** *(Trust Chair)*
2021-22 63		**Declarations of interest** *(Trust Chair)*
2021-22 64		**Questions from members of the public**
2021-22 65	9.10am	**Minutes of previous meetings and matters arising** *(Trust Chair)* *For approval*
65.a		Minutes of the meetings held on 1 August 2021
65.b		Actions' log: 1 August 2021
2021-22 66	9.15am	**Patient's story** *(Steph Lawrence)*
QUALITY AND DELIVERY		
2021-22 67	9.35am	**Chief Executive's report: including Covid-19 update** *(Thea Stein)*
2021-22 68	10.05am	**Committee Chairs' Assurance Reports:**
68.a		Charitable Funds Committee: 17 September 2021 *(Trust Chair)*
68.b		Nominations and Remuneration Committee: 17 September 2021 *(Trust Chair)*
68.c		Quality Committee: 27 September 2021 – Verbal update *(Helen Thomson)*
68.d		Business Committee: 29 September 2021 – Verbal update *(Richard Gladman)*
2021-22 69	10.25am	**Performance Brief:** August 2021 *(Bryan Machin)*
2021-22 70	10.35am	**Significant Risks and Board Assurance Framework (BAF) Summary Report** *(Thea Stein)*
2021-22 71	10.45am	**Provider Collaborative Application for Lead Provider Selection: Tier 4 CAMH Services, Business and Clinical Case – confirmation of funding – verbal report** *(Bryan Machin)-*
FOR APPROVAL		
2021-22 72	10.55am	**Workforce Strategy: 2021-25** *(Jenny Allen/Laura Smith)*
2021-22 73	11.10am	**a. Workforce Disability Equality Standard annual report 2020/21 and action plan**

		b. Workforce Race and Equality Standard –annual report 2020/21 and action plan *(Jenny Allen/Laura Smith)*
2021-22 74	11.30am	**Item removed**
2021-22 75	11.35am	**Infection Prevention and Control: Annual Report 2020-21 (reviewed by Quality Committee on 27 September 2021)** *(Steph Lawrence)*
INFORMATION FOR NOTING		
2021-22 76	11.45am	**Board workplan** *(Thea Stein)*
CLOSE		
2021-22 77	11.45am	**Any other business and questions on Blue Box items** (Trust Chair)
2021-22 78	12.00noon	**Close of the public section of the Board** *(Trust Chair)*

Additional items (Blue Box)	
2021-22 79	Engagement strategy update – seen by Quality Committee September 2021
2021-22 80	Digital strategy update – seen by Business Committee September 2021
2021-22 81	Infection prevention and control assurrance framework – seen by Quality Commitee September 2021

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 6 August 2021

Agenda item number: 2021-22 (65a)

Title: Draft Trust Board meeting minutes 6 August 2021

Category of paper: for approval
History: N/A

Responsible director: Chief Executive
Report author: N/A

Attendance

Present:	Brodie Clark CBE	Trust Chair
	Thea Stein	Chief Executive
	Richard Gladman (RG)	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 (AHPs)
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Professor Ian Lewis (IL)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	Diane Allison	Company Secretary
	Rhian Fox	Specialist CAMHS Assistant (for Item 37)
	John Walsh	Freedom to Speak Up Guardian (for Item 42)
	Dr Nagashree Nallapetta	Guardian of Safe Working Hours (for Item 43)
	Em Campbell	Health Equity Lead, Leeds Community Healthcare NHS Trust (for Item 46)
	Leanne Wilson	Head of Medical Education and Revalidation (for Item 48)
Minutes:	Liz Thornton	Board Administrator
Observers:	Mark Holmes	Relationship Manager, Care Quality Commission (CQC)
Members of the public:	None present	

Item 2021-22 (33)

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 Mark Holmes, Relationship Manager CQC, attending as an observer and members of staff from the Trust who were attending to support items on the agenda.

Apologies

Apologies were received and accepted from Professor Ian Lewis, Non-Executive Director, Dr Ruth Burnett, Executive Medical Director and Jenny Allen, Director of Workforce, Organisational Development and System Development.

Trust Chair's introductory remarks

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

He opened with a very strong message of support across the organisation and more directly, support to the Board members. He said that the sense of 'never ending' felt prevalent and the sense of 'long distance' to the race was increasingly profound. Staff across the Trust had been outstanding, the Board, and the community, owed them a great deal of thanks. Demand continued to be exceptional and the Board must continue to support, inspire and to lead. This was not a time to ease off or slow down, when mistakes could happen, and opportunities could be missed. The Trust must continue to drive home the successes, make the necessary changes, and build new agendas in a way that testifies to the character and the strength of the organisation.

He said that there were many things on the agenda for this Board meeting, from the immediacy of the day by day operational priorities, to the medium-term priorities and this gave testimony to the relentless focus on each of those levels of change, development, and delivery. The operational; the medium term; the strategic and governance context were all covered by items for discussion, agreement and noting at this meeting.

To conclude he set out some overarching imperatives that must never be lost in the important drive for change:

- **Quality** must always remain at the heart and core of what we do, and the complexity of the agenda should never compromise on the quality of our delivery.
- **Our relationship with the communities we serve** – so, new ways of working should always be understood and accessible and co-produced.
- **Our care for our staff** – and there is much in place to support that.
- **Our commitment to support partners** and the broader NHS changes in ways that promote and deliver yet better front-line services.

Item 2021-22 (34)

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. No additional potential conflicts of interest regarding the meeting's agenda were raised.

Item 2021-22 (35)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2021-22 (36)

Discussion points:

Minutes of the last meeting, matters arising and action log

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) Minutes of the meeting held on 11 June 2021

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

c) Actions' log 28 May 2021

There were two actions on the action log. The Board noted that both had been completed and were now closed.

Item 2021-22 (37)

Discussion points:

Patient's Story

The Executive Director of Nursing and AHPs advised that members of the family were unable to attend the meeting today to present the story. Rhian Fox, a member of staff from the Trust's CAMHS Service was in attendance and had been given permission to give a brief account of the family's experience.

The patient's birth parents had separated when he was a young child and the birth mother had been the primary carer for a number of years, the young person's desire was to be identified as male rather than female and eventually he came to live with his father and stepmother.

He was referred into CAMHS following a deliberate self-harm (DSH) episode after taking small overdose. Amy Jenkinson a Senior Mental Health Practitioner in the CAMHS Service was on the Deliberate Self Harm rota at the hospital and met the young person. Initially he was reluctant to engage with professionals due to a previous poor experience elsewhere, but eventually agreed to meet with her. His stepmother describes this as a 'sliding doors' moment and wonders how different things could have been if it hadn't been Amy that he had met with; she built up trust within an hour and was able to persuade him to accept ongoing support.

The young person took a larger overdose last year. The family felt that initially they were passed rapidly between the ambulance service, CAMHS crisis and CAMHS community services without any continuity of care. However, eventually they were able to meet with a CAMHS Consultant for follow up treatment and he was able to validate the young person's feelings, prescribe the appropriate medication and set up a treatment plan.

The family feel that the young person has had many 'ups and downs' but the CAMHS practitioners have been key in stabilising the position by actively listening and allowing him to lead the therapy. The service has also supported the wider family by signposting the other services available to them and been very responsive to requests for help.

On the negative side there are long waits for CAMHS appointments.

The Trust Chair thanked Rhian for attending the Board and relaying the story on behalf of the patient's family. He invited questions from Board members.

Non-Executive Director (KR) noted the many positive comments about the practitioners supporting this young person and asked if the Trust was confident that this approach was consistent across the CAMHS service.

Rhian said that she was not personally involved in assessments, but she believed that the service was developing a more streamlined approach across all areas and good practice was disseminated through supervision and mentoring sessions.

Associate Non-Executive Director (RB) asked how the Trust could ensure that all practitioners had the skills to build a rapport with patients, listen and respond compassionately.

The Director of Workforce, Organisational Development and System Development (LS) said that the Trust recruited against a set of core values and behaviours designed to ensure that individuals who secure posts have the skills required to enable them to build a rapport with patients quickly and treat them with compassion. The Trust also offered opportunities for continuing education including support from the Better Conversations Team.

Non-Executive Director (RG) asked if the Trust was seeing an increase in demand for CAMHS services and if there was sufficient capacity to support this.

The Executive Director of Operations said that the number of urgent and routine referrals had increased. She provided assurance that the Trust was engaging in positive discussions with commissioners and this had already resulted in an increase in investment to support and improve mental health services. The Trust was also reviewing the skill mix of staff in the service to develop the right mix of registered and non-registered staff to support the delivery of a quality service.

The Chief Executive reminded the Board that the CAMHS service had a specific role in supporting the mental health of children and young people but other partners across the city also had important responsibilities to fulfil alongside the Trust.

The Trust Chair said that the story was an important reminder for the Board about the importance of building a rapport with patients and listening, responding appropriately, and building the right networks to connect with key stakeholders and agencies across the city.

In terms of demand and delivery the Board had received assurance that the Trust was developing the CAMHS service to meet the increased demand and improve delivery

Item 38 2021-22

Discussion points:

Chief Executive's report –including Covid-19 update

The Chief Executive presented her report particularly highlighting:

- Involvement in the Long Covid study
- Listening to staff
- Integrated Pharmacy and Medicines Optimisation
- Signing up for the anti-racism campaign
- Youth Board update report
- Trust's role as an anchor institution

The Executive Director of Operations provided a verbal update on the vaccination programme. The millionth dose of the vaccine had been delivered in Leeds and this would be publicised more widely on Monday 9 August 2021. 75% of the registered population had received a first dose and 62% a second dose. The momentum continued to promote uptake by engaging with community groups and leaders, the deployment of the vaccine bus, pop-up vaccination stations and work with local employers.

The Executive Director of Operations provided a verbal update on operational pressures in the Trust. The infection rate had reduced in Leeds by 20% since last week to 388 per 100,000. Currently there were 100 patients who had tested positive for Covid-19 and were being treated as in-patients. Eleven were occupying intensive care beds.

Phase three of the programme would be development of a system to deliver booster vaccinations which would be led by the Primary Care Networks with the aim for it to form part of the flu vaccination campaign.

The Trust Chair asked about the management of patient flow across the City.

The Executive Director of Operations indicated that the pressure was significant and there were challenges in ensuring that the staffing levels in the Neighbourhood Teams was sufficient to allow the Trust to provide a good service. The pressure had been impacted by the amount of annual leave being taken at this time of year, but the situation was being managed effectively in partnership with other key stakeholders across the city.

Outcome: The Board

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

Item 2021-22 (39)

Discussion points:

Assurance reports from sub-committees

- **– Charitable Funds Committee 25 June 2021**

The report was presented by the Trust Chair as Chair of the Charitable Funds Committee. He said that a comprehensive update on charitable developments was included as an appendix to the report and Kirsty Drakes, Charitable Funds Administrator was attending the meeting to provide more detail.

Other key issues discussed included:

- **The post of charitable funds administrator:** would be made permanent as the progress made since the inception of the post was clear.
- **Comms strategy for the charity:** to be discussed by the operational group and a plan returned to the Committee for consideration.
- **Finance:** the draft Charitable Funds and Related Charities Annual Report was discussed and agreed by the Committee and referred for review by the Audit Committee before final adoption.
- **Quality:** the Committee discussed the aspiration for the work of the Committee to enhance the quality of the care the Trust provides through the use of funds to enhance patient care but also to ensure staff are supported in terms of their health and wellbeing.

<u>Charity Development update</u>

Kirsty Drakes, Charitable Funds Administrator led members through the update on charitable development and activities between January and 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 Board welcomed the report and information about how chartable funds had been allocated to provide practical support for the health and wellbeing of staff. The success in relation to increasing fund raising and promotion of the charity were to be commended. It was suggested that the Operational Group should consider how the Trust's drive to raise the profile of its fundraising might impact on the fundraising efforts of other partners in the City.

b) – Audit Committee 23 July 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 (TIAA)**: the Committee received a report from the Head of Internal Audit 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.

- **Annual Audit Letter (External audit Mazars):** Mazars provided the Committee with 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.
- **Leeds Community Healthcare Charitable Funds and Related Charities draft annual report and accounts 2020-21 –** the Committee was provided with the Trust's Charitable Trust and Related Charities draft annual report and accounts for 2020-21 together with the findings of the independent examination. The Committee recommended the adoption of the accounts by the Charitable Funds Committee at its meeting in September 2021.

b) – Quality Committee – 21 June 2021 and 26 July 2021

The reports were presented by the Chair of the Committee, Non-Executive Director (HT), the key issues discussed were highlighted, namely:

- **Community Cancer Support Services (CCSS):** The Committee received a presentation about a new service commissioned by the CCG and McMillan initially for two years. The CCSS will act as a key link between primary, secondary and third sector services to bring together services for patients in a more integrated and targeted way.
- **Asymptomatic testing report:** NHS England/Improvement had written to all NHS trusts on 29 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. The Chief Executive provided a verbal update on staff compliance with the required testing regime following a request for clarification about the data presented to the Committee which had shown that a small number of staff had declined to test. It was explained that there were medical reasons why some staff were unable to comply and staff who were on sick leave or maternity leave were also coded as declining to test. Future data reports would be accompanied by more narrative to provide better clarity for the Committee. She added that staff who declined to take the test had been contacted and good conversations were taking place resulting in more staff agreeing to take the tests. The Executive Director of Nursing and AHPs provided assurance that where staff were unable to comply, a risk assessment was conducted, and staff were allocated appropriate duties to ensure that patient safety was not compromised.
- **CQC improvement plan:** the remaining actions on the CQC improvement plan have now been completed.

c) – Business Committee – 23 June 2021 and 28 July 2021

The reports were presented by the Chair of the Committee, Non-Executive Director (RG), and the key issues discussed were highlighted, namely:

- **Reset and recovery:** 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.
- **Relocation from Stockdale House:** 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.
- **Health and Safety Compliance Report:** The Committee received information on the current level of compliance with health and safety legislation and policies and an update on the developments and effectiveness of the Trust's health and safety management system.

d) – Nominations and Remuneration Committee 2 July 2021

The report was presented by the Trust Chair as Chair of the Committee, and the key issues discussed were highlighted, namely:

- **Chief Executive Officer (CEO) and Director Appraisal / Performance:** The Committee discussed assurance relating to Directors' and the CEO's appraisal, all of which have recently been carried out.

- **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 Committee approved the proposed payment structure for GP employment at the Trust 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
- The committee noted the outcome of a recent benchmarking exercise on senior management salary levels across all Trusts. It would give this further consideration in due course.

Outcome: The Board

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

Item 2021-22 (40)

Discussion points:

Performance Brief and Domains Report: June 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. He observed that there were no noteworthy 'trends' of concern of the period in question.

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 June 2021.

The Board noted that the June 2021 performance data had been reviewed in depth by the Quality and Business committees on 26 July and 28 July 2021 respectively.

The Executive Director of Finance and Resources provided a brief verbal update on the financial position in the Trust and an update on the financial regime.

To the end of June year to date expenditure was £2m less than the income the Trust had received leading to a surplus of £2m. This was because the work to recover the backlog waiting lists was timed for later in the year. The forecast outturn at the end of September 2021 was to break even.

NHS England/ NHS Improvement had advised trusts that the amended finance regime introduced in 2020/21 to support the NHS in dealing with the Covid-19 pandemic would continue through the first half of 2021/22 (H1). The Executive Director of Finance and Resources said that under the current finance regime the Trust's Income and Expenditure revenue plan extends to the end of September 2021 (H1).

The Board was advised that further guidance had not yet been released. The likelihood was that this organisation would get a similar resource to H1 less 3% CIP. Uncertainty remained about the finance regime for the second part of the financial year, and about the implications of the recently announced pay award for trust finances.

Non-Executive Director (RG) asked about the Trust's involvement in discussions relating to the financial regime for the Integrated Care System and Integrated Care Providers.

The Chief Executive and the Executive Director of Finance and Resources both agreed that finance directors across all organisations in Leeds and at West Yorkshire level worked collaboratively and they were confident that the Trust would be actively involved in discussions around the future financial regime.

There were no questions related to the other domains covered by the performance pack.

Outcome: The Board:

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

Item 2021-22 (41)

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 Digital/Information Technology (IT) systems.

The Board noted changes to the risk register as follows:

- no extreme risk scoring 16 (extreme) were currently on the register
- 15 risks scoring 12 (very high). Two of these were newly identified risks:
  - 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.
  - Increased volume of callers using the Sexual Health appointment line due to no walk-in service.

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

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

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 (LS) said that resourcing was a top priority in the workforce plans for each of the Trust's business units. Thirteen risks related to staff capacity due to an increase in demand, eight concerned vacancies including difficulties in recruiting staff to posts and five related to services being paused in response to Covid-19 which had resulted in an increase in workload and waiting times.

The Trust Chair sought assurance that the Trust had enough staff in post with the right skills to deliver the required services and that the Recruitment Team was able to support effective recruitment processes.

The Director of Workforce, Organisational Development and System Development (LS) said that steps had been taken to recruit temporary and substantive staff to support the Recruitment Team and she was confident that the Team had sufficient capacity. The focus was on attracting additional clinical staff including offering more options for flexible working and supporting the health and wellbeing of existing staff to ensure they were able to work or returned to work as quickly as possible. She added that staff shortages in some specialities was a national issue and was further impacted by the number of staff intending to retire.

Non-Executive Director (HT) whether the Trust had a sense of how many staff were considering retirement this year and in what staff groups.

The Director of Workforce, Organisational Development and System Development (LS) explained that work was being done to assess the numbers approaching retirement age and looking at data on those staff accessing pre-retirement courses.

The Executive Director of Nursing and AHPs said that she was holding drop-in sessions for nurses which included discussions on what more could be done to ensure that nurses wished to remained part of the workforce for as long as possible.

Associate Non-Executive Director (RB) asked about the ability of managers to identify where the health and well-being of staff was being impacted and whether they had the appropriate skills to support them.

The Director of Workforce, Organisational Development and System Development (LS) said that the leadership and management support on offer to managers should ensure that they had the skills to identify potential concerns and equip them with the skills to have appropriate conversations with staff.

Outcome: The Board

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

Item 2021-22 (42)

Discussion points:

Freedom to Speak Up Guardian: annual report 2020-21

The Freedom to Speak Up Guardian (FTSUG) provided an overview of his work for the period 1 August 2020 to July 2021, basic activity data, themes that have emerged from the work to date and assurances on the direction of the role.

He was pleased to report that the Trust had won the Health Service Journal Award for Speaking Up Organisation of the Year this year and several NHS trusts and national NHS bodies have had consultations and conversations with him about the approach to speaking up.

The work has continued to develop over the last year to ensure the voices of staff are fully heard and understood. There had been 36 concerns that were raised formally. Staff reported that the experience of contacting the FTSUG and champions is a positive one.

The FTSUG placed on record his thanks to the Board and senior leaders for their commitment and support for his role, without which the work could not develop and flourish.

Non-Executive Director (AL) referred to the data for the year 2020/21 and noted that there were four formally raised concerns related to issues of race and asked whether the FTSUG was concerned about the level of concerns reported.

The FTSUG said that he was seeing an increase in staff raising race as an issue or possible issue. He said that the organisation was learning to respond and address this. When issues of possible racial injustice arose, he always ensured every support was offered and everything was done to make the person's voice and story heard and understood by the organisation. The Race Equality Network was involved in these cases to ensure the issues were properly evaluated and addressed. Work in this area was improving but it was a work in progress and learning continued to develop. He said that he had confidence that the Trust's current approach was a robust and appropriate one.

The Board discussed whether it would be helpful to include information about the outcomes from the concerns formally raised and more information about the informal concerns. The FTSUG agreed to consider including this information in future reports.

The Chief Executive reported that in terms of satisfaction with the outcomes, over the last 18 months only one member of staff had expressed dissatisfaction.

Non-Executive Director (KR) suggested that future reports should include comparative activity data for previous years, which was agreed and accepted.

The Trust Chair thanked the FTSUG for presenting his report and commended his work in the Trust, his positive interaction with staff and particularly his recent work to support Black, Asian and Minority Ethnic staff

Outcome: The Board

- noted the report, activity to date and continued to support the role of the FTSUG to enable embedding of this work across the Trust.

Item 2021-22 (43)

Discussion points:

Guardian of Safe Working Hours (GSWH) – Quarter 1 report 2021-22

The GSWH presented the report for 2021-22 Q1 to provide the Board with assurance that trainee doctors and dentists working within the Trust are working safely and in a manner consistent with the Junior Doctors Contract 2016 Terms and Conditions of Service.

The report covered the progress made with ensuring compliance of CAMHS trainee rota pattern and the internal locum cover. An update on the improved engagement with Junior Doctors in the Junior Doctor Forum (JDF) and the work started to explore and support paediatric Junior Doctor training opportunities. She particularly drew attention to the ideas from the JDF for using the remaining money from the Fatigue and Facilities funding set out in the paper which had been put forward to the Senior Management Team for approval.

The Trust Chair thanked the GSWH for presenting a comprehensive report.

Outcome: The Board

- received assurance regarding Junior Doctor rotas and working conditions within the Trust
- supported the GSWH with the on-going work to ensure CAMHS trainee rota gaps and locum cover arrangements are compliant with the Junior Doctor terms and conditions
- supported the GSWH and JDF with regards to spending Fatigue and Facilities funds on ideas and suggestions as agreed by JDF.

Item 2021-22 (44)

Discussion points:

Nursing and Allied Health Professionals (AHP) re-validation and registration

The Executive Director of Nursing and AHPs presented the report which provided the Board with an update on nursing and AHP revalidation and registration.

The Board noted the positive position of nursing and AHP registration for those professionals employed by the Trust.

The Executive Director of Nursing and AHPs drew the Board's attention to the two referrals by members of the public to the Health and Care Professionals Council (HCPC). Both cases were currently in the HCPC fitness to practice process, but no restrictions or interim orders had been placed on the individuals concerned whilst investigations were ongoing.

The Board noted that one referral to the Nursing and Midwifery Council (NMC) had occurred over two years ago and supported the decision by the Executive Director of Nursing and AHPs to escalate this to the NMC because of the ongoing impact on the individual's health and wellbeing.
The Board discussed the data on staff in the group "nursing and midwifery" and received assurance that all those working in posts which required NMC registration had a current registration.

Outcome: The Board

- noted the position on nurse and AHP revalidation and re-registration.

Item 2021-22 (45)

Discussion points:

Workforce Strategy – 2021-25

The Director of Workforce, Organisational Development and System Development (LS) presented the draft Workforce Strategy 2021-2025 for discussion.

She explained that discussion and stakeholder engagement has been sought with a wide variety of forums and key feedback from stakeholders was summarised and reflected in the draft presented for this meeting.

Board members reviewed the draft and provided detailed feedback on style, tone and alignment with the Trust's strategy and priorities. The Director of Workforce, Organisational Development and System Development (LS) noted the numerous helpful points that were raised and agreed to contact individual non-executive directors outside the meeting to follow up on various aspects of the strategy in more detail.

A further Draft Workforce Strategy would be shared for comment with key stakeholders during August and September 2021. The Trust Board is due to receive a final version of the Workforce Strategy 2021-25 on 1 October 2021.

Outcome: The Board

- noted the progress in development of the Draft Workforce Strategy 2021-25; and provided views on its content; style, tone and alignment with overall Trusty strategy and priorities.

Item 2021-22 (46)

Discussion points:

Health Equity Strategy

The Trust's Health Equity Lead presented the report which provided an update on progress since the Strategy was approved by the Board in May 2021 and information about the planned activity to December 2021.

The Health Equity Lead led Board members through the detail of the implementation plan and the cross-cutting themes and the further joint work within Board's own assurance routes to facilitate further discussion and progress.

The Board acknowledged that a shared purpose of improving health equity would require the practical application of working across boundaries and to ensure the success of the Strategy, a break from working in silos, whether that be between services, strategies, programmes and organisations at place or at Integrated Care System (ICS) level.

The Trust Chair welcomed the update report which he said provided the Board with assurance that the work underpinning the delivery of the strategy was progressing well and the direction of travel was clear. He added that the ICS focus on leadership in improving health equity was a key factor and the Trust's leadership and governance would contribute to system leadership at ICS level.

Outcome: The Board

- received the update report and noted activity to December 2021
- noted the cross-cutting themes and supported further joint working within Board members' own assurance routes to facilitate further discussion and progress
- acknowledged the ICS focus on leadership in improving health equity and the ways this could be reflected in the Trust's own leadership and governance, as well as the way it contributed to system leadership and governance at place and ICS levels.

Item 2021-22 (47)

Discussion points:

Research and Development Strategy - update on progress

The Chief Executive presented the report on behalf of the Executive Medical Director which provided an update on the implementation of the Research and Development Strategy 2020-2025.

She said that implementation of the strategy had 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 Rehabilitation Service as part of a collaboration who have been awarded grant funding to explore and compare gold standard care

Outcome: The Board

- received and noted the update on the Research and Development Strategy 2020-25

Item 2021-22 (48)

Discussion points:

Medical Director's Annual Report – including approval of compliance statement

The Head of Medical Education and Revalidation presented the report on behalf of the Executive Medical Director which provided the Board with an update overview of the Trust's responsibilities regarding the employment of medical and dental staff within the Trust including, appraisal and medical revalidation, managing concerns and pre-employment checks. She added that it also fulfilled the requirements set by NHS England/NHS Improvement in relation to annual organisational audit, designated annual Board report and the statement of compliance.

The Board reviewed the report and approved the statement of compliance for signature and submission to NHS England and NHS Improvement.

Outcome: The Board:

- noted the contents of the 2020-21 Executive Medical Director's Annual Report
- approved the statement of compliance and agree submission to NHS England/NHS Improvement.

Item 2021-22 (49)

Discussion points:

Safeguarding Annual Report

The Executive Director of Nursing and AHPs presented the report which provided a brief overview of the safeguarding achievements and challenges in 2020-21 and outlined the key ambitions for 2021-22.

The annual report had been reviewed by the Quality Committee on 26 July 2021 and was recommended for approval.

Outcome: The Board:

- noted the report and approved its publication.

Item 2021-22 (50)

Discussion points:

Review of Standing Orders and Standing Financial Instructions

The Executive Director of Finance and Resources presented the paper. He explained that in order to ensure that the Board was 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.

The paper summarised several 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.

The Audit Committee had reviewed the proposed amendments at its meeting on 23 July 2021 and agreed, subject to one amendment, to recommend that the Board approves the revisions to the standing orders and standing financial instructions.

Outcome: The Board:

- approved the revisions to the standing orders/standing financial instructions.

Item 2021-22 (51)

Discussion points:

Quality Strategy

The Executive Director of Nursing and AHPs presented the Strategy for the next three years which had been developed with communities as a central focus. The Strategy set out the key priorities for 2021-2024, included learning from the Trust's experience of the international COVID-19 pandemic and information about how the Trust had responded to the challenges it had presented.

The Strategy had been reviewed by the Quality Committee on 26 July 2021 and was recommended to the Board for approval.

Non-Executive Director (KR) suggested that consideration should be given to including more explicit references to the innovations around the use of digital technology in care setting and how this impacted on quality. Particularly referencing links to the Trust's Digital Strategy.

Outcome: The Board

- approved the Quality Strategy 2021-2024.

Item 2021-22 (52)

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 (53)

Discussion points:

Any other business and close

The Trust Chair referred Board members to the additional Blue Box items (54 – 61) on the agenda and the papers which had been circulated to support those items. He explained that the Blue Box had been introduced on a trial basis for items that have already been discussed at a committee in full and where any concerns are escalated via the Chairs' assurance reports.

The Trust Chair invited any questions or comments on the Blue Box items. None were raised.

Date and time of next meeting
Friday 1 October 2021 9.00am-12.00 noon
Both virtual meeting and live streamed

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
6c	Business Committee: 26 May 2021 and 23 June 2021

AGENDA ITEM 2021-22 (65b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 1 October 2021

Agenda Number	Action Agreed	Lead	Timescale	Status
6 AUGUST 2021				
	None to note			

Actions on log completed since last Board meeting on 6 August 2021	
Actions not due for completion before 1 October 2021; progressing to timescale	
Actions not due for completion before 1 October 2021; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 1 October 2021; not having met agreed timescales and/or requirements	

Leeds Community Healthcare NHS Trust

Public Board Meeting: 1 October 2021

Agenda item number: 2021-22 (67)

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:

- Double Vaccination Requirement for Staff Entering Care Homes
- Listening to staff
- Health & Wellbeing Guardian
- Quarterly Staff Survey

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

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 including the most up to date figures on infection rates and system pressures.

3 Double Vaccination Requirement for Staff Entering Care Homes

The government requirement that all staff entering Care Homes from 11 November 2021 must be either doubly vaccinated or medically exempt affects approximately 1400 Leeds Community Healthcare NHS Trust LCH staff, who have been identified as filling roles that may be required to enter Care Homes in the course of their duties.

A rapid data collection and triangulation exercise has been undertaken. At the time of writing, a small percentage of staff are confirmed to be unvaccinated by choice, and further work is taking place to work with these individuals to work through next steps, including how their care home duties could be reassigned, and the possibility of redeployment.

The national position is that, where an affected member of staff without a medical exemption declines to take up the vaccination, and efforts to identify duties for them that do not require entry to Care Homes are not successful, termination of employment contract must be considered. Termination of any employee's contract at LCH is always a last resort, and we continue to approach this complex situation sensitively on a case-by-case basis, working hard to support managers and staff.

4 Listening to staff

Between the last Board meetings, I and the Senior Management Team (SMT) have continue to visit a range of teams at their bases. The Executive Director of Nursing and Allied Health Professionals continues to do sessions in clinical practice at the places she visits. The sessions are designed to be listening events for staff to allow us to hear directly from a range of front-line staff about their experiences.

As ever these meetings are invaluable and help shape all our practice. In particular, we have been discussing current pressures and concerns and ways in which we can work as a Trust to mitigate and support. That thinking feeds across all our work,

During the past period , senior managers 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 joined the following teams for events or meetings to listen and learn:

Armley Neighbourhood Team (NT)
Beeston NT
Meanwood NT
Seacroft NT
MindMate SPA (Single Point of Access)
Paediatricians' meeting
0-19 Leadership Team
Dental team meeting
Police Custody Suite, and Liaison and Diversion services in Hull
Directors' Personal Assistant (PA) Team

I also ran a session of '50 Voices' – the open forum for staff to talk with me about key issues. This session was focussed on health and wellbeing during the coming months – understanding what is working and what isn't.

All the SMT have been giving 'Thanks a bunch' presentations to staff to thank them for particular work – this is publicised on our intranet.

Other members of the SMT have recently visited the following services:

Executive Director of Finance and Resources – Reception staff at Armley, Bramley and Pudsey.
Executive Medical Director – Wetherby NT, Community Dental Middleton, Leeds Sexual Health Service.
Executive Director of Nursing and Allied Health Professionals – Community Matrons Seacroft, Virtual Frailty Ward, Primary Care Morley Health Centre, Child and Adolescent Mental Health Services (CAMHS) Crisis Team, Paediatric Audiology, Young Offenders' Institute and Police Custody Suite Sheffield.
Directors of Workforce – Chapeltown Neighbourhood Team, Twilight Nursing Team Armley, Facilities team meeting.
Executive Director of Operations – Wetherby Neighbourhood Team, ABU Leadership Team, CAMHS Leadership Team, Long Covid Pathway, Musculo Skeletal (MSK) Leadership Team, Wetherby Reception, Vaccination Team Elland Rd.

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 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 and which are informing all of our work

5 Health & Wellbeing Guardian

The health & wellbeing of our workforce continues to be a top priority. With this in mind we are delighted that Associate NED Rachel Booth has agreed to take up the role of Health & Wellbeing Guardian at LCH. The role of the Wellbeing Guardian has been introduced across the NHS, and organisations are strongly encouraged that the role is held by a Non-Executive.

The role was defined in the **NHS Staff and Learners' Mental Wellbeing Report NHS Staff and Learners' Mental Wellbeing Report**, which determined:

> *"The NHS Workforce Wellbeing Guardian will seek to assure and continue to re-assure the board that their organisation is a wellbeing organisation and a healthy workplace in which NHS staff and learners can work and thrive. The role will ensure that sufficient information is being provided to the Board, so it can benchmark, set organisational expectations and monitor performance in this regard."*

Rachel will be supported in her role by the Director and Assistant Director of Workforce.

6 National Pay Award

The NHS Pay Award of 3%, which affects the majority of NHS staff including all Agenda for Change staff and most of those on Medical & Dental Terms & Conditions, is being paid to LCH staff on Monday 27 September 2021. The award is made retrospectively with effect from 1 April 2021.

7 Annual General Meeting

The Trust's Annual General Meeting (AGM) took place on Tuesday 14 September 2021 with presentations from the Chair, Chief Executive and Executive Director of Finance and Resources. The event was held online for the second year running and was well attended by members of staff, third sector partnership colleagues and members of the public. A video was included which was accompanied by a poem written and read out by Fiona Johnson, Associate Community Matron called 'Today I cried' which was addressed to the citizens of Leeds and described how it felt to be working in community during the pandemic. In addition, Steph Lawrence, Executive Director of Nursing and Allied Health Professionals talked about Leeds Community Healthcare Charity's fundraising activities and the many ways that our charitable funds have supported patients, carers and staff throughout the last year.

You can watch a recording of the AGM on You Tube: https://youtu.be/exIxUYWBIGo

8 Quarterly Staff Survey

It has previously been reported to Board that the new Quarterly Staff Survey was launched during the summer. The results of the Quarter 2 Survey have now been received and are broadly positive. Full details are at Appendix 1. Results at service level are being disseminated to inform and supplement local Staff Survey actions plans, with Organisational Development and Improvement team members working alongside Business Units to support this.

During Q3 the national NHS Staff Survey will take place. Plan are in place to launch the Survey in LCH during week commencing 4 October, with the completion window running until the end of November. The Quarterly Staff Survey will return in Q4.

As ever this information is triangulated with other local knowledge and qualitative knowledge to inform our practice and focus.

9 Awards

9.1 Medipex NHS Innovation Awards 2021

We had two nominations for the "management of long-term conditions category" and both the LCH Long Covid service and the digital C19-YRS system were joint winners in this category:

"Design and implementation of the Leeds Long Covid Community Rehabilitation service"

Jennifer Davison and Rachel Tarrant on behalf of The Leeds Long COVID Community Rehabilitation Service based at Leeds Community Healthcare NHS Trust and in partnership with Leeds Teaching Hospitals, Leeds GP Confederation, Leeds CCG and University of Leeds

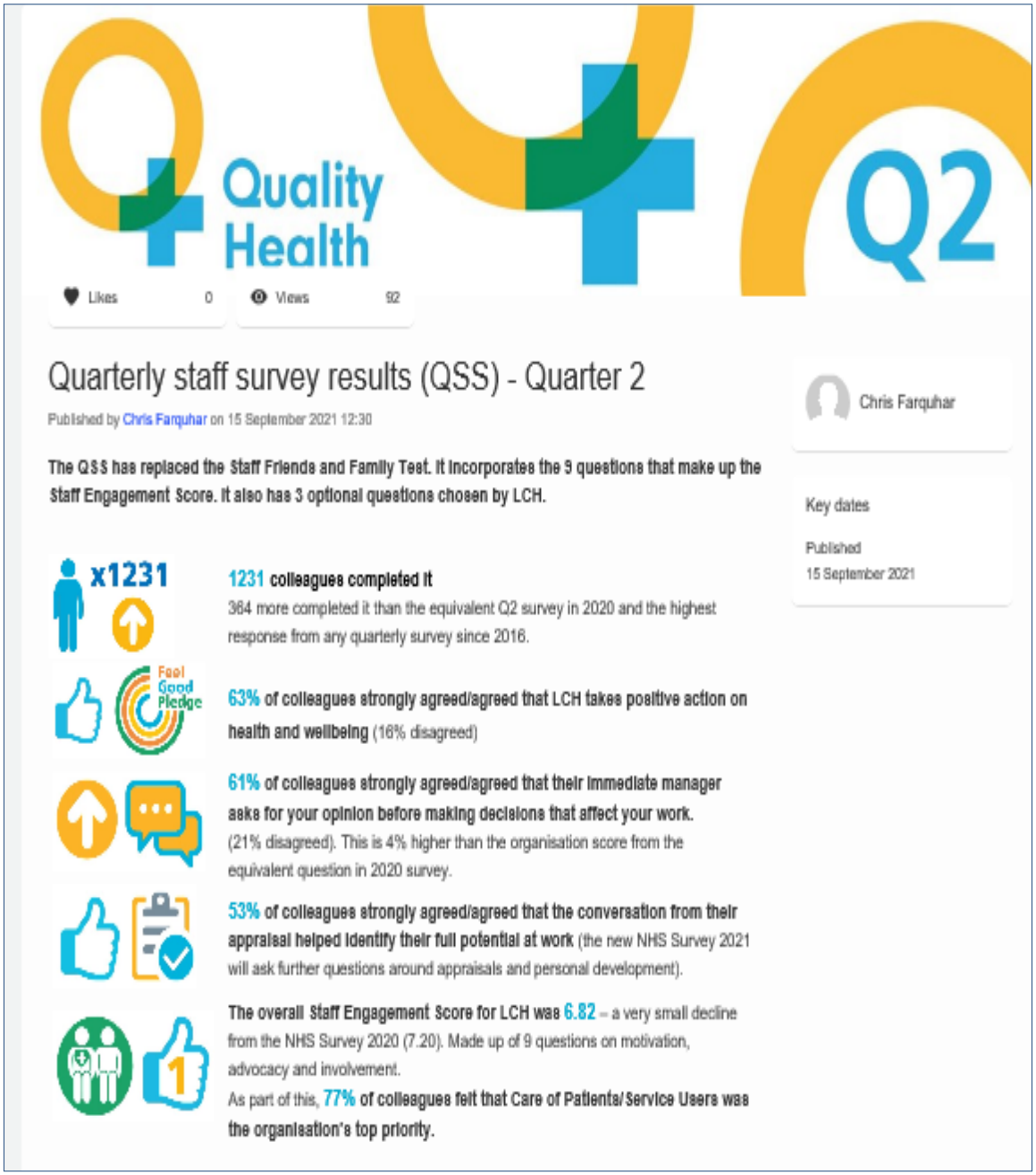
"The world's first validated digital assessment, triage, management, and monitoring system for Long COVID"

Dr Manoj Sivan from Leeds Teaching Hospitals NHS Trust in conjunction with Paul O'Brien from Elaros Ltd. and colleagues from Leeds Community Healthcare NHS Trust and the University of Leeds.

9.2 Health Service Journal Awards

Leeds Community Healthcare & Leeds Teaching Hospitals Trusts - Leeds Virtual Ward (Frailty) was a finalist in the 'Best use of integrated care and partnership working' category at the Health Service Journal Patient Safety Awards held in September 2021.

Appendix 1.


Quality Health
Q2
Likes 0
Views 92
Quarterly staff survey results (QSS) - Quarter 2
Published by Chris Farquhar on 15 September 2021 12:30
Chris Farquhar
The QSS has replaced the Staff Friends and Family Test. It incorporates the 9 questions that make up the Staff Engagement Score. It also has 3 optional questions chosen by LCH.
Key dates
Published
15 September 2021
x1231
1231 colleagues completed it
364 more completed it than the equivalent Q2 survey in 2020 and the highest response from any quarterly survey since 2016.
Feel Good Pledge
63% of colleagues strongly agreed/agreed that LCH takes positive action on health and wellbeing (16% disagreed)
61% of colleagues strongly agreed/agreed that their immediate manager asks for your opinion before making decisions that affect your work. (21% disagreed). This is 4% higher than the organisation score from the equivalent question in 2020 survey.
53% of colleagues strongly agreed/agreed that the conversation from their appraisal helped identify their full potential at work (the new NHS Survey 2021 will ask further questions around appraisals and personal development).
The overall Staff Engagement Score for LCH was 6.82 – a very small decline from the NHS Survey 2020 (7.20). Made up of 9 questions on motivation, advocacy and involvement.
As part of this, 77% of colleagues felt that Care of Patients/Service Users was the organisation's top priority.

Trust Board meeting held in public: 1 October 2021

Agenda item number: 2021-22 (68a)

Title: Charitable Funds Committee September 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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board from the Charitable Funds Committee held on 17 September 2021.

Recommendations

For the Trust Board to receive this assurance report from the Charitable Funds Committee.

1 Introduction

The Charitable Funds Committee is a sub –committee of the Trust Board who also act as the Board of Trustees for the Charity. 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

Charitable development updates

- Progress continues to raise the visibility of the charity internally and externally, including a presentation at the AGM.
- Ongoing planning for fundraising events continues and one of the Non-Executive Directors with experience of working for a charity has offered to attend an operational group meeting to support and discuss this further.
- The charity will have a presence at the Leeds Becket University Freshers week – an opportunity to promote the charity as well as share health advice.
- The charity raised over £2,000 on its 3 peaks walk in June 2021.
- The NHS Big Tea event was supported by the charity.
- There was a conversation about the funding of a minibus for Hannah House and work is underway to establish the best way to do this. A lease has been ruled out due to the high cost of this but other options around a second hand vehicle are being discussed. At the group there was discussion about the potential to work with another charity around this and that will be explored.

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.

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 report.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in Public: 1 October 2021
Agenda item number: 2021-22 (68b)

Title: Nominations and Remuneration Committee 17 September 2021: Chair Assurance Report

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Category of paper: for assurance
History: n/a

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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting scheduled for Friday 17 September, and it indicates the level of assurance based on the evidence received by the Committee.

Please note that this committee conducted its business virtually in February 2021 and that the last regular quarterly meeting of the committee was last held in July 2021.

Items discussed:

Board Appointments and Succession:
This was an annual item for consideration by the committee updating its members of Board appointments. The Committee approved this paper and concluded that they were assured by its contents.

Recommendations

The Board is recommended to note this information.

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 1 October 2021

Agenda item number: 2021-22 (69)

Title: Performance Brief and Domain Reports

Category of paper: Assurance

History: Senior Management Team – 22 September 2021, Quality Committee 27 September 2021 and Business Committee 29 September 2021

Responsible Director: Executive Director of Finance and Resources

Report author: Head of Business Intelligence

Executive Summary (Purpose and main points)

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

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

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

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

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

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

Recommendations

The Board is recommended to:

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

Performance Brief – August 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.

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

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

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

Committee Dates

Quality Committee – 27th September 2021
Business Committee – 29th September 2021
Trust Board – 1st October 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

A number of indicators, particularly within the Responsive and Well Led areas, triangulate to suggest an organisational picture of high pressure. The measures and their triangulation have informed detailed Senior Management Team discussions and action planning regarding demand and capacity. At the same time, the Trust continues to see a reduction in the number of serious incidents, which is one of our key Safety indicators.

In the **safe** domain an Assurance Review of Management of Incidents, Serious Incidents and Pressure Ulcers has taken place with a recommendation to ensure learning and actions are captured in Datix from the report.

102 incidents were reviewed at the Rapid Review Meetings in July and August, of which eight escalated to Serious incidents (7.8%). 25/45 day SI review meetings to quality assure all reports commenced in July and are chaired by one of the 3 BU Quality Leads; members of the group include Patient Safety Team, Safeguarding, subject matter expert and the Deputy Director of Nursing (DDoN) or Head of Clinical Governance (HoCG).

The Trust achieved 100% compliance in relation to Duty of Candour. Eight were completed within the LCH 10-day timeframe.

Bespoke Datix and SI training is ongoing within the Health Case Management (HCM Team) to support completion of investigations.

Datix improvement work has commenced for the Children's Business Unit with an anticipated date of completion by 1 October 2021.

A deep dive in the Adult Business Unit resulted in

- A review of the correct categorisation of Cat 2 Pressure Ulcers and MASD
- Armley/Yeadon have improvement plans in place.
- Middleton is being monitored due to early warning flags in June/July.
- Seacroft is being monitoring to assure sustained improvement

The Children's Business Unit are to perform deep dive relating to gastrostomy feed and information governance incidents.

There were 15 Central Alert System (CAS) notifications in the period.

In the **caring** domain there were 617 Friends and Family Test (FFT) responses in July and August 2021 or which 93.35% rated their care as good or very good.

The implementation of a new FFT business card, which includes a QR code that allows patients and carers to complete the FFT online.

The SystmOne communication template, as part of the demonstrating the Trust's commitment to Accessible Information Standards, went live 19 July 2021 as planned.

There were 17 complaints received in July and August 2021. 1 complaint exceeded the internal target of 40 working days to receive a response. In this case an extension was agreed with the complainant.

There were 91 concerns received in July and August 2021, most concerns (21) were received by the Leeds Sexual Health Service.

In the **responsive** domain performance against the waiting list standards is still below expectations. A separate paper on waiting list backlogs will be presented to Business Committee

In the **well-led** domain, the overall Sickness absence rate for August is 6.8% (1.7% short term and 5.1% long term) which is higher than those usually seen during summer months and is now 1% above the overall 2021/22 target outturn sickness absence rate of 5.8%. We have noted significant increases within the Operations Business Unit at 8.7% and the Specialist Business Unit at 7.1%. Following further analysis we are taking action both centrally in relation to capacity management, and in partnership with Business Units to support service leads in their management and support for staff experiencing ill health.

Over 50% of the 45 staff who left this month, were within the Registered Nursing Profession. Scrutiny around this will take place within the work currently underway to address capacity and demand.

The overall Appraisal position continues to be on a downward trend, at 71%. Our latest figures show over 700 appraisals are outstanding, with 45% of those within Adult Business Unit. A Plan has been put in place where managers across the Trust, will support Neighbourhood Teams with appraisal conversations, and we expect to see improvements in compliance rates by the end the year.

The overall Statutory and Mandatory position for the 13 MaST topics, continues to hover just slightly below the overall 2021/22 target outturn at just over 88%. During the next quarter work will continue in partnership with Subject Matter Experts to focus on low performing subjects, where compliance is below 80%.

Financial Performance to the end of August 2021 is as follows: 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 throughout 2021/22. At the time of writing there are no details as to the level of funding for the second half of the year.

The Trust's financial plan for the six months to the end of September (H1) is to breakeven on income and expenditure and this is expected to be the reported position.

There are 225 whole time equivalent vacancies for August, 75 of these relate to additional capacity planned to address waiting lists. The Trust is facing severe challenges in recruiting additional staff to address the backlog waiting lists whilst business as usual vacancies are increasing. Agency staff expenditure has remained fairly consistent throughout the year; despite the rise in vacancies.

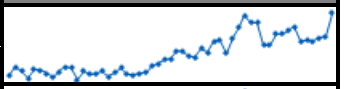
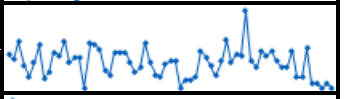
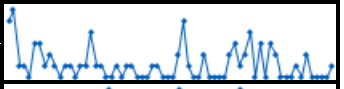
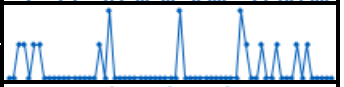
This vacancy and financial picture on pay is consistent with the information about service pressures that the Committees and Board will hear about elsewhere on their agendas.

Capital expenditure is £0.2m at the end of August which is £0.8m less than planned. The Trust expects to spend in full against its plan.

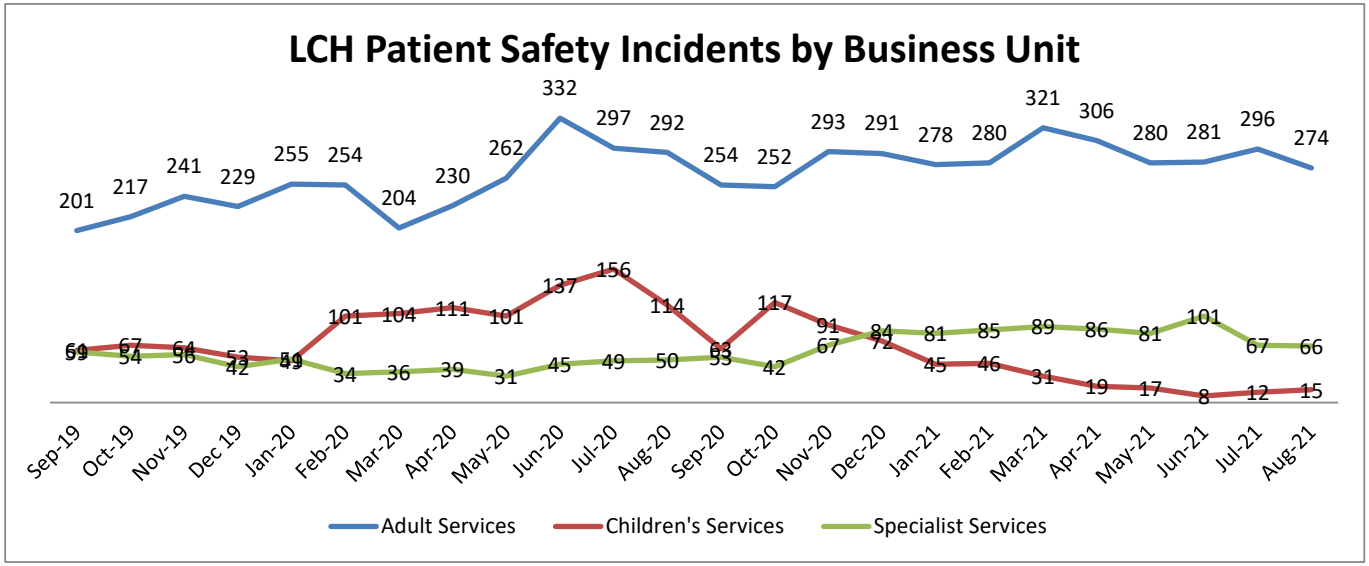
Safe – August 2021

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	Forecast	Financial Year	Q1	Jul	Aug	Time Series
Patient Safety Incidents Reported in Month Reported as Harmful	SL	1.06 to 1.73	●	2021/22	1.74	1.83	2.47	
				2020/21	2.12	2.18	2.17	
Serious Incident Rate	SL	0 to 0.1	●	2021/22	0.01	0.01	0.00	
				2020/21	0.05	0.06	0.07	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	3	●	2021/22	1	1	0	
				2020/21	3	3	2	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	●	2021/22	0	0	0	
				2020/21	1	0	0	
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	4	●	2021/22	1	1	0	
				2020/21	4	0	1	
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	RB	No Target	●	2021/22	63%			

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



During this reporting period, 730 LCH patient safety incidents were recorded in Datix. The Adult Business Unit (ABU) reported 570 (78.1%); Children's Business Unit (CBU) 27 (3.7%) and Specialist Business Unit (SBU) 133 (18.2%).

There is a clear decrease in reporting from the ABU; this relates to a reduction in medication and hospital discharge incidents; additional detail is provided within the report.

LCH Patient Safety Incidents Occurring in July and August 2021

There were 1224 incidents recorded in Datix in this reporting period. Of these, 730 (59.6%) 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	
Jul-21	352 (93.9%)	20 (5.3%)	3 (0.8%)	375
Aug-21	320 (90.1%)	29 (8.2%)	6 (1.7%)	355

**August 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 July & August 2021):

There were 49 moderate harm incidents reported, compared to 71 in May & July reporting period. Incident categories are as follows:

- 32 x Skin Damage (27 x Pressure Ulcers, 3 x Traumatic Skin Damage, 1 x device-related, 1 x DTI)
- 10 x Falls
- 2 x Implementation of care
- 2 x Medical Device
- 3 x Access/Appointment/Admission/Transfer/Discharge

Summary of Major Harm Incidents

9 major harm incidents were recorded this reporting period:

- 6 x falls (4 reviewed at Rapid Review Meeting (RRM) concluded no lapses in care, the remaining 2 has review dates booked in September).
- 1 x Self Harm reported by Leeds Mental Wellbeing Service (LMWS) - concluded no lapses in care at RRM
- 2 x Category 4 pressure ulcers reported by Woodsley and Yeadon Neighbourhood Teams. One of the 2 was reviewed at the RRM required further information and has a second review booked in September. The remaining one has a review date booked in September.

Rapid Review Meeting Outcomes in July & August 2021

102 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 outcomes are shown in the table below.

Total no.	No lapses in care Learning Identified	Progressed to Internal Investigation	Progressed to comprehensive SI with lapses in care	Further details required	Not a reportable incident or rejected
102	73 (71.6%)	5 (5%)	8 (7.8%)	15 (14.7%)	1 (1%)

The learning and good practice from the concluded reviews are shared with the reporting teams and the business unit following each review some of these are:

- Clearer documentation to be fully evidenced within clinical records.
- The importance of a multidisciplinary approach and handover.
- The need for therapy and nursing assessment on discharge from hospital.
- The importance of updating pressure ulcer management plans.
- To improve communication with the hospital regarding discharge concerns.
- To improve documentation concerning pressure risk assessment and management.
- Advice to be given to patients, carers and relatives on ways to reduce the risk of pressure damage

- Staff to ensure the identified risk of pressure ulcer has been recorded in the pressure ulcer risk management plan with clear action and plan to mitigate
- Appropriate delegation of complex wound care to qualified and senior staff only.
- Appropriate liaison with external diabetes service to ensure timely Blood Glucose level insulin review.

In addition to the early learning identified and shared with the reporting teams, any incidental learning identified from incidents concluded as having no contributory lapses in care, and therefore not progressed to serious incidents, are shared with the individual teams, actions recorded in Datix® and monitored by the patient safety team with support from the Business Unit Quality Lead.

Serious Incidents (SI) Investigations July & August 2021

Of the 102 incidents reviewed at the Rapid Review Meeting, 8 incidents progressed to Serious Incident and were reported on the Strategic Executive Information System (StEIS). These were:

- 3 x unstageable pressure ulcers by Seacroft, Middleton and Morley NT.
- 2 x fall incidents: A fall resulting in a left fractured neck of femur reported by Armley Neighbourhood Team and an unwitnessed fall resulting in an unexpected death of a palliative patient reported by Morley Neighbourhood Team. The initial review of the unexpected death has highlighted areas for further investigation and potential early learning of:
  - Bed rails were not in place due to miscommunication within the multidisciplinary team arranging discharge and generalisation of equipment being confirmed as in place,
  - Further identification of missing bed rails at the home assessment was not escalated at the first opportunity and not expedited to ensure prompt delivery,
  - A falls mat was not considered as a safety option, and the Wendylette was not removed to reduce risk of falls.
- 1x Abuse & violent incident involving a young person known to the Youth Justice Service who assaulted a member of the public with a knife and caused life-changing injuries is being reviewed.
- 1 x Category 3 pressure ulcer reported by Holt Park Neighbourhood Team.
- 1 x unexpected death reported by Middleton Neighbourhood Team. Further investigation is required to understand any delay in the escalation of patient self-neglect to safeguarding, whether the patient was discussed in MDT and whether the family were involved in the patient's care.

All eight remain under investigation; the learning will be shared in the quarterly Serious Incident report

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

LCH was 100% compliant with the Duty of Candour regulation. All eight incidents resulted in an initial letter within the LCH standard of 10 days during this reporting period.

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

Business Units Updates

Adult Business Unit (ABU)

Medicines Management

Following the review of medication incidents by the Medicine Management Team, ABU has noted a gradual decrease in medication incidents. During this reporting period, 74 medication incidents were recorded compared to 88 in June-July. Of these, 67 (90.5%) were no harm, and 7 (9.5%) were minimal harm. No incidents of moderate harm were recorded.

Hospital Discharge related incidents

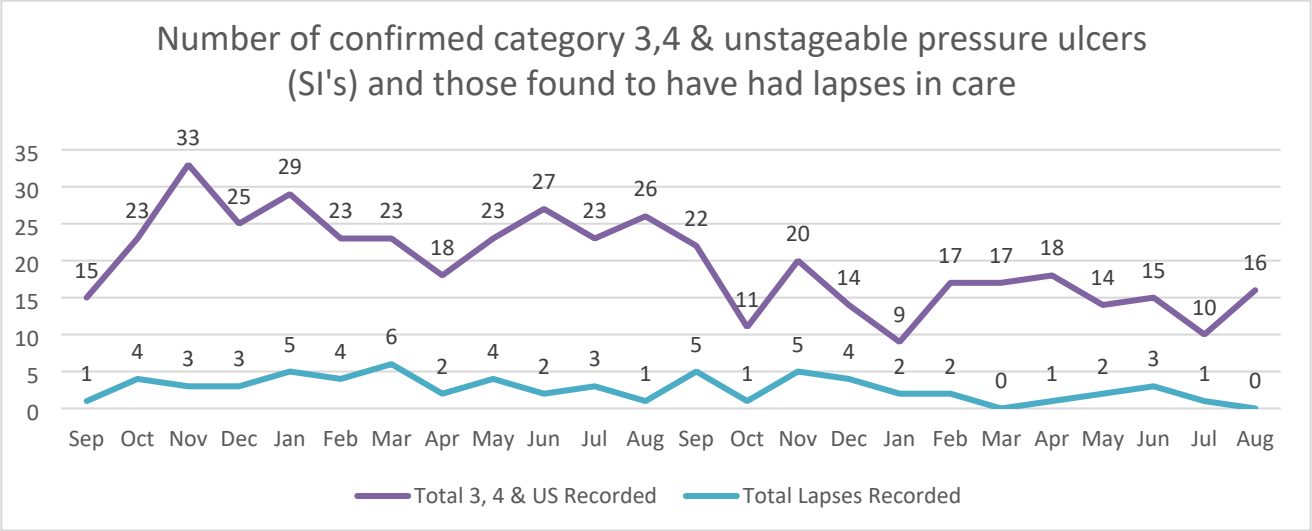
The number of incidents related to hospital discharge has decreased significantly from 9 (May-June) to 1 in this reporting period. In addition to the work with LTHT, quarterly meetings have now been set up with Airedale Hospitals Trust and Harrogate Hospitals Trust to present the hospital with incidents and themes to ensure shared learning.

Armley Neighbourhood Team

The Armley Neighbourhood Team conducted a Deep Dive following an increase in Moisture Associated Skin Damage (MASD) with the support of Tissue Viability. This has confirmed that care plans are not personalised in terms of titles and instructions. The Purpose T section for the moisture is often not completed accurately, treatment pathways are not followed, and appropriate medication is not given. An improvement plan is now being developed based on the action plan from the Deep Dive. This plan is monitored by the service with support from Quality Lead.

Pressure Ulcer Focus

Serious Incidents overview of Category 3, 4 and Unstageable pressure ulcers (PU's), within LCH recorded and closed during 2019/2020.



The tables show that overall, the Trust has reduced SI pressure ulcers month on month but has exceeded its 2020/21 target for category 3 and 4 pressure ulcers, see Appendix 2. Work is underway to review and produce a proposed KPI for 2021/22 with Deputy Director of Nursing, Clinical Pathway Lead for Tissue Viability Service and the Head of Clinical Governance.

Continued Improvement

- The SI templates were reviewed to support the overall PU improvement to identify contributory factors, care and delivery problems, and root causes to develop relevant, proportionate, and meaningful action plans. In addition, improvement work in Datix® has improved the recording of learning to enhance the quality of reporting and monitoring.

- The introduction of the Neighbourhood Team Coordinator (NTC) role in ordering and tracking equipment in Neighbourhood Teams is intended to free up clinical capacity and ensure the timely provision of pressure-relieving equipment

- A pressure ulcer scoring matrix was introduced during the reporting period to assess the harm caused by category 3,4 and unstageable pressure ulcers.

Category 4 Pressure Ulcer update

Two category 4 pressure ulcers reported.

Woodsley NT - reviewed at the Rapid Review Meeting on 20/09/2021, the service was requested to provide further information to support the decision.

Yeadon NT - reviewed on 10/09/2021 concluded a debridement of an already investigated pressure ulcer which was confirmed to have no lapses in care, no further actions required.

Children's Business Unit – Themes

Incidents

The CBU reported 38 incidents in July & August compared to 25 in May and June; 36 (94.7%) were no harm incidents, and 2 (5.3%) were minimal harm. The increase in reporting is not due to any category, trend or theme. It is worth noting that after trend analysis of blood sample incidents, no more incidents were recorded, we also saw a significant improvement in data accuracy in Datix incident completion.

The minimal harm incidents relate to a gastrojejunostomy being accidentally removed during moving and handling. The service will perform a deep dive; the outcome will be shared in the next reporting period.

The moderate harm Serious Incident from June that involved a young person known to Youth Justice Service (YJS) who assaulted a member of the public with a knife and caused life-changing injuries, was reviewed at RRM on 27/08/21 and concluded lapses in care with:

- There were missed opportunities to intervene that will be reviewed.

- Inaccurate information was passed from Youth Justice Nurse to Youth Juvenile Service senior management within CAMHS.
- Long delays in treatment at the medication clinic required escalation by the CAMHS Senior Manager to provide the young person with this service.

Themes

There is a theme within information governance incidents this month relating to incorrect details on records. A deep dive will be conducted in September to investigate this further. The result will be shared in the next report.
There are no noted trends in reporting over the last six months.

Specialist Business Unit (SBU) – Themes

After a steady increase during the three months between April and June, the number of patient safety incidents in SBU seems to have stabilised in the last two months.

Recurrent Themes

The top 3 categories within SBU that remain consistent are:

- Abusive, violent, and self-harming,
- Access, appointments, transfers and discharges
- Medication

It was noted that the number of incidents in Access, appointments, transfers and discharges increased between February and June and has reduced in July and August. An investigation will be carried out next month to see if this is due to the impact of the disruption of Covid services.
It was also noted that the number of incidents reported in Adel Beck has gradually increased since January 2021, which could indicate increased complexity of individuals, delayed transfer of individuals to the appropriate settings and a good reporting culture. A deep dive will be conducted next month to assess this further.

Learning

It was noted from an incident that a patient left a voice message on staff work mobile during crisis. Review of this incident identified a learning for all services to review local guidelines when giving out staff work mobile numbers for patients' crisis contact. Not all services have access to appropriate cuffs for blood pressure monitoring. The service should review that it has a range of cuff sizes (especially large) for measuring blood pressure.

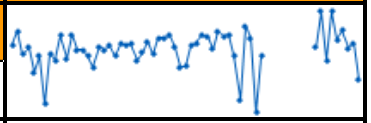
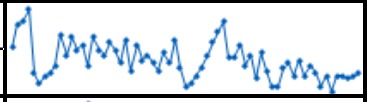
Central Alert System (CAS) Notifications

There were 15 alerts logged on Datix: five drug alerts, five supply disruption alerts, four patient safety alerts and one field safety notice.
All have been reviewed, and 13 have been updated and closed; 2 have actions ongoing and are within the timeframe for completion.

Caring – August 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	Forecast	Financial Year	Q1	Jul	Aug	Time Series
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%	●	2021/22	96.7%	96.4%	93.4%	
				2020/21	-	-	-	
Total Number of Formal Complaints Received	SL	No Target		2021/22	**23**	**8**	**9**	
				2020/21	19	13	8	
Number of Compliments Received	SL	No Target		2021/22	**237**	**67**	**67**	
				2020/21	148	97	68	

Friends and Family Test (FFT)

Overall, in July and August 2021, 93.35% of community patients/service users reported their experience as good or very good. 617 total responses were received in July and August 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, through the Engagement Champions within services and includes:

- The implementation of a new FFT business card, which includes a QR code that allows patients and carers to complete the FFT online.
- Developing translated versions of the FFT, initially in Urdu, Punjabi, Slovak, Romanian and Polish, which are the top five spoken languages in Leeds after English.

Patient Feedback of note during July and August 2021

Feedback from Virtual Services

Several services offering virtual approaches have started to collect FFT feedback from patients and carers in relation to this approach to clinical care. The objective is to identify the experience of attending virtual appointments whilst face to face consultations have been paused due to the COVID pandemic.

These services include the Cardiac Activity Programme, Virtual Pulmonary Rehabilitation and MSK. During July and August, there were 55 responses from patients who had received a virtual offer within these services of which 97.87% of rated their care as very good or good. This is slightly higher than for all services across the Trust, but it should be remembered this was a smaller sample group. Specific comments:

"On the whole I found my experience to be positive. I struggled with the video call but H talked me through what I needed to do which really helped. Personally I prefer face to face consultations but due to COVID I think this was a clever solution to an unprecedented situation."

"Call as expected, advice and exercises provided to aid further recovery of injury to arm and shoulder as follow up to previous treatment"

"I was sceptical that a telephone physio appointment would establish the cause of my symptoms but M took time to carefully go through my symptoms to arrive at a likely diagnosis."

Specialist Weight Management Service

In previous reports it was highlighted that the service had received some "poor" FFT responses. Comments pertained to service users feeling that a more individual approach was required in relation to diet plans and virtual group sessions, that individual support was lacking, and users were concerned they would be discharged if they failed to attend a session. Following these comments, the service has reflected and put in the following changes based on the feedback:

- Amended the Service's Attendance procedures to ensure that a user will not be discharged after missing 1 appointment but will be offered a further 2 appointments. This change has been shared with all new patients when starting to work with the service. Additionally, these changes are being added to the Trust's website. Secondly, all users will be sent a text if they have missed an appointment stating another appointment will be made and encouraging the user to contact the service.
- The service is working to extend duration of dietetic assessment in-line with British Dietetics Association good practice recommendation to 45-60 minutes, which will provide more time to explore users' needs requirements and expectations.
- The service is putting in place in-house and external Group Facilitation Training and Development for staff leading group sessions which focus on improving on improving the users experience of attending a group.

0-19 Health Visiting

A comment received in July from a parent related to an appointment feeling like a 'tick-box exercise' and feeling they were being 'talked down to' by a clinician. They also commented that better communication would be appreciated if an appointment is running late. The 0-19 PHIN Service, reflected on this comment and have:

- Changed the format on clinic invitations to ensure the length of appointments is made clearer and will work with the services' user group to ensure this meets their needs
- The 6–8 week appointment does include the Infant Mental Health screening tool which supports a discussion about looking at the world from their baby's viewpoint. The service is working with its service user group to explore how the purpose of this tool can be shared with parents, to avoid it feeling like a 'tick-box exercise'.

Engagement Champions

Service's Patient Engagement Champions continue to meet bi-monthly, with drop-in sessions available to all Champions for support and advice, and to check-in around ongoing engagement from the Patient Experience Team. As well as supporting services FFT usage and responses to FFT comments they are taking a lead role in supporting the implementation of the revised Communication Template on SystmOne to capturing the communication needs and digital literacy status of patients.

Champions attended a Health Equity workshop led by the Trust's Health Equity Lead that focused on how we ensure equitable access to services. Champions were challenged, with their services, to think about how they ensure equitable access and optimal outcomes for users of their services. A follow up session is being planned, asking champions to feedback their service thoughts and actions.

Accessible Information Standards

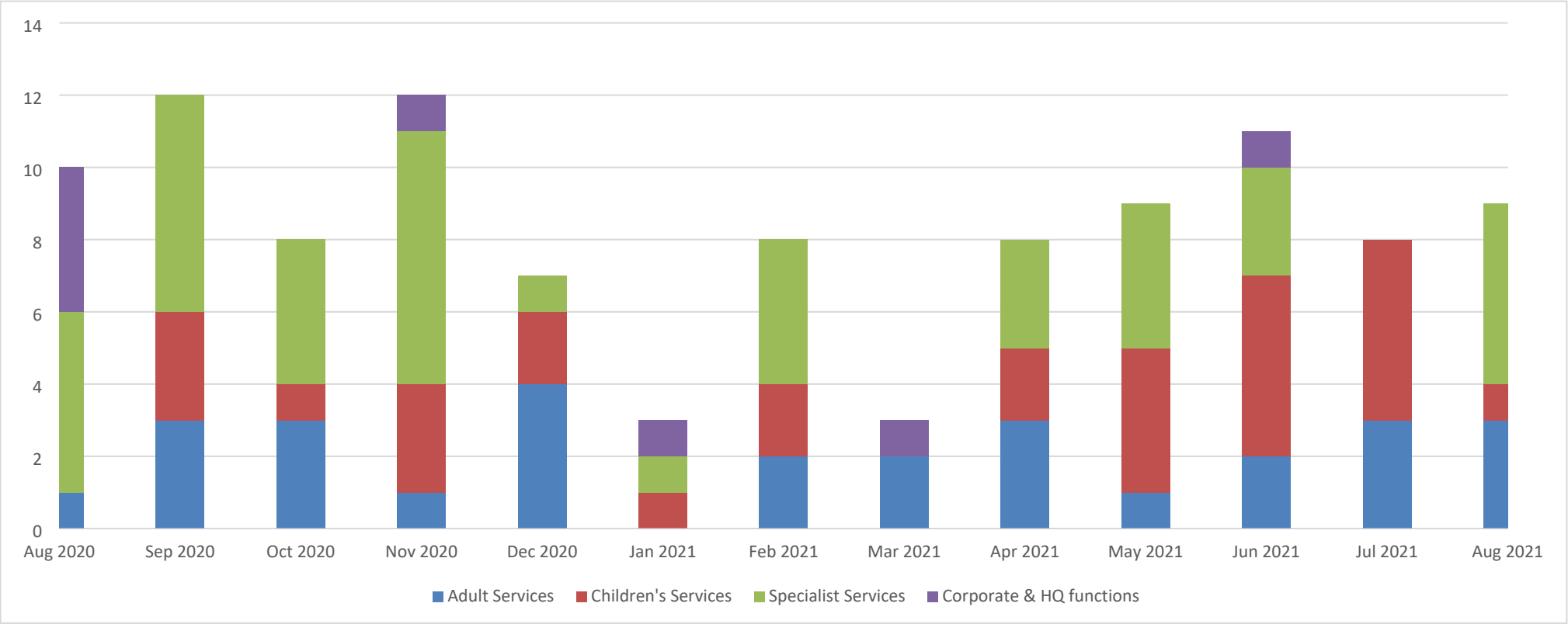
The SystmOne communication template to embed the Accessible Information Standards across the Organisation and to include digital literacy went live 19 July 2021 as planned. A frequently asked questions factsheet is being developed following requests from staff to support them completing the template. Staff have also raised the need to record communication needs of parents and carers alongside the community patient/user. This is being developed and will be shared at the LCH Carers Group before implementation.

Complaints, Concerns and Claims

There were 17 new complaints received in July and August 2021, with all acknowledged within 3 working days.

17 current complaints were closed with written responses sent to the complainant, of which 7 were partially or fully upheld following investigation. 1 complainant response exceeded the internal Trust target of 40 working days, receiving a response on day 47. The delay in response was due to the original investigator leaving the Trust and waiting for the new manager to come into post. This was shared with the complainant who agreed the extension.

The graph below highlights the number of complaints that have been received by the Trust over the last 12 months for comparison, an average of 8-10 per month. July and August 2021 complaints received are in line with expectations. There were no complaints received relating to the Specialist Business Unit in July 2021.



Learning from the closed complaints:

- The importance of services responding immediately to any concerns or complaints by community patients/users and/or their carers (Service complaint: ICAN Service)
- Service users have contact points for services, including services being referred to by Trust clinicians (Service complaint: Recovery Hub)

Following 2 complaints to ICAN Services the service has responded and changed processes to provide even better services.

- During initial triage, information is sought from other Trust services working with the child/young person to support quicker clinical decision making.
- If during triage another children's service is identified as needed, this is done directly rather than asking the referrer to make a second referral. The referrer is made aware of the changes and reasons why. The aim is for children/ young people to be seen by the right service quickly

Since August 2021 "learning from" posters are being produced by the Patient Experience Team to share learning across services, these are circulated and discussed using Quality Leads and Patient Engagement Champions.

There were 91 concerns received in July and August 2021, a slight increase from the last report. The majority of concerns (21 / 23%) were received by the Leeds Sexual Health Service, with 9 (10%) concerns reported by Community CAMHS and 8 (9%) by MSK.

19 of the reported concerns to Leeds Sexual Health Service related to ongoing issues with accessing the service via the telephone system. This issue has been raised previously, is on the Trust's risk register with a new system due for installation late summer 2021.

Community CAMHS have received 9 concerns during this time frame. The themes remain consistent with those over previous months; waiting times to be seen and to receive an autism/ADHD assessment. The service has a transformation plan in place to address these concerns. All families expressing concerns have had a conversation with a clinician, with clinical information reviewed to ensure all waiting time decision are based on clinical presentation

Claims

There have been zero clinical claims received. There has been 1 non-clinical claim received in July – August 2021.

Covid-19

We have received 1 Covid-19 related complaint in August 2021, and 4 Covid-19 related concerns between July and August 2021

The complaint received in August 2021 related to several issues and included the family being unable to view care facilities when making decisions for their relative due to Covid-19 restrictions. The complaint is being investigated.

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 continues to receive individual donations and following the success of the LCH 3 Peaks Challenge an annual events calendar is being developed.

As part of the Digital Inclusion Project for Unpaid Carers a user has described the effect of exclusion and the impact on their family of being given a free tablet. The story video will be available on YouTube in September 2021.

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.

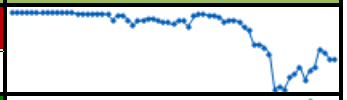
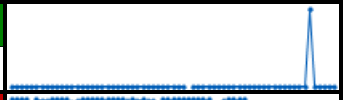
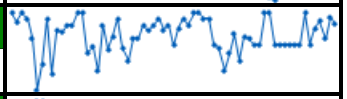
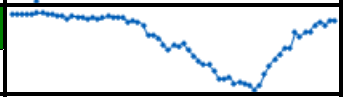
Leeds Community Healthcare NHS Trust

Measures in the effective domain are reported quarterly. There is therefore not an update in this report.

Responsive – August 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	Forecast	Financial Year	Q1	Jul	Aug	Time Series
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	●	2021/22	87.3%	85.1%	85.3%	
				2020/21	88.7%	87.3%	76.1%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	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%	●	2021/22	43.7%	44.4%	34.7%	
				2020/21	24.1%	26.3%	20.6%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	●	2021/22	76.1%	82.1%	84.5%	
				2020/21	69.2%	64.4%	62.8%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	●	2021/22	99.5%	99.9%	99.6%	
				2020/21	99.3%	99.6%	99.3%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	●	2021/22	89.6%	92.8%	92.8%	
				2020/21	37.9%	52.6%	59.2%	

Consultant-Led Waiting Times

Performance against the 18-week referral to treatment standard is below expectations with 85.3% of patients being seen within the 18-week standard (target 92%). There equates to 261 patients waiting more than 18 weeks. The table below provides details on the number of patients waiting on each consultant-led pathway. The challenges in the Paediatric Audiology (Consultant-led) have now been addressed and 99% of children are now being seen within the 18-week standard. The challenges remain in Paediatric Neurodisability where 73% of children are seen within the timeframe. This is a deterioration in

performance from 76.6% last month. Community Paediatric Clinic waits have improved to 78.0% (up from 75.2% last month). There are currently capacity and skills gaps within ICAN medical teams, specifically related to PND and Integrated Health Needs Assessments. PND-trained locums are currently being recruited, and the team is also working with the Looked After Children Team and other system colleagues to develop sustainable solutions for Initial Health Needs Assessments gaps.

Diagnostic Waiting Times (DM01)

Audiology has not met the DM01 6-week standard for diagnostic tests in August, achieving 34.7% (against a target of 99%). This is partly associated with backlog caused by the closure of the service in the first wave of Covid-19 but more recently due to increased rates of referral over the last 4 months. Analysis has shown that almost all the growth in referrals comes from internal sources such as Children's SLT and 0-19 Services, who are working at enhanced levels to clear their own backlogs. The service has been successful in clearing almost all 18+ week waiters (25 patients in July, compared to the high of 265 in October 2020), and the number of patients waiting 12-18 weeks has also decreased (183 in July, down from 230).

Improving Access to Psychological Therapies

Performance remains good against the 6-week and 18-week standards.

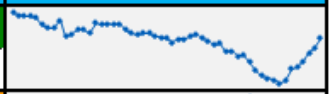
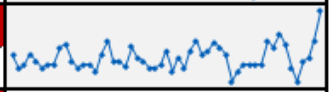
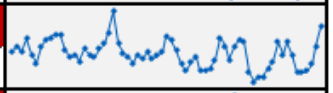
Waiting List Backlog

A separate paper on this issue will be discussed by Business Committee on 29 September

Well-Led – August 2021

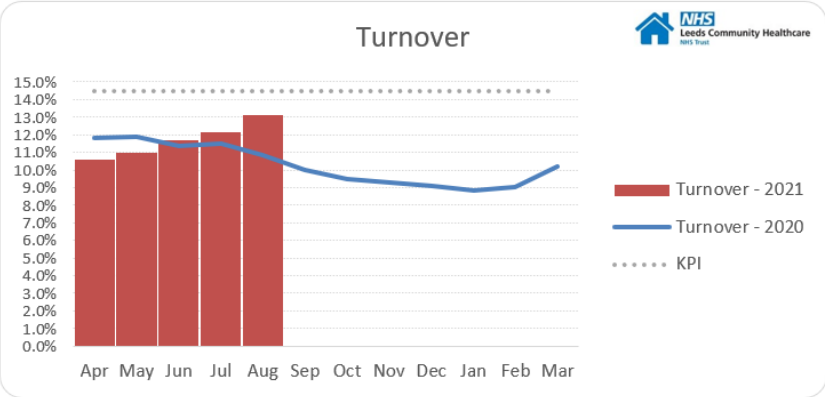
By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high quality person-centred care, encourages learning and innovation, and promotes an open and fair culture.

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	Q1	Jul	Aug	Time Series
Staff Turnover	LS/JA	<=14.5%	●	2021/22	11.7%	12.1%	13.1%	
				2020/21	11.4%	11.5%	10.8%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	●	2021/22	18.8%	20.5%	19.2%	
				2020/21	21.6%	23.2%	26.5%	
Stability Index	LS/JA	>=85%	●	2021/22	85.8%	85.3%	84.0%	
				2020/21	88.6%	88.4%	89.0%	
Short term sickness absence rate (%)	LS/JA	<=2.2%	●	2021/22	1.4%	1.7%	1.7%	
				2020/21	1.0%	1.0%	0.9%	
Long term sickness absence rate (%)	LS/JA	<=3.6%	●	2021/22	3.7%	4.2%	5.1%	
				2020/21	3.9%	3.3%	3.7%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=5.8%	●	2021/22	5.1%	5.9%	6.8%	
				2020/21	4.3%	4.5%	4.5%	
AfC Staff Appraisal Rate	LS/JA	>=90%	●	2021/22	72.9%	72.7%	71.0%	
				2020/21	81.8%	83.9%	84.3%	
Statutory and Mandatory Training Compliance	LS/JA	>=90%	●	2021/22	89.2%	88.4%	88.2%	
				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	Q1	Jul	Aug	Time Series
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	LS/JA	>=52.0%		2021/22				
				2020/21		71.0%		
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	**5**	**0**	**0**	
				2020/21	2	1	0	
Percentage of staff in each of the AfC bands 1-9 and VSM (including exec. board members)	LS/JA	No Target		2021/22	**11.4%**	**11.5%**	**11.6%**	
				2020/21	10.9%	10.4%	10.9%	
Total agency cap (£k)	BM			2021/22	**1153**	**230**	**233**	
				2020/21	2546	219	167	
Percentage Spend on Temporary Staff	BM	No Target		2021/22	**4.8%**	**4.5%**	**4.9%**	
				2020/21	5.0%	4.5%	3.6%	

Retention



	Target	Apr	May	Jun	Jul	Aug
Turnover - 2020	(14.5%)	11.8%	11.9%	11.4%	11.5%	10.8%
Turnover - 2021		10.6%	10.9%	11.7%	12.1%	13.1%
Adult Business unit - 2021		9.2%	9.1%	9.5%	9.8%	10.5%
Children's Business Unit - 2021		14.9%	16.2%	15.9%	15.9%	16.9%
Corporate Directorate - 2021		7.7%	8.7%	12.0%	11.5%	12.5%
Operations - 2021		6.8%	6.7%	8.1%	9.1%	10.1%
PCN Business Unit - 2021		35.1%	30.6%	36.1%	36.4%	39.1%
Specialist Business Unit - 2021		8.6%	8.8%	9.3%	10.6%	11.8%

The totality of our Well Led indicators this month suggest that our workforce capacity is experiencing higher impact than normally seen during this quarter, with turnover and sickness in particular both increasing. As described at the beginning of this month's Well Led report, these indicators and their triangulation with other data, have informed Senior Management Team discussions in relation to organisational demand and capacity.

Turnover continues to be on an increasing trajectory and whilst still within tolerance at 13.1% our organisational stability rate has continued to decrease since March 2021 and is now reporting 84% which is below the target of 85%. The pandemic did initially have a positive impact on turnover and stability rates and the Trust experienced the lowest rates since it was established in 2011. The easing of Covid restrictions has coincided with a steady increase in turnover which is expected to continue in line with the latest labour market reports. Additionally, this trajectory of higher turnover and less stability is one that is tracking the NHS wide trend across all types of Trusts.

Staff leaving within the first 12 months of employment has steadily increased since March 2021 but is still just within tolerance at 19.2% (2.9 WTE) and below the target of 20%. Action has been taken on this with the establishment of a new starters forum monthly to meet with those new to LCH and within their first couple of months of employment. This will be hosted by the Chief Executive with the Director of Workforce and Chair of the REN network and aims to connect new starters to each other as well as understand their experiences and solve any particular issues and challenges.

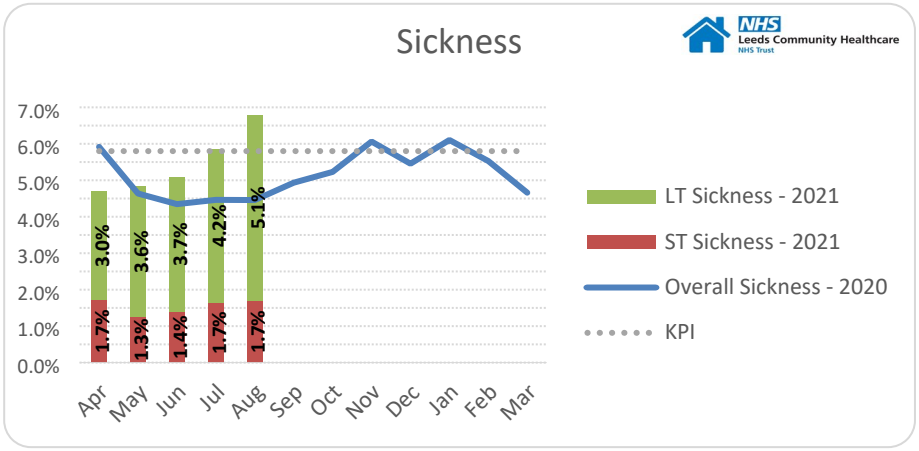
We have noted that over 50% (18.6 WTE) of staff leaving this month were within the Registered Nursing Profession. Scrutiny around this will take place within the work currently underway to address capacity and demand.

The reasons for leaving remain consistent across the business units and staff groups with the highest reasons being for promotion closely followed by voluntary resignation (reasons not known). Further work will be undertaken during Q3 to revisit the exit interview process, with the intention of "closing the gap" of "unknowns" and ensuring that appropriate actions are implemented.

Background detail associated with retention is set out in **Appendix 3.**

Sickness Absence

Overall Trust Wide Sickness Absence Rate



	Target	Apr	May	Jun	Jul	Aug
Overall Sickness - 2020	(5.8%)	5.9%	4.6%	4.3%	4.5%	4.5%
Overall Sickness - 2021		4.7%	4.8%	5.1%	5.9%	6.8%
Adult Business unit - 2021		6.4%	6.6%	6.7%	7.7%	8.2%
Children's Business Unit - 2021		4.0%	3.8%	4.9%	6.0%	6.2%
Corporate Directorate - 2021		2.3%	1.8%	2.0%	1.5%	1.0%
Operations - 2021		3.9%	5.9%	4.7%	3.6%	8.7%
PCN Business Unit - 2021			0.0%	0.0%	0.3%	1.1%
Specialist Business Unit - 2021		4.0%	4.3%	4.3%	5.3%	7.1%

Throughout 2020/2021 and during the pandemic we have seen sustained improvements in a reduction of sickness absence levels in comparison with the previous year. The general downward trend continued across all Business Units and Corporate Teams through to April 2021.

Since then the overall sickness absence figures have started to increase with the most notable increase to 5.9% for July (1.7% short term and 4.2% long term) and 6.8% for August 2021 (1.7% short term and 5.1% long term).

Sickness absence rates are higher than those usually seen in LCH during summer months and is now 1% above the overall 2021/22 target outturn sickness absence rate of 5.8%. The main reason for long term absence continues to be anxiety, stress, and depression. The primary reason for short-term sickness absence is “infectious diseases”, which is not unexpected during a prolonged pandemic period.

The areas with the highest increase in overall sickness absence rate is the Operations Business Unit and Specialist Business Unit.

The overall sickness absence rate within the Operations Business Unit, is 8.7%, with 6% of this attributable to long term absence. The hot-spot areas identified are shown below.

833 Admin Estates Area 2	26.64%
833 Domestics Team	14.36%
833 Electronic Patient Record	14.04%

The overall sickness absence rate within the Specialist Business Unit, is 7.1%, with 5.7% of this attributable to long term absence. The hot-spot areas identified are shown below.

833 HH Custody Suite	20.35%
833 Liaison & Diversion Humber	16.86%
833 NY Custody Suite	20.60%
833 Respiratory service	16.75%
833 WY Custody Suite	16.33%

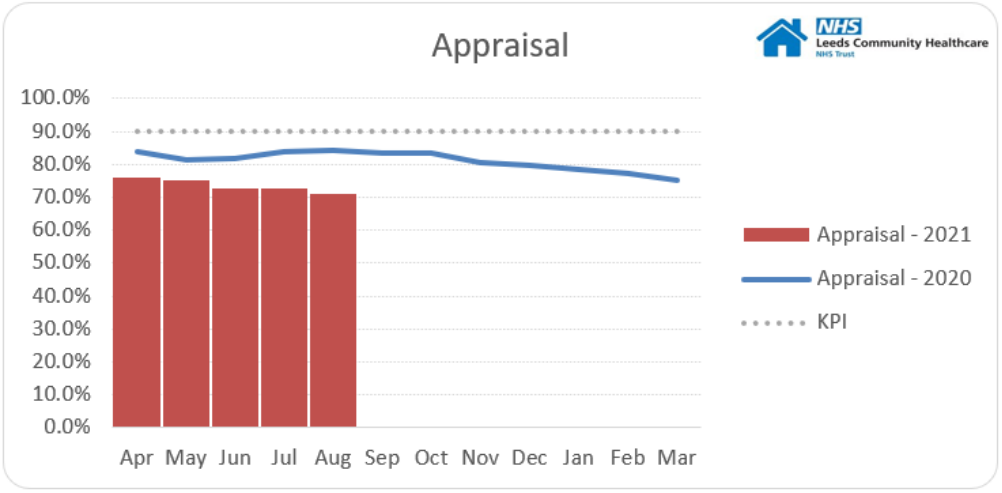
The HRBP will continue to work closely alongside line managers and staff to support those who are currently absent from work. The CEO recently promoted the entirety of the LCH health and wellbeing offer, with easy access to the HWB offer in “one easy click” on desk-tops, with personal message to access via works mobile phones. We continue to develop and deliver psychological wellbeing support and have secured funding from NHS Charitable Funds to further support this work.

Engagement is currently taking place through the HWB Group and with staff with a disability or long-term condition to further develop and refine the current Workforce Disability Equality Standard (WDES) Action plan, to ensure our future HWB offer is aligned with the needs of its workforce and crucially to ensure that staff can and do access what is available to them when they need it.

Appraisal

Linked with the current actions we have taken under organisational protocols in response to demand and capacity, the overall Trust appraisal position continues to be below target, and has reduced to 71%.

Overall Trust Wide Appraisal Rate



	Target	Apr	May	Jun	Jul	Aug
Appraisal - 2020	90%	84.0%	81.4%	81.8%	83.9%	84.3%
Appraisal - 2021		76.2%	75.0%	72.9%	72.7%	71.0%
Adult Business unit - 2021		63.2%	61.5%	58.3%	54.9%	53.9%
Children's Business Unit - 2021		87.6%	86.4%	83.6%	85.4%	83.4%
Corporate Directorate - 2021		88.1%	90.0%	86.4%	85.9%	86.2%
Operations - 2021		89.1%	88.9%	88.5%	89.1%	88.7%
PCN Business Unit - 2021			100.0%	97.0%	94.1%	88.2%
Specialist Business Unit - 2021		75.3%	73.1%	72.9%	75.2%	72.5%

The latest available figures show 743 are outstanding appraisals across the Trust.

- 140 (22%) are new staff who have not had an objective setting meeting recorded in ESR. Further promotion to take place around this requirement, which will hopefully increase compliance rates.
- ABU has the largest number of outstanding appraisals at 410, the majority of these are from Neighbourhood Teams (335) which represents **45%** of all outstanding appraisals across the Trust. As this is a significant number to recover; a plan has been devised and approved by SMT where managers across the Trust, will support Neighbourhood Teams with appraisal conversations. We expect to see improvements in compliance rates by the end the year.
- Specialist Business Unit has 174 outstanding appraisals. Hot spot areas within Specialist Business Unit are Podiatry Services (22% of SBU), Leeds Mental Wellbeing Service (11% of SBU) and Sexual Health (11% of SBU).
- Children's Business Unit has 110 outstanding appraisals. Hot spot areas are within CAMHS (42%of CBU) and ICAN (19% of CBU).
- Corporate has 27 outstanding appraisals, (37% are from the Finance Team). Targeted reporting has been provided to Corporate Managers to ensure these are actioned.
- Operations Business Unit has 22 outstanding appraisals. Leeds Equipment Service make up nearly half of these (45% of Operations) and the L & D Manager has a meeting arranged with the Manager.

Statutory and Mandatory Training

The overall Statutory and Mandatory position continues to hover just slightly below the overall 2021/22 target outturn at 88.2**%**

Overall Trust Wide Statutory & Mandatory Training Rate

	Target	Apr	May	Jun	Jul	Aug
Training - 2020	90%	86.7%	89.7%	91.3%	92.5%	93.0%
Training - 2021		89.9%	87.9%	89.2%	88.4%	88.2%
Adult Business unit - 2021		84.2%	82.0%	83.5%	83.4%	83.2%
Children's Business Unit - 2021		92.1%	90.3%	91.3%	91.1%	91.4%
Corporate Directorate - 2021		93.5%	91.5%	93.0%	93.0%	92.8%
Operations - 2021		94.0%	93.5%	94.1%	94.2%	92.2%
PCN Business Unit - 2021			62.6%	70.1%	42.7%	54.7%
Specialist Business Unit - 2021		93.3%	92.0%	93.1%	92.3%	91.6%

The overall compliance rate now includes reporting across all 13 MaST subjects as defined by the Trust (previously it was 6) and the Workforce Information Systems have been modified to ensure that any new positions created are allocated the correct MaST training requirements.

Over the next quarter work will continue to focus on low performing subjects, where compliance is below 80%, through targeted communications and reporting analysis in partnership with Subject Matter Experts. These include:

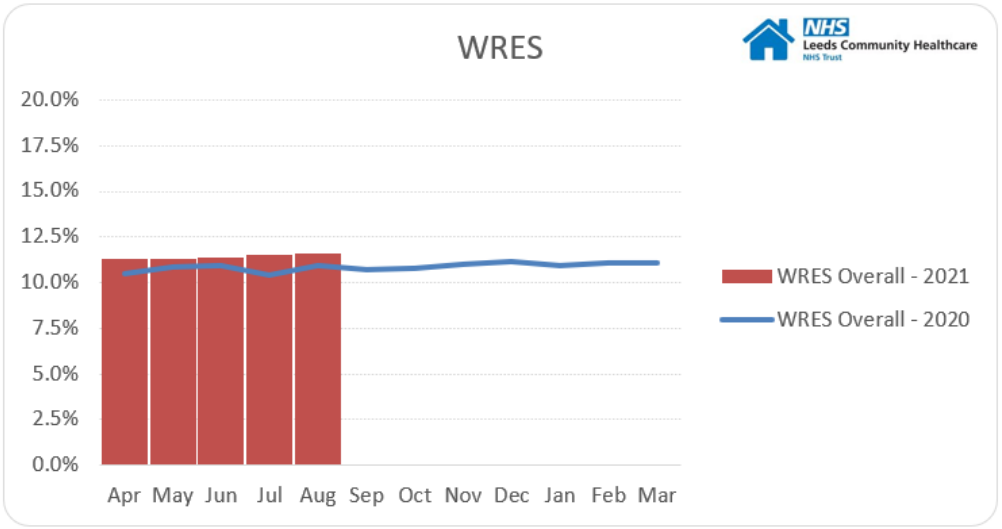
- Resus/CPR (current compliance 79%)
- Dementia Tier 2 (76%)
- Mental Capacity Act (current compliance 79%)
- Moving and Handling Inanimate Loads for Leeds Equipment Service (79%).

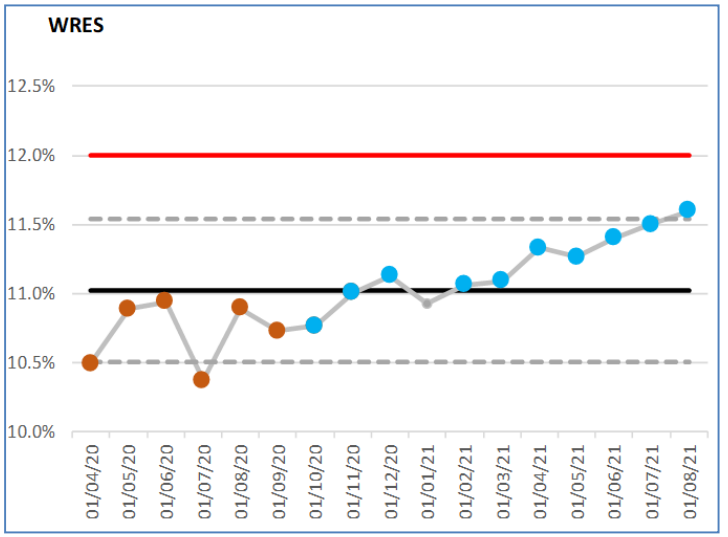
Workforce Racial Equality Standard (WRES indicator 1)

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 aspirational goals to reflect this more up to date position.

The percentage of BME staff employed in the overall workforce has continued to rise steadily over the preceding 12 months, with the most notable increase in Bands 8-9, which has seen more than 2% increase.

	Apr	May	Jun	Jul	Aug
WRES Overall - 2020	10.5%	10.9%	10.9%	10.4%	10.9%
WRES Bands 8-9 - 2020	4.0%	4.0%	4.1%	4.0%	4.1%
WRES Overall - 2021	11.3%	11.3%	11.4%	11.5%	11.6%
WRES Bands 8-9 - 2021	5.1%	5.5%	5.5%	5.8%	6.2%





Work continues on the WRES agenda with the inclusion in the new Workforce strategy of the theme that *we are much more representative of our communities.* Engagement is currently taking place with the Race Equality Network (REN) Group and other key stakeholders in revising the current WRES action plan 2021/22, prior to approval at Trust Board and posting on the Trusts webpage at the end of October 2021.

The WRES action plan 2012/22 will be a standing item agenda at the newly created *Diversity & Inclusion Forum*, chaired by the LCH Chairman. The forums inaugural meeting is due to take place on the 20 October 2021.

Finance – August 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	Q1	Jul	Aug	
Net surplus (-)/Deficit (+) (£m) - YTD	BM			2021/22	-2.0	-2.0	-1.0	
Capital expenditure in comparison to plan (£k)	BM			2021/22	228	-18	49	
CIP delivery (£k)	BM			2021/22	220	44	44	

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 throughout 2021/22. At the time of writing there are no details as to the level of funding for the second 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); 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

Income and Expenditure is planned to breakeven at the end of September (table 1). To the end of August **year to date** expenditure is £1m less than the income the Trust has received leading to a surplus of £1m. The **forecast outturn** at the end of September is breakeven. This is because the work to recover the backlog waiting lists was weighted to the end of the first six months and then the remainder of the year.

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 £0.6m of Covid-19 vaccination related additional costs; this is matched by additional funding from NHS England.

There were net 225 vacancies in August this is an increase on 40 on last month; 75 of the vacancies are in respect of additional resource identified for waiting list work meaning 150 vacancies are in respect of business as usual. Non-pay and reserves expenditure totals £2m more than the plan for August; 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 August clinical income is marginally ahead of plan; the £0.3m is the net of increased income for infection control, Leeds equipment and Wetherby Young Offenders services less penalties expected for the 0-19 and police custody services and an under-trading on income from schools. Non patient care income is overachieving by the Covid vaccination programme costs £0.6m plus £0.2m additional training and education income from Health Education England and small amounts of other 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 slippage on plans to address back-logs.

There were a net 225 whole time equivalent (wte) vacancies for August; up from 185 for July. 75 of the vacancies are in respect of new posts created to support waiting list initiatives.

The vacancies are in the following business units:

Business Unit	Total WTE Vacancies	Waiting list posts vacant	BAU posts vacant
Specialist Business Unit	-98	-59	-39
Children's Business Unit	-48	-15	-33
Adults' Business Unit	-57		-57
Operational Management	1		1
Corporate	-10	-1	-9
Estates including front of house	-19		-19
Covid	6		6
Total Vacancies	**-225**	**-75**	**-150**

Vacancies in Specialist BU are for:

- Podiatry 13 (11.5 staff for backlog/waiting list)
- Community Rehabilitation Neurological Services 17 (8 waiting list)
- LMWS 17 (10 waiting list)
- Police Custody 6 (penalties are incurred for missed shifts for this service)
- MSK 12 (1 waiting list)
- Dental 8 (3 waiting list)
- Cardiac 6 (there are 8 additional waiting list posts)

Vacancies for Children's BU are in:

- 0-19 Service 20 (penalties are incurred in respect of staff numbers being below planned levels)
- CAMHS Crisis Helpline 8 (service development)
- Continuing Care and Respite 8 (16% of establishment)
- Speech and Language Therapies 5 (there are 6 additional waiting list posts)
- CAMHs psychology 8 (6 are waiting list posts)

Vacancies for Adult's BU are in:

- Neighbourhood teams 35 (5.7% of the planned capacity)
- Therapy Support Discharge 9 (service development)
- Virtual Ward Frailty 5 (service expansion)
- Integrated Discharge service 6 (23% of the planned capacity)

The Trust is facing severe challenges in recruiting additional staff to address the backlog waiting lists whilst business as usual vacancies are increasing. The WTE exclude agency staff, the levels of which have remained fairly consistent throughout the year; circa the £230k that was spent in August.

This vacancy and financial picture on pay is consistent with the information about service pressures that the Committees and Board will hear about elsewhere on their agendas.

Non-pay, excluding reserves and non-recurrent (table 3), is £420k underspent at the end of August. 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 is 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 capital expenditure financed from depreciation and the Trust's cash reserves built up from historic surpluses.

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 capita expenditure is £0.2m expenditure against planned expenditure of £1.0m. The slippage is mostly in respect of IT related expenditure and is a matter of timing. The Trust will continue to review its capital requirements as the year progresses but fully expects to spend in line with plan.

Cash

The Trust's cash position remains very strong with £48.4m 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 finance team continue to take measures to ensure compliance is maintained.

Appendix 1 – August 2021

KPIs associated with financial sanctions

Leeds Community Healthcare NHS Trust

Measures with Financial incentives/Sanctions	Responsible Director	Threshold - YTD	Forecast	Financial Year	Q1	Jul	Aug	Potential Financial Impact
LMWS – Access Target; Local Measure (including PCMH)	SP	9715		2021/22	5686	1838	1465	
LMWS - Number of IAPT patients being assessed within two weeks of referral	SP	TBC		2021/22	71.6%	74.4%	67.3%	
LMWS - Number of people from Black, Asian and Minority Ethnic (BAME) groups entering IAPT treatment (access)	SP	TBC		2021/22	19.8%			
LMWS - Number and % of people from BAME groups who have accessed IAPT treatment moving to recovery	SP	TBC		2021/22	36.0%			
LMWS - % of older people (65+) entering IAPT treatment (access)	SP	TBC		2021/22	2.8%			
LMWS - Number and % of older people (65+) who have accessed IAPT treatment moving to recovery	SP	TBC		2021/22	48.1%			
T3WM - Percentage of patients currently waiting under 18 weeks	SP	>=92%		2021/22	88.2%	100.0%	100.0%	
LCPS - Number of Serious Incidents and Never Events not reported by email within 2 working days	SP			2021/22				
LCPS - Number of Serious Incidents and Never Events where final investigation wasn't completed within 60 working days	SP			2021/22				
LCPS - Annual audit report of referrer satisfaction with the service to be received by the CCG within 1 month of the date it is due	SP			2021/22				
LCPS - Any patient listed for a category 2 procedure listed in the NHSE EBI guidance should has within the record agreed documentation that the patient meets the required inclusion criteria	SP			2021/22				

Measures with Financial Sanctions	Responsible Director	Threshold - YTD	Forecast	Financial Year	Q1	Jul	Aug	Potential Financial Impact
0-19 - % of infants who had a face to face newborn visit within 14 days of birth.	SP	>=87%		2020/21	92%			
0-19 - % of 6-8 week reviews completed within 12 weeks of birth.	SP	>=83%		2020/21	43%			
0-19 - % of 12 month reviews completed within 12 months.	SP	>=80%		2020/21	79%			
0-19 - Number of PBB Programmes commenced	SP	>=83		2021/22				0.25% of contract value (annual)
0-19 - Number of HENRY Programmes commenced	SP	>=80		2021/22				0.25% of contract value (annual)
0-19 - Percentage of actual staff in post against funded establishment	SP	>=95%	●	2021/22				
0-19 - % of 0-19 staff (excluding SPA) co-located in Children's Centres	SP	43%		2021/22				
0-19 - Roll Out of Chat Health to secondary schools	SP	>=95%		2021/22	100.0%			
PolCust - % of calls attended within 60 minutes	SP	>=95%	●	2021/22		87.0%	89.0%	0.50% deduction from monthly invoice
PolCust - Provision of a full rota	SP	>=90%	●	2021/22		99.3%	97.8%	£350 deduction per missed shift

Appendix 2 – August 2021

A comparative 2-year Pressure Ulcer SI data

Leeds Community Healthcare NHS Trust

2019/20 financial year

There were 310 incidents reported meeting the above criteria acquired under LCH care during 2019/20.

Of the 310-incident recorded

- 128 (41.2%) were Category 3
- 161 (52%) were Category U (unstageable)
- 21 (6.8%) were Category 4

Of the 310 incidents recorded, 45(14.5%) concluded with lapses in care - this is broken down below:

128 Cat 3 recorded; 19 (15%) concluded with lapsed in care and reported on StEIS
161 Cat U recorded; 22 (13.6%) concluded with lapses in care and reported on StEIS
21 Cat 4 recorded; 4(19.0%) concluded with lapses in care and reported on StEIS

2020/21 financial year

There were 180 incidents reported meeting the above criteria acquired under LCH care during the financial year 2020/21

- 97 (54%) were Cat 3
- 75 (41.6%) were Cat U
- 8 (4.4%) were Cat 4

Of the 180 incidents recorded, 33 (18.3%) concluded with lapses in care-this is broken down below:

97 Cat 3 recorded; 14 (14.4%) concluded with lapses in care and reported on StEIS
75 Cat U recorded; 14 (18.6%) concluded with lapses in care and reported on StEIS
8 Cat 4 recorded; 5 (62.5%) concluded with lapses in care and reported on StEIS

Appendix 3 – August 2021

Leeds Community Healthcare NHS Trust

Retention background data

In August 2021 there were 45 leavers (38.7 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	Service	More than12Months	Less than 12 Months	Grand Total
2021 / 08	833 Adult Business unit		8.4	0.9	9.3
	833 Children's Business Unit		13.6	1.0	14.6
	833 Corporate Directorate		1.7		1.7
	833 Operations		1.1		1.1
	833 Specialist Business Unit		11.1		11.1
	833 PCN Business Unit			1.0	1.0
2021 / 08 Total			35.8	2.9	38.7
Grand Total			35.8	2.9	38.7

By Staff Group

Business Unit	(All)
Service	(All)

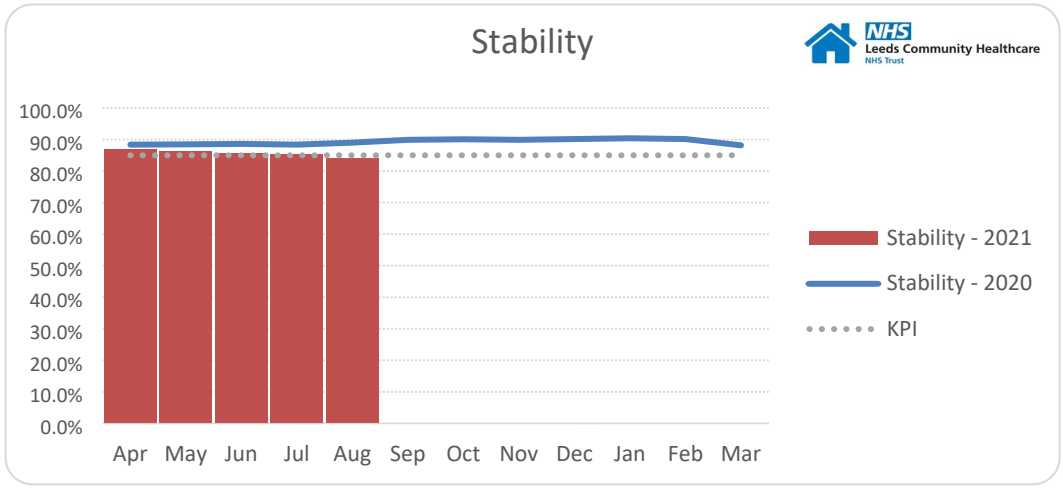
Sum of FTE		Less than 12 Months		
Month	Staff Group	More than12Months	Less than 12 Months	Grand Total
2021 / 08	Add Prof Scientific and Technic	2.7	2.0	4.7
	Additional Clinical Services	3.6		3.6
	Administrative and Clerical	8.4		8.4
	Allied Health Professionals	3.4		3.4
	Nursing and Midwifery Registered	17.7	0.9	18.6
2021 / 08 Total		**35.8**	**2.9**	**38.7**
Grand Total		**35.8**	**2.9**	**38.7**

By Leaving Reason

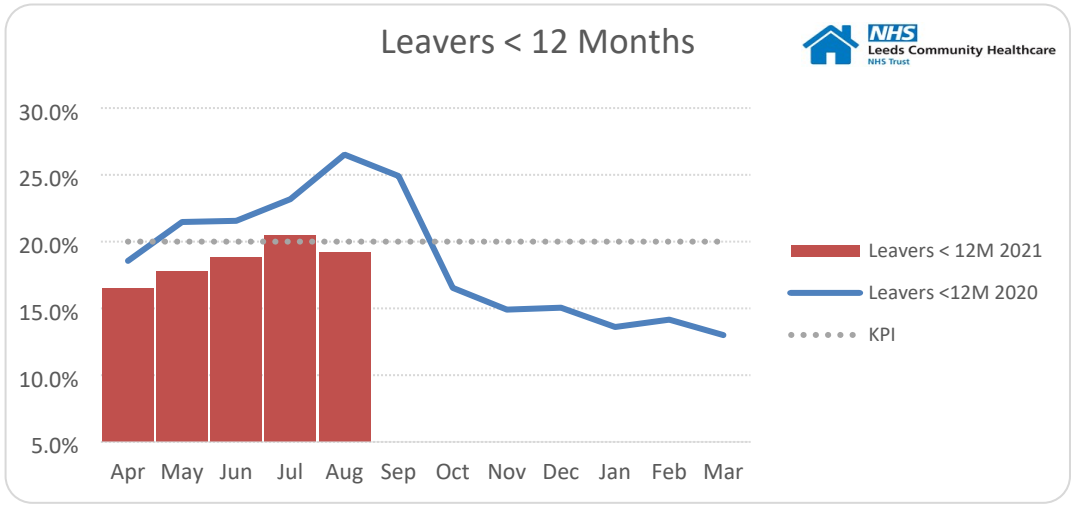
Business Unit	(All)
Service	(All)

Sum of FTE		Less than 12 Months		
Month	Leaving Reason	More than12Months	Less than 12 Months	Grand Total
2021 / 08	Death in Service	2.6		2.6
	End of Fixed Term Contract	0.8		0.8
	Retirement Age	3.5		3.5
	Voluntary Resignation - Better Reward Package	1.0		1.0
	Voluntary Resignation - Child Dependants	0.9		0.9
	Voluntary Resignation - Lack of Opportunities	1.9		1.9
	Voluntary Resignation - Other/Not Known	6.1	1.9	8.0
	Voluntary Resignation - Promotion	6.6		6.6
	Voluntary Resignation - Relocation	4.7		4.7
	Voluntary Resignation - To undertake further education or training	3.8	1.0	4.8
	Voluntary Resignation - Work Life Balance	3.8		3.8
2021 / 08 Total		**35.8**	**2.9**	**38.7**
Grand Total		**35.8**	**2.9**	**38.7**

Overall Trust wide stability rates for 2020/21



Overall Trust wide turnover rates for staff with < 12 months service - 2020/21



Appendix 4 – August 2021

Detailed Financial Data Tables

Leeds Community Healthcare NHS Trust

Table 1 Income & Expenditure Summary	August Plan WTE	August 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			(75.6)	(75.9)	(0.3)	(90.7)	(91.1)	(0.3)	(0.4)
Other Income			(3.3)	(4.4)	(1.1)	(4.0)	(5.7)	(1.7)	(1.9)
Total Income			***(78.9)***	***(80.4)***	***(1.4)***	***(94.7)***	***(96.8)***	***(2.1)***	***(2.3)***
Expenditure									
Pay	3,101.8	2,876.4	54.2	52.7	(1.6)	65.3	63.3	(2.0)	(1.9)
Non pay including reserves & non recurrrent			23.5	25.5	2.0	27.9	32.0	4.1	4.3
Total Expenditure	***3,101.8***	***2,876.4***	***77.7***	***78.3***	0.5	***93.2***	***95.4***	***2.2***	***2.4***
EBITDA	**3,101.8**	**2,876.4**	**(1.2)**	**(2.1)**	**(0.9)**	**(1.5)**	**(1.4)**	**0.1**	**0.1**
Depreciation			0.9	0.8	(0.1)	1.0	1.0	(0.1)	(0.1)
Public Dividend Capital			0.4	0.4	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	**3,101.8**	**2,876.4**	**0.0**	**(1.0)**	**(1.0)**	**(0.0)**	**(0.0)**	**0.0**	**0.0**
	Variance =	**(225.4)**							

Table 2 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	YTD Actuals £k
Directly employed staff	9,829	9,978	9,620	9,720	9,687	48,834
Seconded staff costs	263	283	283	258	260	1,347
Bank staff	330	227	276	237	250	1,320
Agency staff	155	227	308	230	233	1,153
Total Pay Costs	**10,577**	**10,714**	**10,486**	**10,445**	**10,430**	**52,653**

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	338	378	41	38
Clinical Supplies & Services	8,576	8,737	161	(269)
General Supplies & Services	2,048	2,070	22	17
Establishment Expenses	2,983	2,573	(410)	(382)
Premises	6,041	5,539	(502)	(322)
Other non pay	703	971	268	324
Total Non Pay Costs	**20,688**	**20,268**	**(420)**	**(594)**

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	221	221	0	265	265	0	0%
Total Efficiency Savings Delivery	**221**	**221**	**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	(0.2)	0.7	0.7	0.0
Seacroft Estates	0.3	0.0	(0.3)	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	**1.0**	**0.2**	**(0.8)**	**3.7**	**3.7**	**0.0**

Table 6 Statement of Financial Position	Plan 31/08/21 £m	Actual 31/08/21 £m	Variance 31/08/21 £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	30.4	(0.7)	*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	**31.3**	**30.6**	**(0.7)**	***31.2***	**32.8**	**32.8**	**0.0**
Current Assets							
Trade and Other Receivables	8.1	7.4	(0.6)	*5.6*	8.1	8.1	0.0
Cash and Cash Equivalents	38.3	48.4	10.2	*39.6*	35.0	35.0	0.0
Total Current Assets	**46.4**	**55.9**	**9.5**	**45.2**	**43.1**	**43.1**	**0.0**
TOTAL ASSETS	**77.7**	**86.5**	**8.8**	***76.4***	**75.9**	**75.9**	**0.0**
Current Liabilities							
Trade and Other Payables	(17.4)	(24.1)	(6.8)	*(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	**(18.1)**	**(25.9)**	**(7.8)**	***(16.8)***	**(16.3)**	(16.3)	**0.0**
Net Current Assets/(Liabilities)	**28.2**	**30.0**	**1.7**	***28.4***	**26.7**	26.7	**0.0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**59.6**	**60.6**	**1.0**	***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**	**60.6**	**1.0**	**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	27.1	1.0	*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**	**60.6**	**1.0**	**59.6**	**59.6**	**59.6**	**0.0**

Table 7 BPPC Measure	Performance YTD	Target	RAG
NHS Invoices			
By Number	99%	95%	G
By Value	100%	95%	G
Non NHS Invoices			
By Number	98%	95%	G
By Value	97%	95%	G

Trust Board Meeting held in public: 1 October 2021

Agenda item number: 2021-22 (70)

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

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Category of paper: For assurance
History: Senior Management Team 15 September 2021

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

Please note: this report has been formatted for compliance with the Accessible Information Standard.

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 report provides the Board with information about risks currently scoring 15 or above, after the application of controls and mitigation measures. It also provides a description of any movement of risks scoring 12 (high risks) since the last report was received in August 2021.

A Board Assurance Framework (BAF) summary has not been produced for this report as there was no committee activity during August 2021.

There are no extreme risks scoring 15 (extreme) currently on the risk register

One risk that is already on the risk register is currently being re-evaluated and may have its risk score increased:

- Risk 877 Risk of reduced quality of patient care in Neighbourhood Teams due to an imbalance of capacity and demand (see section 3.1 of the risk report)

There are 12 risks scoring 12 (very high). One of these is a newly identified risk and has been added to the risk register:

- Primary care reduced staffing levels - Wetherby Young Offenders Institute (YOI) and Adel Beck

Two risks have been de-escalated form a score of 12

- Delays in treatment for podiatry patients due to COVID 19
- Connection issues to the WIFI at Stockdale House affecting Police Custody Service

One risk has been recently added to the risk register and is awaiting assessment:

- Risk 1067 Introduction of female children into the Secure estate (see section 3.4 of the risk report)

Recommendations

The Board is recommended to**:**

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

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.

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), which have been scrutinised by the Quality and Business Committees.

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

2. Background

This paper has previously been considered by the Senior Management Team (SMT) at its meeting on 24 September 2021.

3. Risk register movement

3.1 New or escalated risks (scoring 15+)

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

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

One risk that is already on the risk register is currently being re-evaluated and may have its risk score increased:

- Risk 877 Risk of reduced quality of patient care in Neighbourhood Teams due to an imbalance of capacity and demand.

The reason for reassessing this risk is that Neighbourhood Teams continue to be in an escalated position (OPEL 3E) as a result of additional staffing pressures related to sickness, Track and Trace and vacancies.

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

No risks have been deescalated below 15 since August 2021

3.3 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
1006	Concern with ongoing patient safety incidents within one of the Neighbourhood Teams	12
1017	Delay to improving the Electronic Patient Record system (EPR)	12
1025	Information Technology (IT) Helpdesk Support Capacity	12
1036	Delayed delivery of immunisation programme to children and young persons (0-19 Public Health Integrated Nursing Service)	12
1041	PCMIS (patient information system) used by LMWS does not have the functionality to run a system capture of all safeguarding cases	12
1047	Increased volume of callers using the Leeds Sexual Health Appointment Line due to no walk-in service	12
1057	**NEW**: Primary care reduced staffing levels - Wetherby YOI and Adel Beck	12

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

One new risk scoring 12 has been added to the risk register since August 2021, and details of this risk (controls and actions) has been provided to the Quality and Business Committees for scrutiny:

Risk 1057 Primary care reduced staffing levels - Wetherby YOI and Adel Beck

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

Description:
As a result of five out of twelve nursing posts being vacant, the required staffing levels are not in place. There is a risk that Primary Care will not be able to deliver a full service. This could result in a potential for missed care because of uncoordinated responsive healthcare delivery, performance indicators not being met, increased staff turnover or sickness levels, and possible reputational damage.

Date to reach Target: 05/11/2021
Risk Owner: Head of Service, Wetherby YOI and Adel Beck Secure Children's Home
Lead Director: Executive Director of Operations

One risk has been recently added to the risk register and is awaiting further assessment. Further information about this risk will be included in the next risk report to the Committee:

Risk 1067. Introduction of female children into the Secure estate

Wetherby YOI has been identified as a placement to receive female children between the ages of 15 and 18 years old and has received female children from court without adequate planning and co-ordination of services. A 12 bedded unit has been identified on site and girls with complex and high-risk needs are arriving . The Gender specific needs of this cohort has not previously been cared for in this environment as a result not all staff may not have suitable training. The environment is not within the control of the service nor is the service involved in pre arrival assessment as a decision maker.

Lead Director: Executive Director of Nursing and AHPs

3.5 **Risks de-escalated from a score of 12**

Two risks have been de-escalated from a score of 12 (high) and as a result have had further scrutiny at Quality Committee and Business Committee in September 2021:

Risk 1015 Delays in treatment for podiatry patients due to COVID 19

Previous risk score: 12 (high)
Current risk score**:** 9 (high)

Description: As a result of a reduced workforce, there is a risk that patient care is significantly delayed or in many cases paused. The impact of this could be that the

service will need to treat an increasing number of foot wounds which are more severe in presentation. As a result, the workforce may not be able to manage these additional demands, there could be a negative impact on staff wellbeing, increased referrals to hospital services for wounds and potentially an increased number of wounds could require surgical intervention.

Reason for de-escalation: Numbers of Category 1 patients who are waiting for appointment are reducing on a monthly basis. Patients have been following advice to call if they require an appointment sooner than the one being offered.

Expected date to reach target: 01/10/2021
Risk Owner: Service Manager (Podiatry)
Lead Director: Executive Director of Operations

Risk 1040 Connection issues to the WIFI at Stockdale House affecting Police Custody Service

Previous risk score: 12 (high)
Current risk score**:** 9 (high)

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

Reason for de-escalation: A fault which was identified as the root cause of the WIFI dropping was rectified on 23rd April 2021 which has brought a much more stable internet connection. The new LCH phone system is currently planned for October 2021. No new notifications of downtime have been reported and it appears the resolution of the connection issue and improved access to desk based and mobile telephony has mitigated the risk.

Expected date to reach target: 29/10/2021
Risk Owner: Deputy CIO/Head of Community Informatics
Lead Director: Director of Finance and Resources

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4. 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.

A Board Assurance Framework (BAF) summary has not been produced for this report as there was no committee activity during August 2021.

5. Recommendations

The Board is recommended to**:**

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

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 1 October 2021

Agenda item number: 2021-22 (72)

Title: Draft LCH Workforce Strategy 2021-25

Category of paper: for approval
History: Business Committee 29 September 2021

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

Executive summary (Purpose and main points)

The LCH Workforce Strategy 2021-25 (Final Draft) is presented here for Board consideration and approval.

In addition to coming in Draft form to the Board in August 2021, further discussions about the Strategy have taken place during August and September 2021 with a range of stakeholders including individual Board members.

A further range of updates and amendments have now been incorporated into the new Draft, based on Board and stakeholder feedback and discussions. These are summarised below for ease of reference:

- Further explanation on how data, evidence and benchmarking are used to inform the Strategy's work and measure its progress and impact
- Additional information about the research and innovations considered in the development of the Strategy and the innovations delivered to date.
- Improved emphasis of the importance in LCH of talent management, succession planning and the link between this and excellent leadership
- Amendment of the "Golden Thread" wording with a view to better inclusivity; replacing the word "right" with the word "best"
- Clarification on the alignment between the LCH Workforce Strategy and the national NHS People Plan, including the NHS People Promise.
- Additional detail on workforce ambitions in relation to working across organisational boundaries.
- Reordering of the Strategy contents to create an improved narrative flow for the Ambition, Objectives and Measures against each of the seven Themes.

This draft is also being presented to the Business Committee on 29 September 2021.

Subject to Board approval, the Workforce Strategy 2021-25 would be launched in LCH in the coming weeks.

Recommendations

The Board is recommended to

- note the further stakeholder engagement, development and amendments to the Draft Workforce Strategy 2021-25

- approve the Draft Workforce Strategy 2021-25 for launch

Laura Smith & Jenny Allen
Director of Workforce
22 September 2021

Draft LCH Workforce Strategy 2021-25 (V0.7)

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 and a half years.

Many people and services from across LCH have contributed to the Strategy's development, 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 best 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

Jenny Allen & Laura Smith, Director of Workforce, September 2021

1. 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 of how we performed against the 2019-21 Strategy's ambitions are shown in the diagram below (Fig 1).

Fig 1: Examples of performance against 2019-21 Workforce Strategy ambitions

1. Where have we been? (continued)

In addition to achievements against the overall ambitions of the 2019-21 Strategy, a range of additional innovations were identified, planned and introduced. These include the LCH Employ / Deploy model, designed by LCH to meet the needs of primary care partners in PCNs looking to secure roles designated by the national Additional Roles Reimbursement Scheme; the central role played by LCH in the design and delivery of the Leeds System Leadership Training Programme; and the Workforce Sharing Agreement designed by LCH to enable the transition of staff across organisational boundaries in support of Care Home partners.

Further detail and examples of workforce innovations and achievements delivered during 2019-21 can be found at ***Appendix 1a***.

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.

2. What is important now?

Many factors both internal and external to LCH have also been taken into account during the development of this Strategy. We have summarised them in the diagram on the following page (Fig 2), using the well-regarded Harvard and Warwick models of HR Management to identify the different types of factor.

In developing the LCH Workforce Strategy 2021-25 we have sought to take into account the current and future working environment; to consider where employee and employer needs, expectations and opportunities are now and will go in future; how technology can support and accelerate change; and to determine how LCH can use all of this knowledge to achieve the very best outcomes possible for its workforce and its communities. ***Appendix 1b*** provides additional detail about the innovations and context of the future world of work which have informed the Strategy.

The global COVID-19 pandemic has accelerated and disrupted some of those future innovations; and we continue to work in a VUCA environment (Volatile / Uncertain / Complex / and Ambiguous). A key focus for us throughout the Strategy, will be on supporting and enabling LCH in its handling of and recovery from the pandemic period; and with this in mind we expect to retain a particularly sharp focus on the optimal resourcing of the workforce and the wellbeing and employee experience of LCH staff.

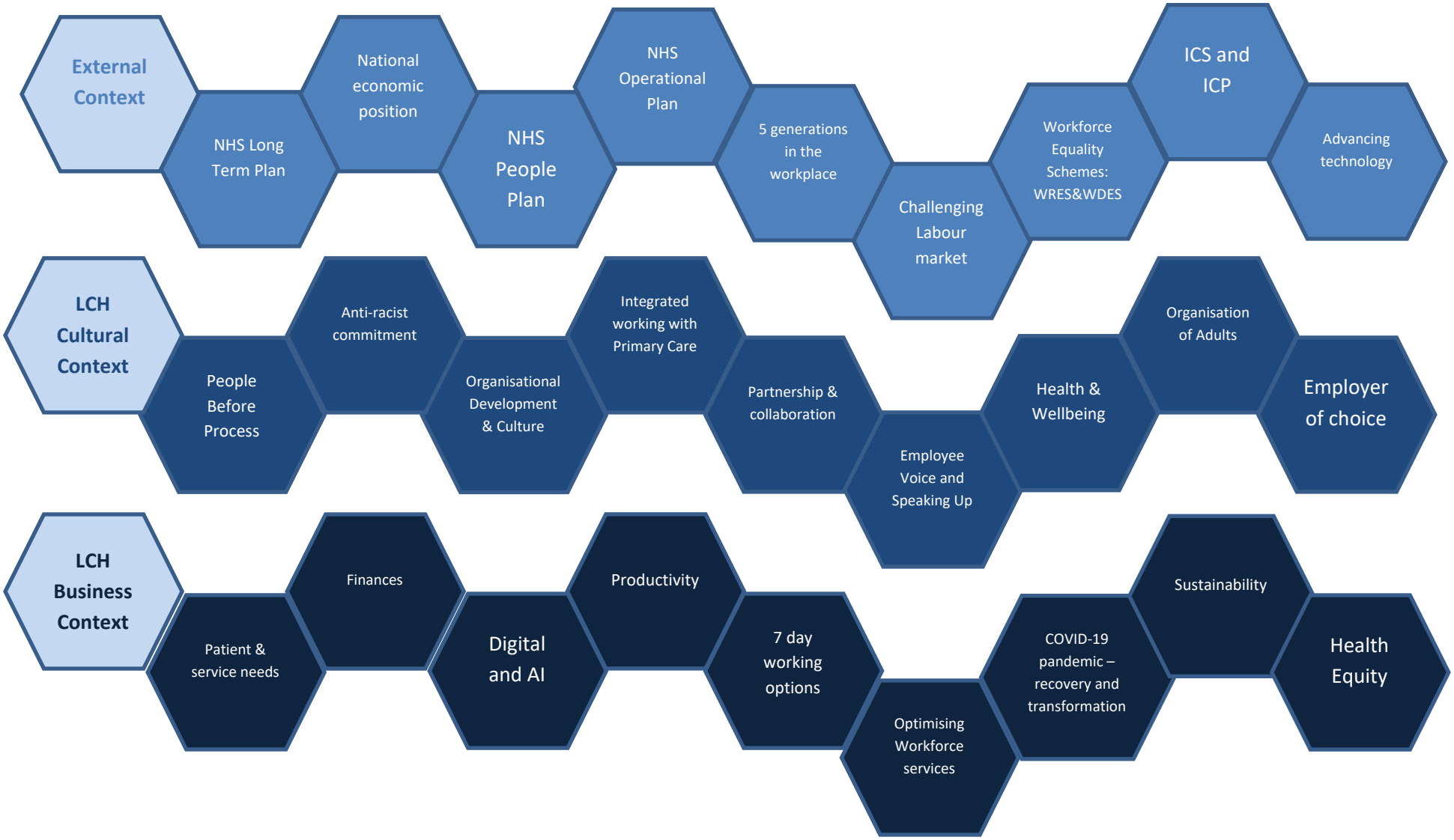
Our Strategy ambitions are well-aligned with the aim of the NHS's national NHS People Promise and the NHS People Plan which seeks for the NHS to have, *more staff, working differently, in a compassionate and inclusive culture*.

Whilst the NHS is a heavily regulated environment both in terms of the performance management regime and expectations as well as the mandated way in which we employ, reward and deploy our staff there are opportunities for us at LCH to understand better a disrupted world of work and to implement aligned solutions to some of our workforce challenges. There were many examples of this through the previous Workforce Strategy, as described in our opening section and at ***Appendix 1a***, and our continued focus on solutions aligns well with the *New ways of working and delivering care* pillar of the NHS People Plan.

All of the above feeds into our **Golden Thread** for this Strategy, **to attract, develop and keep the best people**, in order to deliver outstanding care. This is the Strategy's guiding principle and ultimate aim. We have tested it during the development stages of the Strategy, refining it through the engagement process to ensure that it embodies what we seek to achieve.

2. What is important now? (continued)

Fig 2: Factors influencing Strategy development:



3. How will this Strategy help LCH to attract, develop and keep the best people, in order to deliver outstanding care?

There are seven Themes in this Strategy: **Organisation Design**; **Resourcing**; **Inclusion**; **Wellbeing**; **Leadership**; **System Partner** and **Foundations**. These are described in more detail, together with their accompanying Ambitions, in section **3b**.

The Strategy's Themes are underpinned by three Enablers, which contribute to every Theme: *Employee Voice; Data & Evidence*; and *Digital & Technology*. The purpose, content and importance of each Enabler is summarised below:

3a. Enablers

Employee Voice

Employee Voice permeates every element of our work. It is a critical aspect of LCH's cultural identity as we seek to listen, learn and grow as an Employer of Choice. 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, some of which are highlighted in the pink boxes below, and our strong partnership working arrangements with Trade Union colleagues; our Freedom to Speak Up (FTSU) Guardian, Champions and approach are vital here. Our Freedom to Speak Up Strategy, currently under development, will be appended to the Workforce Strategy document upon its approval, emphasising the vital interrelationship between the two.

- JNCF & JNC
- Leaders Network
- FTSU
- Service visits
- Formal engagement exercises
- Ask Thea
- Exit Interviews
- Staff Networks
- 50 Voices
- Staff Surveys
- Diversity & Inclusion Forum

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. 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. Examples of new technology development and optimisation of existing technologies that are expected during the lifespan of the Strategy are highlighted below in orange boxes; all of which must be underpinned by appropriate implementation programmes and training on use of systems.

- NHS Jobs 2
- InstantPay
- eJob Planning
- Learning Management System
- eRostering
- Data Warehouse > PIP
- ESR2
- New Starter Workflow
- ESR Self Service

3a. Enablers (continued)

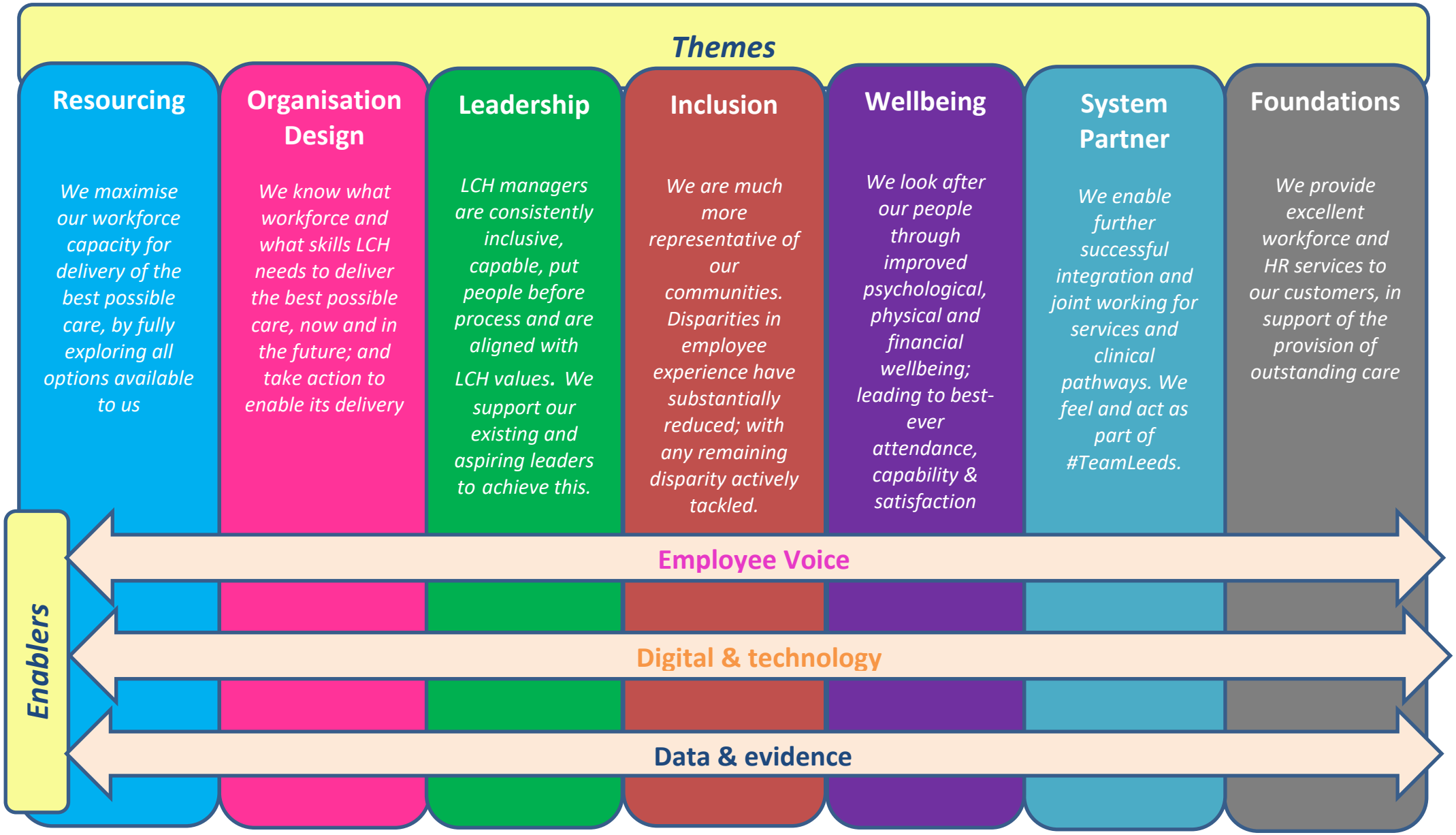
Understanding the case for, and the impact of, interventions is vital, to ensure efficacy and minimise waste. Our commitment with this Workforce Strategy is to base the interventions we prioritise and implement on evidence gleaned from data and / or research with appropriate data standards and governance; 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 can reasonably 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. Examples of the data & evidence to be used are highlighted below, in navy boxes.

Further information about research & evidence underpinning this Strategy is at ***Appendix 2****.*

Vacancy & recruitment data | Well Led metrics | WRES & WDES data | Staff Surveys | Exit data | Training & Skills records | External research & academic journals | NHS & industry benchmarking | Economic & labour market data | Employee Voice

3b. Themes and Ambitions

The Ambition for each of the Strategy's seven Themes is shown in italics in the Workforce Strategy infographic below. Each Ambition describes what we want to have achieved by 31 March 2025. In determining each one, we have asked ourselves our **Golden Thread** question: Will this help us to **attract, develop and keep the best people**, in order to deliver outstanding care?



3b. Themes and Ambitions (continued)

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.

In line with our Data & Evidence Enabler, we will be monitoring progress towards and achievement of our Ambitions using a range of target quantitative and qualitative measures, which are summarised against each theme in the following pages.

Our focus is on measuring outcomes more than inputs; although some input measures (for example the measurement of leaders undertaking LCH leadership training & development) are important to include.

Our objectives and their measures are described on the pages that follow (p9-22):

Theme 1: Resourcing

We maximise our workforce capacity for delivery of the best possible care, by fully exploring all options available to us

During the lifespan of this Strategy, LCH will become increasingly sophisticated in our understanding and analysis of, and our responses to, the resourcing needs of LCH and the means of securing the workforce we need. Working increasingly in partnership across organisations; with third sector partners, primary care and within our Leeds ICP and West Yorkshire & Harrogate ICS footprints, we will leverage a broad range of resourcing approaches. We will focus in particular on those roles and professions requiring most support; and on attracting and supporting under-represented groups to join our workforce. Together with operational expertise we will maintain and enhance our targeted LCH resourcing plan, aligning well with the *Growing for the future* pillar of the NHS People Plan

As a relatively small NHS organisation, opportunities for staff to progress their careers via promotion wholly within LCH can be constrained by the number of senior roles available and our related aspiration to maintain high organisational stability by limiting turnover. To maximise retention of our talented staff we must therefore work even harder on other means of ensuring LCH is an Employer of Choice, as well as maximising those career development opportunities that are available and considering additional innovations with partners to enhance careers and retention, for example rotations and secondments between organisations.

How will we achieve this?

OBJECTIVES

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 meet regularly with LCH new starters to understand and address specific unmet needs they may have, including implementing any required improvements to processes to improve the new starter experience*

How will we know we've achieved our ambition?

MEASURES

- Bank fill rates increase by 10% and active Bank capacity increases by 20%
- Turnover is below 13%, with stretch target of 11%
- Vacancy fill rates achieve 90%, with more applicants for hard-to-recruit roles than in 2020/21
- Range of advertising and marketing options is increased, with regular targeted campaigns for high priority roles / services
- Recruitment Service offer is clearly specified, with associated KPIs regularly monitored and achieved

What difference will this make for LCH people?

For leaders: *I am able to target the widest possible pool of suitable prospective applicants when I recruit to a vacancy*

For everybody: *I am happy with my working life and my opportunities for development*

Theme 2: 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

Our ambition for improved **Organisation Design** relies upon an accurate and detailed understanding, informed by services, data and external factors, of the required and likely shape of the LCH workforce in the short, medium and long term; and any associated gaps in capacity and skills.

This ambition extends beyond the boundaries of LCH, and links closely with our **System Partner** theme (Theme 6). We propose to continue and develop our close working with partner organisations to support the co-design of a One Workforce approach across care pathways and services, ensuring that the delivery of outstanding care for our communities is not constrained by organisational boundaries.

Meanwhile, innovations and expectations within the broader labour market are driving different behaviours amongst existing and prospective workforces in multiple sectors including health. We will be working to ensure that the LCH *benefits offer* as well as opportunities for flexibility in work are as attractive as possible. This must be within the context of our heavily regulated public sector environment and nationally-determined terms and conditions; as well as within the context of our patient facing services, which are increasingly moving towards seven-day working and require a careful balance between the commitment that LCH and its staff have towards delivering outstanding care; and the individual needs and aspirations of staff in relation to the crucial balance between work and home.

How will we achieve this?

OBJECTIVES

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 as well as the requirements of the NHS People Plan and revised Agenda for Change terms & conditions.*
5. *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*

How will we know we've achieved our ambition?

MEASURES

- Resourcing plans are in place for each Business Unit and refreshed annually
- The overall LCH Workforce Plan reflects system partnership approaches to specific pathways, careers or roles
- eRostering is fully implemented, enabling systematic skills and capacity planning by services
- Hybrid Working is fully embedded, supporting and informing the design and delivery of LCH approaches to Estates, Sustainability and Digital
- A new LCH approach to Flexible Working is developed and introduced, with some form of flexible working taken up by >50% of LCH staff

What difference will this make for LCH people?

For leaders: *I anticipate and plan for my team's long term and short term skills requirements*

For everybody: *I have the opportunity to use technology and remote working practices to enhance both my working life and the service I deliver*

Theme 3: Leadership

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

We will build on the success of the LCH Leadership Programme; developing it further in partnership with operational leads to anticipate and align with new and emerging local and external requirements and aspirations. Our leadership training is a culture carrier in LCH. It aims to ensure that our leaders fully understand and role model our organisational culture and priorities, enabling and empowering their teams. We will therefore require all new and middle LCH managers to undertake specific modules; and commission a detailed 360 assessment of senior leaders, to cement their understanding and role modelling. With a view to succession and retention we will strengthen our talent pipeline; identifying and offering mentoring to new and aspirant leaders; working in partnership with the ED&I team to ensure those groups underrepresented in our talent pipelines are targeted for appropriate support.

How will we achieve this?

OBJECTIVES

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 and flexible working aspirations; available to all LCH leaders.*
2. *All new leaders at LCH will be required to attend the LCH Leaderships Essentials course. We will monitor uptake of leadership development courses to identify and close gaps in attendance, support or coverage*
3. *Areas of the organisation experiencing detriment associated with leadership behaviours or capability are identified and action plans agreed in partnership with affected services to improve leadership capability, confidence and alignment with LCH values and behaviours, particularly regarding diversity, inclusion and wellbeing.*
4. *We will seek funding for, commission and introduce a 360 degree assessment for our most senior leaders, to robustly evidence quality of leadership and alignment with LCH leadership expectations, with a particular focus on diversity, inclusion and wellbeing.*
5. *Our work on talent management and succession planning will include a focus on underrepresented groups*
6. *We will explore and utilise opportunities to work with system partners in the commissioning and implementation of relevant leadership programmes*
7. *A new mentoring scheme is implemented, targeted at new LCH leaders, or those in need of additional support, enabling experienced and skilled LCH leaders to support and develop others*

How will we know we've achieved our ambition?

MEASURES

- Quarterly and National Staff Survey results evidence overall improvement of at least 5 percentage points in staff experience of their leaders, with areas implementing Leadership Development action plans seeing specific improvement in scores.
- New managers have attended an LCH Leadership Essentials module, or provided evidence of recent equivalent training with a previous employer.
- Every member of the LCH Senior Leadership team has undergone 360 degree assessment and has a resulting individual development plan to address any gaps and / or opportunities for improvement
- LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career

What difference will this make for LCH people?

For leaders: *I have the training and support I need to lead at LCH*

For everybody: *My individual circumstances, perspective and aspirations are understood and taken into consideration*

Theme 4: Inclusion

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

We have experienced a degree of success in LCH with the introduction of initiatives such as Reverse Mentoring and the Allyship Programme. The resulting heightened understanding and acknowledgement of issues and experiences linked to diversity and inclusion is crucial and will continue to be a central plank of our LCH Equality, Diversity & Inclusion (ED&I) programme.

This Strategy will see LCH move increasingly to targeted action in core areas of recruitment, development and health and wellbeing, to improve both the representation levels and experiences in work of underrepresented groups. In particular we will ensure that the voices and views of representatives from those groups are actively involved in the design and scrutiny of our ED&I programme of work; and seek to ensure the long term sustainability of dedicated ED&I resource as part of our core business.

This Theme aligns well with the *Belonging in the NHS* pillar of the NHS People Plan

How will we achieve this?

OBJECTIVES

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, by protected characteristic, between those with and without particular protected characteristics, focusing on Race, Disability and Sexual Orientation; and working with those areas to develop targeted action plans to reduce those disparities*
4. *We will work with our existing and emergent Staff Groups, Forums and 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***
6. *We will seek sustainable funding streams to maintain the LCH ED&I programme in order to achieve its stated objectives*

How will we know we've achieved our ambition?

MEASURES

- 14.5% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% in 2021 and working towards 18% by 2028
- LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career
- 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 via the LCH Leadership Essentials course

What difference will this make for LCH people?

For leaders: *As a leader, I take action to identify and address inequalities*

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

Theme 5: Wellbeing

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

A vital part of **keeping the best people** is looking after people well, creating and sustaining an environment in which they can thrive, and providing support in times where health & wellbeing is at risk or compromised. This Theme of the strategy aligns with the *Looking After Our People* pillar of the NHS People Plan.

Substantial health and wellbeing (HWB) gains have been made at LCH since 2019. With an improved, increasingly tailored HWB offer and plans to develop further psychological support, LCH is in a strong position to facilitate the long term, sustainable recovery of the workforce following the COVID-19 pandemic and to build further HWB gains subsequently. Initiatives aimed at positively supporting wider determinants of health, including financial wellbeing, will be welcome additions to the continuously improving suite of HWB options available for the workforce.

How will we achieve this?

OBJECTIVES

1. *Employee wellbeing is of equivalent importance to the Trust Board as clinical performance, with scrutiny spearheaded by a Non Executive Wellbeing Guardian and the impact of the Covid-19 Pandemic taken into consideration*
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; with particular focus on pandemic-related support*
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 long term health conditions and/or disabilities are empowered to coproduce new LCH health & wellbeing approaches and initiatives to better meet their needs*

How will we know we've achieved our ambition?

MEASURES

- Our "lead indicators" from the Staff Survey around staff engagement, motivation, and support from line managers, improve year on year between the 2021 and 2024 Staff Surveys
- Absence due to stress / anxiety / depression is reduced, with overall annual sickness below 5% by 2025
- Long term sickness absence rates return to target levels of <3.5%, with a stretch target of 3%
- Staff reporting that LCH takes positive action on HWB rises by 5%
- Health & wellbeing conversations are embedded as a regular part of employee / leader conversations, supported by LCH leadership training

What difference will this make for LCH people?

For leaders: *I sensitively discuss individual health & wellbeing needs with my team members*

For everybody: *I am heard, supported and can flourish at LCH*

Theme 6: System Partner

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

Our work in the system space to date gives LCH a strong foundation, including the development of staff sharing agreements for Leeds, workforce expertise for the GP Confederation, and the implementation of the innovative Employ / Deploy approach for PCNs. The advent of a Leeds Integrated Care Partnership (ICP) and the introduction of the new LCH Third Sector Strategy both bring further opportunities for collaboration on shared priorities for the benefit of our Workforce Strategy ambitions, overall business objectives, and, most importantly, our communities.

How will we achieve this?

OBJECTIVES

1. *We develop and share a #TeamLeeds talent pipeline with health & social care city partners, including the Third Sector, 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 work in partnership with other Anchor Institutions in Leeds, to positively influence social, economic and wellbeing prospects for Leeds*
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*

How will we know we've achieved our ambition?

MEASURES

- A minimum of 4 recruitment or training exercises per year, on average, are carried out collaboratively with ICP or ICS partners
- The GP Confederation has a full suite of pay, terms & conditions protocols
- LCH staff in multiple services are working beyond LCH's organisational boundaries in support of LCH and system goals
- LCH staff join ICP and ICS colleagues in undertaking collaborative and system leadership training opportunities

What difference will this make for LCH people?

For leaders: *My team and I are part of **#TeamLeeds***

For everybody: *I feel confident working with people from other health & care organisations*

Theme 7: Foundations

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

Underpinning everything the Workforce Strategy aims to deliver, are the core services that make up the Workforce Directorate: Human Resources; Workforce Systems & Intelligence; Organisational Development; Resourcing; and Equality, Diversity & Inclusion. We seek to further enhance the clarity, accessibility and quality of these services over the lifespan of the Strategy.

How will we achieve this?

OBJECTIVES

1. *Workforce services are benchmarked, consistent, stable, professionally led and with core KPIs visible to customers. Customer feedback informs our planning and priorities.*
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. *LCH's Organisational Training and Development offer and approach is designed and delivered in partnership with the QPD Directorate, to meet organisational needs*

How will we know we've achieved our ambition?

MEASURES

- Service specification with KPIs is in place for Resourcing, Workforce Information and HR
- Core KPIs including "time to recruit"; "average length of formal ER case" are met and within benchmarked norms
- A co-produced Organisational Training & Development offer and approach is in place, in partnership with QPD

What difference will this make for LCH people?

For leaders: *I use the People before Process approach to effectively support and manage my service*

For everybody: *It is easy for me to access high quality, professional Workforce services and information*

4. How will we know we've achieved our Ambitions?

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 LCH Diversity & Inclusion Forum.

5. 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 should that become necessary during the lifespan of the 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 timescales

6. What happens next?

Following approval of the Workforce Strategy we embark upon the welcome challenge of delivering its Ambitions against the seven Themes, underpinned by the three Enablers.

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 best people**, in order to deliver outstanding care.

Thank you for reading this document and sharing in our LCH Workforce Strategy Ambitions for LCH's current and future workforce, our patients, partners 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 1a: Innovations and achievements at LCH since 2019

System Leadership:

LCH employs and has supported the main architects of the trail blazing Leeds System Leadership offer which responded to city calls to strengthen the partnership through engaging leaders at all levels across all partner organisations. This work is a model for other now Integrated Care Partnerships (ICPs) and has been written up and published in a renowned people journal.

Employ and Deploy:

Continuing with the theme of partnership, one of LCH's stated aims has been to partner more fully with primary care. In 2018, the Additional Roles Reimbursement Scheme (ARRS) was launched nationally which resulted in significant amounts of money being made available for Primary Care Networks (PCNs) to secure the professional skills of clinical professionals other than GPs in an attempt to free up more GP expert time on the work that could only be done by GPs.

There are 19 PCNs in Leeds and at that time all were newly formed and in their infancy without the infrastructure or appetite to assume liability for staff. In response to this and with Trust Board approval, within Workforce we developed our Employ and Deploy offer to in effect employ these staff on behalf of PCNs deploying them operationally to PCNs. This remains a unique offer across the country with much interest in the mechanics behind this arrangement and in fact NHS England have recently nationally mandated for a further tranche of ARRS money that NHS Trusts should be looking to employ such roles on behalf of primary care. LCH was and remains the developer and early adopter of this approach and currently employs one third of the ARRS roles within primary care in Leeds.

Diversity and Inclusion:

There is always more work do to in the Diversity and Inclusion space including on Race and it is so important to acknowledge that. As part of the LCH commitment to improving the experience of our Black, Asian and Minority Ethnic staff, we launched our innovative and unique Allyship programme in 2020 to exceptional reviews from participants on the 'life changing' experience. This impact of this transformational programme in LCH is part of a longer study, however, a neighbouring Trust has been so impressed with the programme content and indeed the skill, expertise and passion of the facilitators running it that they have now commissioned it from us – we've run a first cohort for them and will shortly commence with a second cohort of staff.

Resourcing:

LCH has been instrumental in a number of innovative resourcing approaches on its own behalf and in support of partners. Examples include the Community Nursing Bus Tour, which was nominated for a Nursing Standard award; and the resourcing programme for the CAMHS Tier IV Unit that has utilised both hyper-local recruitment techniques to engage and attract applicants from local communities and national recruitment campaigns to reach scarce professional

applicants. Also of note is LCH's leadership of the resourcing for Leeds' Covid Vaccination Programme, which drew on a broad range of resourcing techniques including partnerships with universities and Leeds City Council to target specific candidate pools; the sharing of labour across organisations; and the use of volunteers with the support of third sector partners.

Health and Well-being:

Further examples of innovations in the life span of the previous Workforce Strategy stem from the acceleration of some of our work and thinking as a result of the COVID pandemic. In the health and well-being space and in advance of 2020, our approach could be described as much more generic and traditional – so we had our Feelgood Pledge with a plethora of offers and opportunities for staff alongside an Occupational Health service. The pandemic catapulted LCH into unknown territory in this and other spaces – we were faced with responding much more to the individual needs of our staff both in terms of their home and personal circumstances as well as the demands of their work.

As a Trust we responded well and particular innovations to know include the early insight that staff might suffer trauma from what they were seeing and encountering in their everyday work with many more serious conditions being managed at home and significant increases in the number of patients wishing to access end of life care in their own homes. Our response was to secure the services of a Clinical Psychologist and subsequently to grow and develop that service alongside OD interventions promoting a fuller offer with triage and signposting of individual members of staff and teams to the right psychological support (whether clinical or organisational as needed).

This approach alongside numerous other intervention and support mechanisms kept our staff well and at work through waves 1 and 2 of the pandemic and in fact our sickness absence levels for 2020 and early 2021 tracked beneath those for the same period the year previous. We were early adopters of Clinical Psychology input and NHS E/I recommended in their 2021/22 planning guidance that all organisations should be securing this expert input.

Staff Sharing:

The pandemic also tested LCH as with other partners in the city in terms of resourcing and capacity. There were early concerns in wave 1 that LCH may need to deploy our staff into Care Homes under their direction to support i.e. share our staff. This proposition was fraught with difficulty both in terms of liability and risk but also in terms of assuring and ensuring the protection of our staff. We worked through the challenges engaging with both Trade Union colleagues, Care Home owners and legal advisers to develop an agreed staff sharing approach.

LCH has since led further work to develop and agree with city wide partners a staff sharing approach across the city which enables staff from different sectors to be deployed to partners as needed. This was utilised in late 2020 / early 2021 to deploy staff from partners to LTHT as the lead provider in the COVID vaccine programme and LCH further used this agreement to employ and deploy vaccinators to PCNs delivering the vaccine in the community. Our work led to interest regionally and nationally and has been developed for use elsewhere – it is anticipated we'll need to use this further this coming winter.

Appendix 1b: The Future World of Work

Looking to the future in the ***Employee Experience*** arena, the advent of collective populism and the drive for a consumer like experience for employees leads us to a much more customer focussed way of interacting with both our prospective and well as existing employees. This approach is integrated through our Workforce Strategy from how we recruit to dealing with staff queries on matter from pay to conduct and everything in between with very much a move towards digital first.

Employees are also keen for an approach to employment that takes account of their needs and this is in part driven by the arrival of new generations in the workforce. Our setting out of work on flexibility for individual members of staff in terms of both where, how and when they work (dependent of course on service needs) as well as a much more bespoke and individualised health and well-being offer and investment in management and leadership skills to deal with individuals on that basis all point towards our aspiration within this area.

Similarly with ***Organisational Development and Learning***, the increasing shift towards compassionate leadership is evident in our work at LCH as well as in national mandates and broader employment sector evidence. And accessing training when and where employees can access it most conveniently, with bigger ranges of training media, less "classroom style" teaching and more experiential learning is increasingly evident in the approaches we are taking at LCH.

The ***People Technology*** space is exploding with early adopters of AI (Automated Intelligence) and RPI (Robotic Process Automation), mainly outwith the public sector, to carry out tasks and automate every possible process including those associated with employment (recruitment, pay etc.). Employee wearable tech to track stress levels at work, productivity and working hours are now also fairly readily available on the market.

Our regulatory environment in the form of the prevalence and welcome presence of Trade Union colleagues as well as our digital preparedness mean that the NHS as a whole is somewhat lagging in this space. At LCH though, we are attempting to lay some of the foundations for movement in these space when timely and appropriate. So our ongoing work with partners to understand systems and their inter-operability across organisations to support patient care and a patient pathway approach is one example.

In terms of ***Insights and Analytics*** and aligned with the People Technology space described above, the trends are towards data driven analytics considered alongside more qualitative measures of people management. Our work with Business Intelligence colleagues to link patient and workforce data and integration with the organisational digital strategy to develop the digital skills and thinking necessary for the future. Meanwhile we continue to maximise the capability of the existing national workforce system (Electronic Staff Record - ESR) whilst awaiting national direction on the future digital space which is due soon.

The current UK labour market is extremely tight and in particular with several markets which include health and care. Consequently innovations within the ***Resourcing*** space are driving different behaviours – this includes one off pay rises, additional rewards and perks of a non financial nature and endless flexibility

in terms of where, when and how people work. Again as a part of the public sector which is heavily regulated and due to the nature of the vast majority of our patient facing work there are hard edges around both what reward as well as flexibility in work can be offered.

However, our approach and aspiration in terms of this Workforce Strategy is to ensure that all staff feel and are very much part of Team LCH – we have and will continue to invest significantly in our culture and employee engagement as a key tool in both recruitment and retention. Additionally, we have worked hard on our hybrid working offer and post the initial waves of the pandemic so wherever possible we will offer staff flexibility about where they work and when. Finally in this space, we are embarking on a change piece around flexibility in terms of working hours and contracted WTE – trying to ensure that we are able where we can and within the constraints of service delivery to offer staff the working hours and patterns that best accommodate their working lives.

Appendix 2: Workforce Strategy – Research and Evidence:

In his seminal research into people management and in particular working in terms in the NHS, a clear link was established by Professor Michael West between effective working teams and the leadership of them with a positive impact on patient care. [1] In NHS people management terms this is the the clear 'why'? – all that we do, provide, facilitate, support and lead should lead to better outcomes for our staff and ultimately to better patient care. It is with this ethos that we have developed this Workforce Strategy – both ensuring that our proposed areas of focus and objectives are research and evidence based but also that they will impact positively on our patients.

A number of examples of how this approach is integrated throughout our Workforce Strategy are set out below:

Health and Well-being:

The CIPD's latest survey on health and well-being at work cites the criticality of leaders who demonstrate compassion with staff and foster a culture that leads to trust and kindness. [2] The visibility of the top team within organisations and their ownership of health and well-being is also established as a clear factor in effectively managing health and well-being at work as is taking a holistic approach and one that commits to preventative as well as reactive measures in terms of staff health.

This connectivity of the skills, competence and compassionate approach of leaders feeds directly into our Workforce Strategy aims and aspirations to work hard on the development and support to all of our leaders. There is a clear evidence base for investment in this area as there is for the monitoring and measurement of both qualitative as well as quantitative measures in terms of understanding staff health and well-being at work.

The national NHS People team have invested time and resources in understanding how to measure impact as well as better predict health and well-being activity. Their resounding conclusion in conjunction with research undertaken by Aston University is that lead measures which are largely qualitative in nature and informed by quarterly and annual Staff Surveys, are much better indicators of the health and well-being of staff within organisations.[3] Hence our approach within this Workforce Strategy to rely on both quantitative and qualitative measures of success; this area in particular really is one where what counts – compassion, kindness and culture – cannot always be counted.

Diversity and Inclusion:

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[1] *Developing Team-Based Working in NHS Trusts;* Report prepared for Department of Health; November 2008.
[2] *Health and Wellbeing at Work 2021;* CIPD Survey Report; April 2021.
[3] DN – Steve Lee at national people team providing the reference for this.

Beyond the moral, ethical and legal arguments, there is significant evidence that diverse and inclusive organisations provide better patient care. In term of the business case for inclusion, the CQC in its 2018 publication clearly established the link between equality and inclusion for staff and good care. [4] The publication strongly advocates for the development of compassionate and inclusive cultures in organisations which are inclusive and time and again makes the link between engagement (measured in NHS Staff Survey results) and inclusion.

Added to which, the national NHS WRES team in their published research, clearly established the importance of Race in the inclusion agenda through their evidential basis which set out that where organisations improve engagement for Black, Asian and Minority Ethnic staff, they improve engagement for all staff irrespective of their Race. [5] There is a clear causal link. This research base alongside others, leads us to continue to focus on Race within this version of the Workforce Strategy with the established national WRES indicators which include both quantitative and qualitative measures the ones to focus on.

Leadership and Management:

There is a plethora of evidence for the premise that employees who have good quality jobs and are well led and managed will be both happier at work but also invariably more productive – the interplay of employee engagement and leadership and management is very significant. [6] Add to that the focus in terms of health and well-being and inclusion on the importance of culture and the creation of that by leaders and it is important to conclude that leadership and management should be a key area within this Workforce Strategy.

There are a number of lead and lag, qualitative and quantitative, input and output measures in terms of leadership – the key question to answer in navigating all of this is 'how will we know our leadership is effective?'. We could measure inputs such as number of leaders and managers through development courses, staff appraised etc. – it is important to monitor such indicators and potential leads in terms of performance or leads in terms of where predicted performance may be going of course, but it is more important to measure outputs and ideally outcomes.

Evaluation of leadership and management courses and interventions offered through the duration of this Workforce Strategy will be critical. Kirkpatrick sets this out at four levels, and in this context an ongoing exploration of changes in attitudes as well as skills and behaviours through routine survey at various points post the intervention will be important. [7] Recognising the major limitation in this approach which is that it is self assessed by leaders and managers, it is also proposed that we measure our leadership development impact by seeking out feedback from our staff. The now quarterly and annual Staff Surveys which are designed in part to evaluate exactly the impact of leadership in organisations will be invaluable tools in this respect.

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[4] *Equally Outstanding Equality and Human Rights – Good Practice Resource;* Care Quality Commission; October 2018

[5] Richard Worlock providing this reference.

[6] *Employee Engagement An Evidence Review;* CIPD Scientific Study; January 2021.

[7] Kirkpatrick DL (1959); *Techniques for Evaluation Training Programs (sic).*

Trust Board Meeting held in public: 1 October 2021

Agenda item number: 2021-22 (73a)

Title: Workplace Disability Equality Standard (WDES) annual report and 2021-22 Action Plan

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Category of paper: Assurance/approval
History: SMT, HWB Group, Wellbeing Guardian, Business Committee.

Responsible director: Director of Workforce, OD & System Development
Report author: EDI Lead (Workforce)

Executive summary

The purpose of this report is to outline the WDES actions and progress made over the last 12 months, and to provide assurance that the WDES action plan 2021/22 (Appendices A) will progress workforce disability equality in the Trust and is based on ESR data extracted on the 31 March 2021. *(WDES technical guidance)*

Main issues for consideration based on the recent WDES data

- Overall, 5% of the Trust's workforce had declared a disability through the NHS Electronic Staff Record. In comparison, approximately 20.1% (260) of the Trust's Staff Survey 2020 respondents have indicated that they have a disability or long-term health condition.

- Staff experiencing harassment, bullying or abuse from patients, family, colleagues, and managers remains a concern.

Some highlights of progress made during the last 12 months to progress disability equality include

- During the pandemic a more informal Health and Wellbeing group was formed which flexed and responded to what staff needed at that time, by designing and implementing a wide range of emotional, psychological, physical, and social interventions.

- The Trusts disability and wellbeing forum is in its infancy but does have a number of individuals who contribute and share their lived experiences which are published on MyLCH.

- A Non-Executive Wellbeing Guardian has been appointed which will ensure HWB remains of equivalent importance to the Trust Board as clinical performance.

- The Trusts Freedom to Speak up Guardian continues to lead on maintaining and improving a culture of speaking up, cultivating transparency and confidence in staff and showing that the Trust is committed to support staff where incidents of harassment and bullying in the workplace may occur.

Recommendations

The Trust Board is recommended to:

- Note the progress made over the last 12 months and to confirm they are assured that the WDES action plan 2021/22 will progress workforce disability equality in the Trust.

- Approve the WDES action plan 2021/22 and its subsequent publishing on the Trust's external website

Workplace Disability Equality Standard (WDES) 2021
Annual Report

1 Introduction

As the fifth biggest employer in the world, employing 1.4 million people, the NHS is in a pivotal position to lead the way in the employment of Disabled people in England.

The WDES encourages the development of a more diverse, empowered, and valued workforce and implementing this will support NHS organisations in complying with the provisions of the Equality Act 2010. Underpinning the WDES is the “social model of disability” (1), which recognises that Disabled people face a range of societal barriers and these create disability rather than the impairment or long-term condition. We are committed to creating an NHS is committed to being an employer who respects all staff and values their contribution.

A person is “disabled” under the Equality Act 2010 if they have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on their ability to do normal daily activities.

- substantial’ is more than minor or trivial, e.g. it takes much longer than it usually would to complete a daily task like getting dressed
- ‘long-term’ means 12 months or more, e.g. a breathing condition that develops as a result of a lung infection

Impact of COVID-19 on Disabled people

Official statistics also show that there has been a disproportionate impact on Disabled people in employment. During the pandemic the proportion of Disabled people in employment has gone down, while the proportion who are either unemployed, or economically inactive, has risen from 45.9% to 47.7%.

Whilst non-disabled people have also seen an increase in the proportion who are either unemployed or economically inactive, the increase has been smaller (from 17.8% to 18.9%). This has meant that that the disability employment gap has increased over the past year from 28.1% points to 28.8%.

The WDES became mandatory following the revision to the 2018 NHS standard contract and came into force on 1 April 2019.

There is a requirement for every NHS organisation to publish data annually showing the workplace experience of Disabled staff compared to non-disabled staff following analysis of workforce information, staff survey results and disability representation on boards. The analysis is undertaken against 10 metrics.

There are ten (10) WDES metrics

- Three (3) metrics focus on workforce data, which is taken from ESR either as a snapshot on 31 March 2021 or as data for the year up to this date
- Five (5) are based on questions from the national NHS Staff Survey (NHSS) which is taken from the 2020 NHS staff survey
- One (1) metric focuses on disability representation on boards.
- One (1) metric (metric 9) focuses on the voices of Disabled staff. Metric 9b asks for evidence to be provided within the Trusts WDES annual report.

https://www.scope.org.uk/about-us/social-model-of-disability/

Reporting criteria and timetable - April 2021 - March 2022

	NHS Staff survey year	Reporting period	Local extraction date	Date to upload onto national system	Date to publish report/action plan on Trust external webpage
WDES	2020	April 2020 – March 2021	31 March 2021	30 August 2021	31 October 2021

2 Workforce Disability Equality data as at 31 March 2021

WDES Metrics 1 to 3 compares the workforce data held on ESR, for both Disabled and non-disabled staff. Staff are recorded on ESR as disabled or non-disabled

WDES Metric 1 - Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

WDES technical guidance states organisations should undertake this calculation under “clusters” and separate into *non-clinical* and *clinical staff.*

Cluster 1: AfC Bands - under 1, 1, 2, 3 and 4
Cluster 2: AfC Band 5, 6 and 7
Cluster 3: AfC Band 8a and 8b
Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)
Cluster 5: Medical and Dental staff, Consultants
Cluster 6: Medical and Dental staff, Non-consultant career grade
Cluster 7: Medical and Dental staff, Medical and dental trainee grades

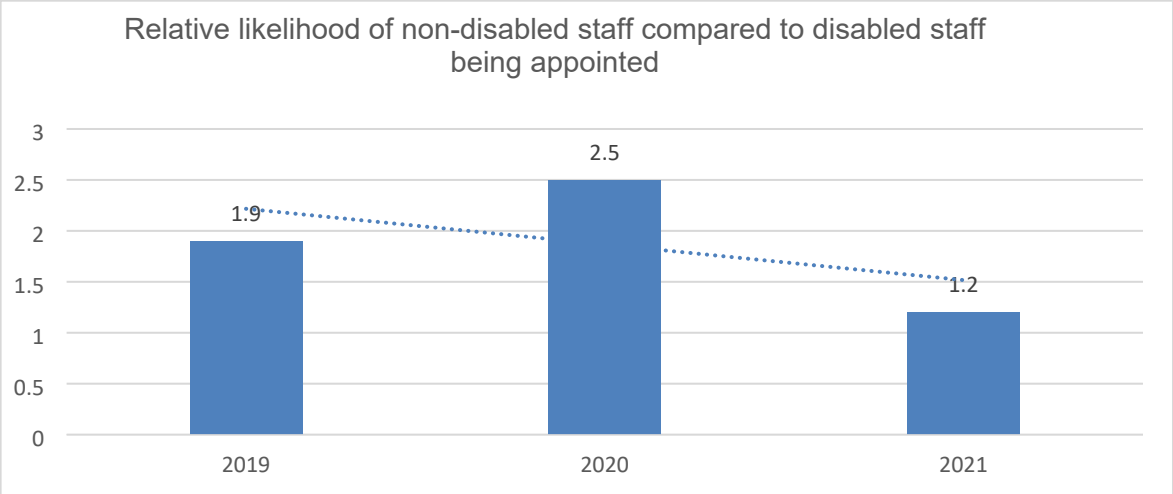
Non-Clinical Staff											
		Disabled			Non-Disabled			Unknown			
		2019	2020	2021	2019	2020	2021	2019	2020	2021	
Cluster 1	Bands 1-4	6%	7%	6%	86%	85%	85%	8%	8%	9%	
Cluster 2	Bands 5-7	5%	6%	5%	85%	87%	89%	9%	8%	6%	
Cluster 3	Bands 8a-8b	4%	3%	3%	91%	89%	87%	5%	8%	10%	
Cluster 4	Bands 8c - VSM	0%	0%	0%	70%	63%	60%	30%	38%	40%	
Clinical Staff											
		Disabled			Non-Disabled			Unknown			
		2019	2020	2021	2019	2020	2021	2019	2020	2021	
Cluster 1	Bands 1-4	4%	4%	4%	81%	82%	84%	15%	14%	12%	
Cluster 2	Bands 5-7	4%	5%	5%	86%	85%	82%	10%	10%	13%	
Cluster 3	Bands 8a-8b	4%	4%	4%	92%	85%	83%	5%	11%	14%	
Cluster 4	Bands 8c - VSM	9%	8%	0%	82%	75%	85%	9%	17%	15%	
Cluster 5	Medical & Dental Staff - consultants	0%	0%	0%	79%	75%	67%	21%	24%	33%	
Cluster 6	Medical & Dental Staff - non consultants career grade	5%	13%	7%	60%	62%	67%	35%	25%	27%	
Cluster 7	Medical & Dental staff - Medical and dental trainee grades	0%	0%	0%	0%	0%	0%	100%	100%	100%	

What it shows us - Overall, 5% of the Trusts workforce has declared a disability through the NHS Electronic Staff Record (ESR). The NHS staff survey results are extracted from our 2020 staff survey results information, which had a 45% overall return rate, of which 20% were from staff who have indicated that they have a disability.

In the 2011 ONS data for Leeds, 9% of the census respondents reported a disability that limited them a lot in their daily activities.

What we are doing - The workforce information team have created and shared, a simplified process for all staff to update their equality details on ESR.

WDES Metric 2 - *Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.*



(i) A relative likelihood of 1 indicates that there is no difference: i.e. non-disabled applicants are equally as likely of being appointed from shortlisting as disabled applicants.

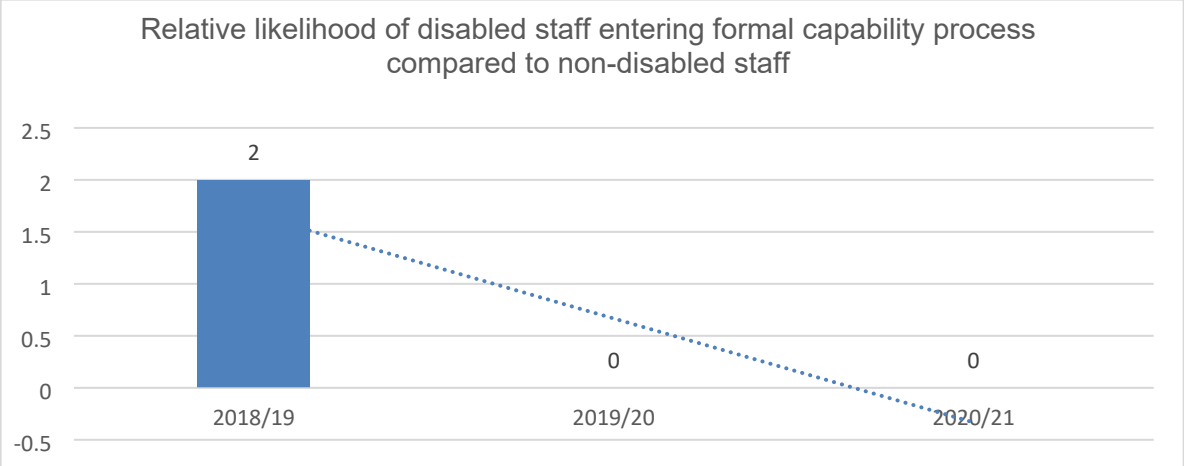
(ii) A relative likelihood above 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to disabled applicants: e.g. a likelihood ratio of 2 indicates non-disabled applicants are twice (2 times) as likely to be appointed from shortlisting as disabled applicants.

(iii) (iii) A relative likelihood below 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to disabled applicants: e.g. a likelihood ratio of 0.5 indicates non-disabled applicants are half (0.5 times) as likely to be appointed from shortlisting as disabled applicants. (WDES Technical guidance)

What it shows us - The data shows us the likelihood for a disabled applicant being appointed from shortlisting has improved over the reporting period. The score for 2021 now falls within the target range of 0.8 and 1.2

WDES Metric 3 - Relative *likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure*

This metric looks at the relative likelihood of Disabled colleagues compared to non-disabled colleagues entering the formal capability process, as measured by entry into the formal capability procedure based on data from a two-year rolling average of the current and previous. It must be noted that this metric looks at capability on the grounds of performance, and not ill health.



i) *A relative likelihood of 1 indicates that there is no difference, i.e. Disabled staff are equally as likely as non-disabled staff to enter formal capability processes.*

ii) *A relative likelihood above 1 indicates that Disabled staff are more likely to enter formal capability processes than non-disabled staff: e.g. a likelihood ratio of 2 indicates that Disabled staff are twice (2 times) as likely to enter a formal capability process compared to non-disabled staff.*

iii) *A relative likelihood below 1 indicates that Disabled staff are less likely to enter formal capability processes compared to non-disabled staff: e.g. a likelihood ratio of 0.5 indicates Disabled staff are half (0.5 times) as likely to enter a formal capability process compared to non-disabled staff.*

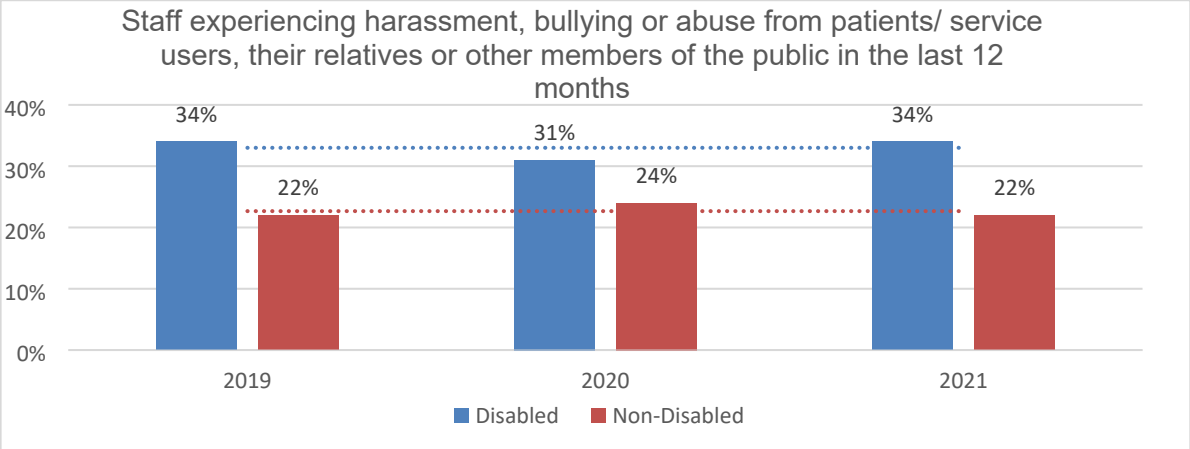
What it shows us - The data shows us that staff with a disability are less likely to enter formal capability process with a reduction in score from 2 in 2018/19 to 0 in the following two years. The score for 2019/20 & 2020/21 is calculated from 0 *disabled staff*, 2 *non-disabled staff* and 2 *disability status unknown* recorded on ESR.

For each of the next four NHS staff survey Metrics, a comparison of the outcomes of the responses for disabled and non-disabled is undertaken.

This information has been extracted from our 2020 NHS staff survey results, which had a 45% (1016 staff) overall return rate, of which 20% (260 staff) were from staff who have indicated that they have a disability or long-term health condition.

WDES Metrics 4 to 7 compares the 2020 NHS staff survey responses for both disabled and non-disabled staff.

WDES Metric 4a (i) - *Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives, or other members of the public in the last 12 months* (*Staff Survey Q13a*)

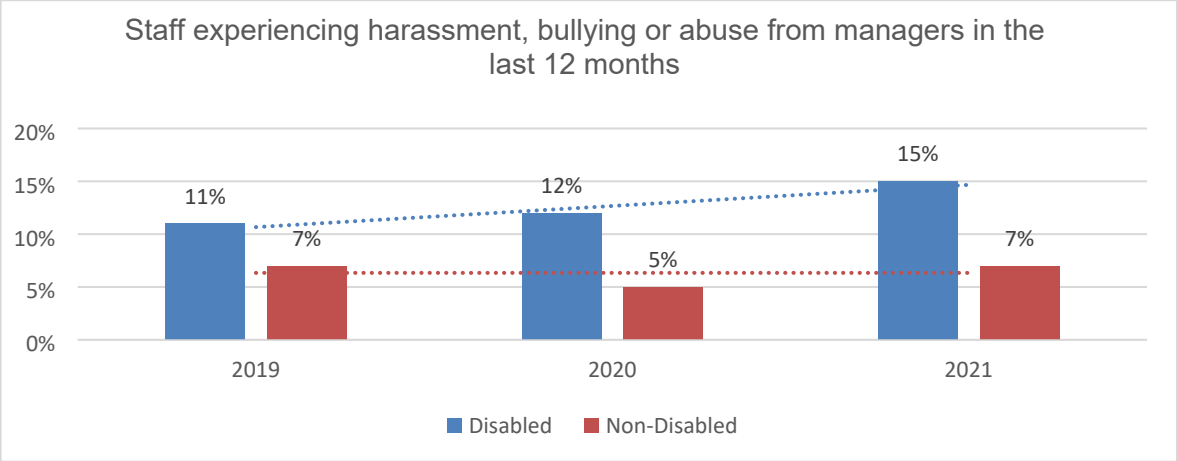


Staff with a disability: Responses 246 Staff without a disability: Responses 979

What it shows us - As the trend lines clearly show the difference gap between staff with a disability and those without remains the same over the reporting period and is 6% above the national community healthcare benchmarking average for staff with disabilities or as defined in the NHS staff survey "Staff with a disability" and 1% higher for staff without.

https://cms.nhsstaffsurveys.com/app/reports/2020/RY6-benchmark-2020.pdf

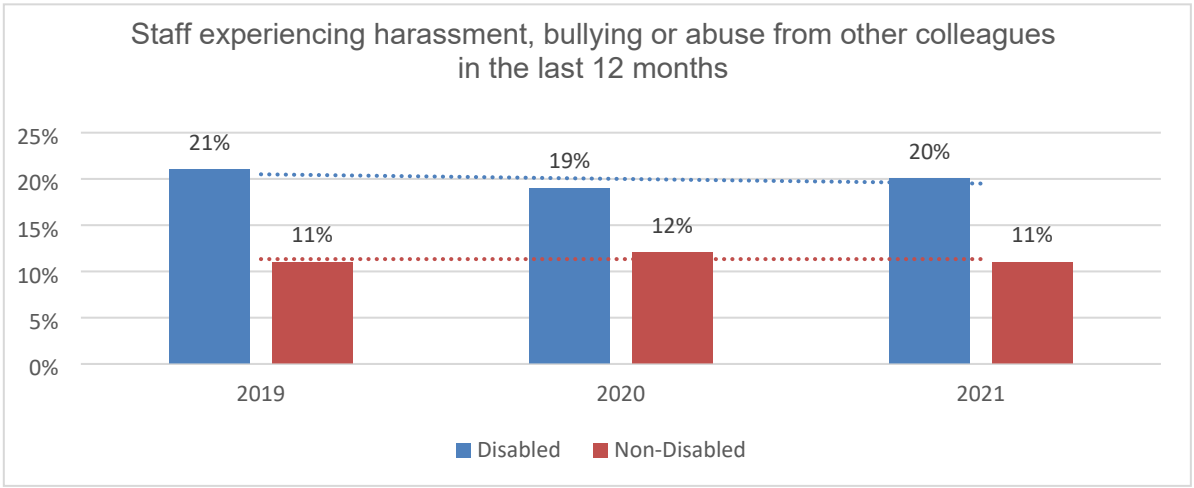
WDES Metric 4a (ii) – *Staff experiencing harassment, bullying or abuse from managers in the last 12 months (Staff Survey Q13b)*



Staff with a disability: Responses 244 Staff without a disability: Responses 978

What it shows us - The difference of experience between staff with a disability and those without increased over the reporting period. The national community healthcare benchmarking data for 2020 mirrors the Trusts position, however the national trend is decreasing unlike the Trust, where the trend line indicates an increase.

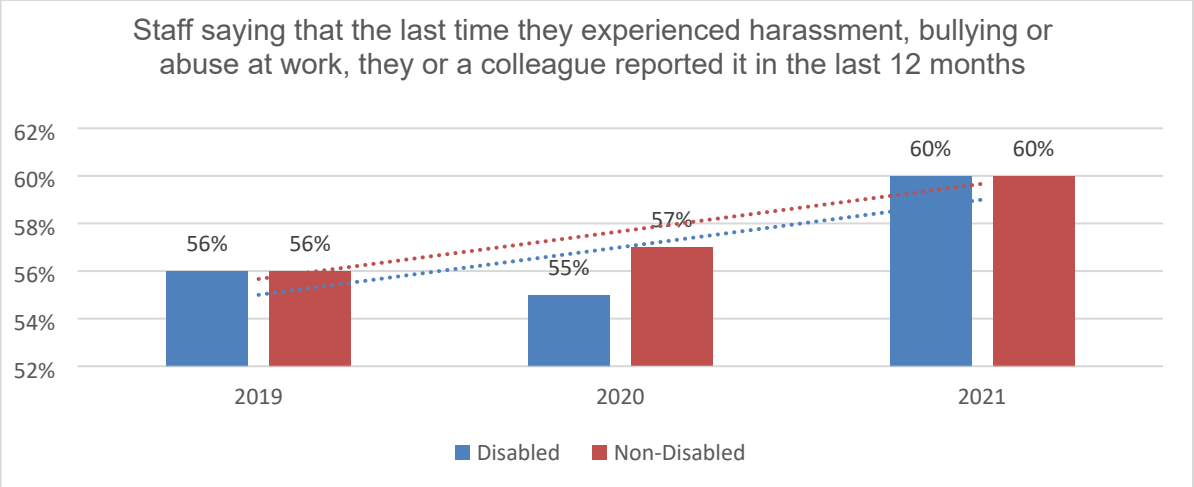
WDES Metric 4a (iii) – *Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months (Staff Survey Q13c)*



Staff with a disability: Responses 260 Staff without a disability: Responses 1,016

What it shows us - the trend lines data over the reporting period indicates a gradual reduction of staff with a disability experiencing harassment, bullying or abuse from other colleagues in the last 12 months, whilst the number of staff without a disability remains roughly the same reflecting national community healthcare benchmarking data. *(19% disabled and 12% non-disabled)*

WDES Metric 4b - *Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months (Staff Survey Q13d)*

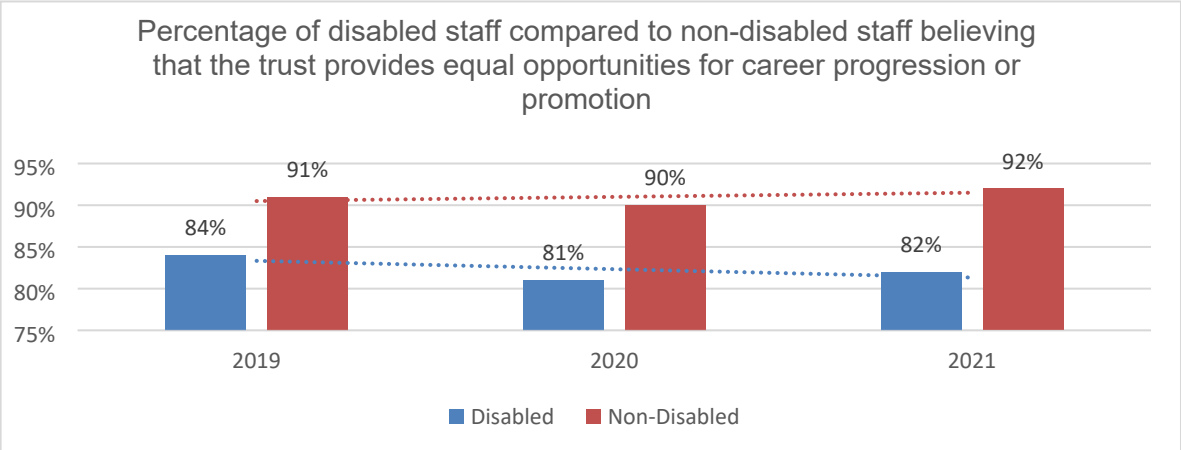


Staff with a disability : Responses 107 Staff without a disability: Responses 268

What it shows us – the trend lines indicate an increase in reporting harassment, bullying or abuse at work for both staff groups

What we are doing – accurate reporting of *harassment, bullying and abuse at work* is an area the ABU is progressing as part of their Open Conversations – Race equality in ABU initiative, is looking how the process for reporting can be streamlined to encourage staff to report occurrences.

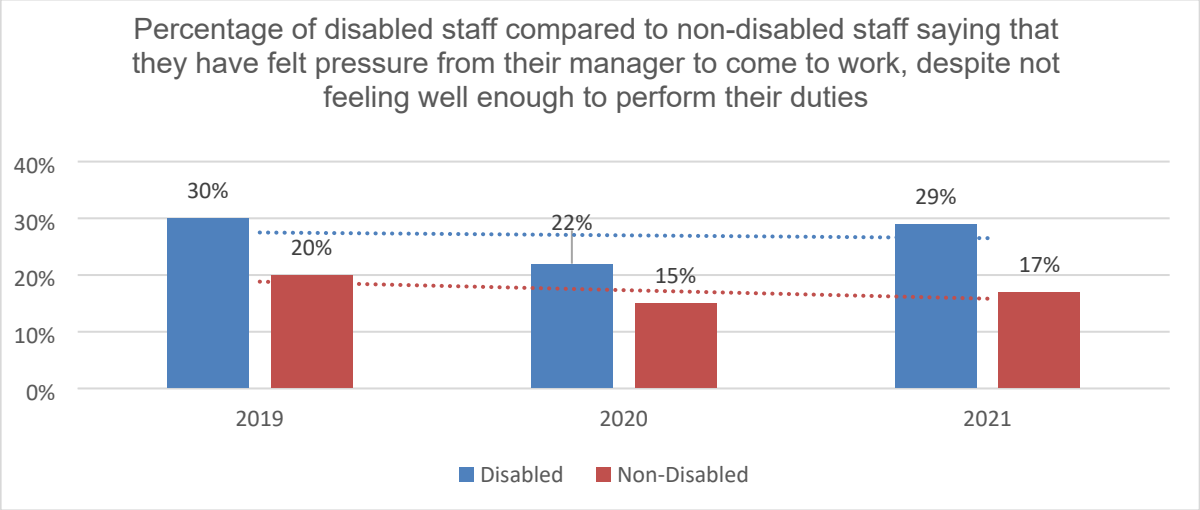
WDES Metric 5 – *Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion (Staff Survey Q14)*



Staff with a disability: Responses 178 Staff without a disability: Responses 711

What it shows us – the trend lines indicate that the "gap" between the two staff groups is widening, the percentage score for non-disabled staff is the same as the community healthcare benchmark percentage, however for staff with a disability the Trust percentage score is 5% lower than the community healthcare benchmarking percentage of 87%.

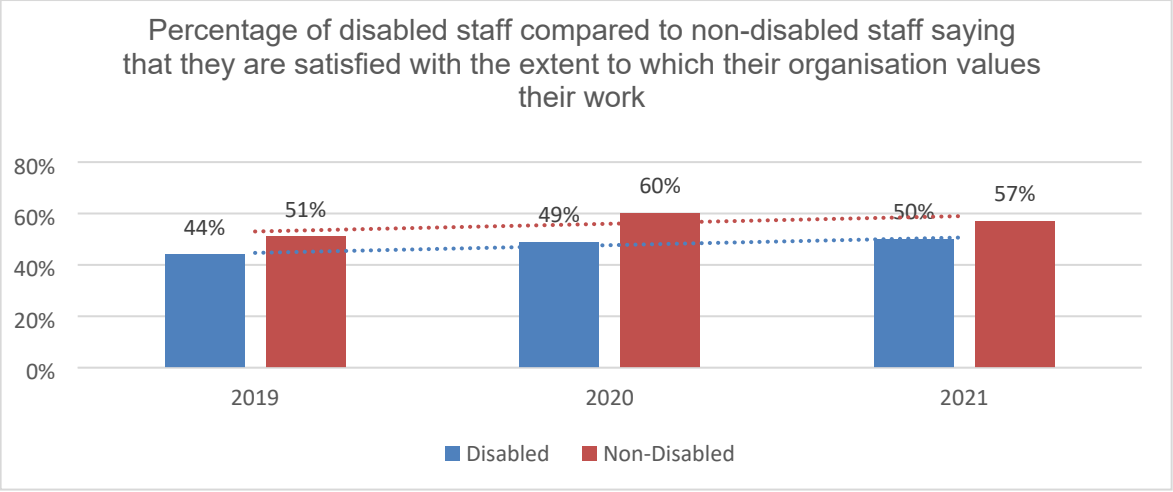
WDES Metric 6 – *Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. (Staff Survey Q11e)*



Staff with a disability: Responses 178 Staff without a disability: Response 451

What it shows us - The trend lines show a slight decrease in the percentage score for both groups of staff, however, a significant "gap" between the two staff groups remains over the reporting period.

WDES Metric 7 – *Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.* *(Staff Survey Q5f)*

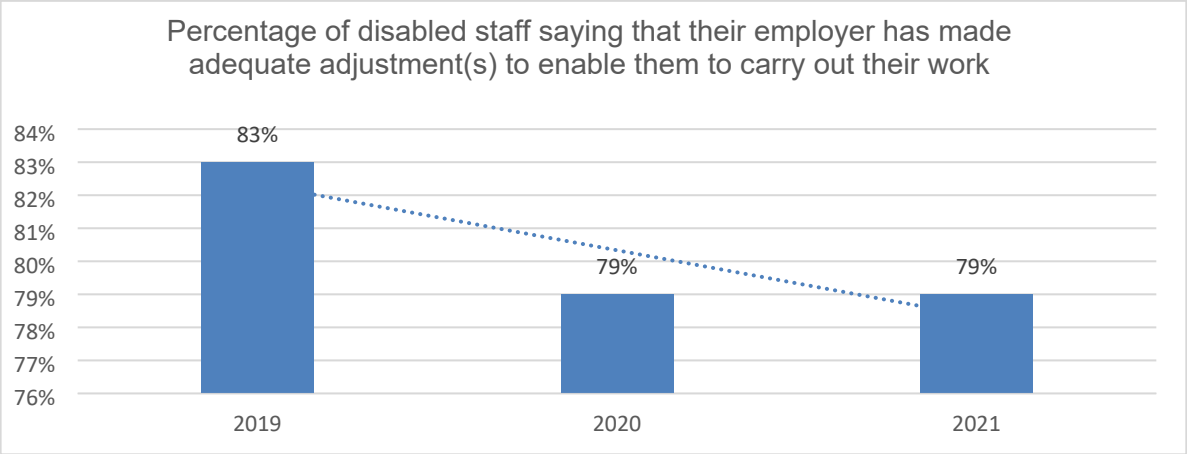


Staff with a disability: Responses 260 Staff without a disability: Responses 1,014

What it shows us – the trend lines indicate a increase in the percentage score over the reporting period for both groups of staff and are broadly refective of national community healthcare benchmarking percentage scores 48% for staff with disabilities and 56% for non- disabled staff.

WDES Metric 8 from the 2020 NHS staff survey only includes the responses of disabled staff

WDES Metric 8 – *Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Staff Survey Q26b)*

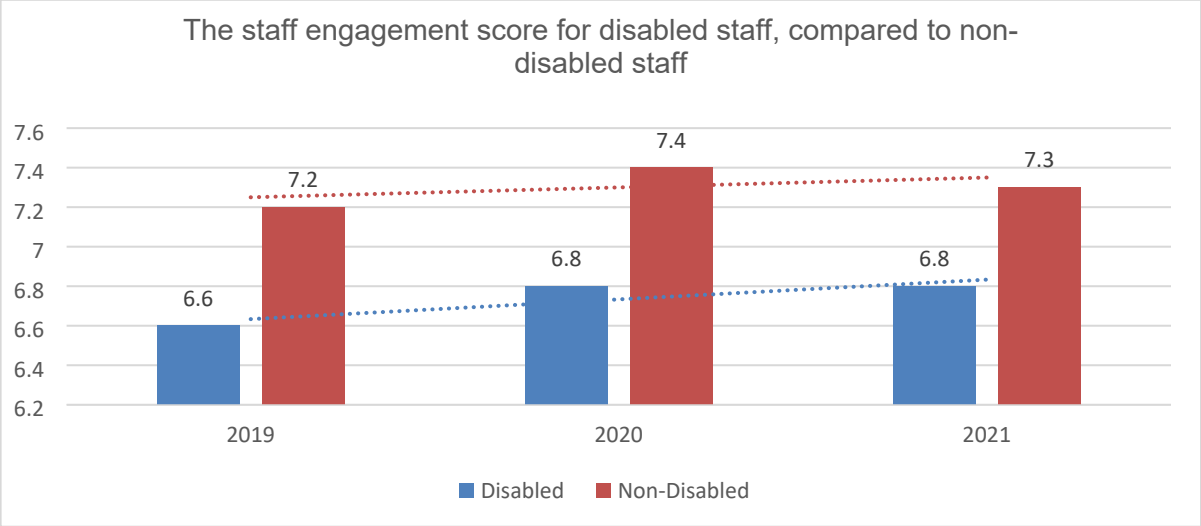


Staff with a disability s: Responses 152

What it shows us – There is still work to be done in raising awareness of the reasonable adjustment process, what it is and what it isn't.

2020 NHS Staff Survey and the engagement of Disabled staff

WDES Metric 9a – *The staff engagement score for disabled staff, compared to non-disabled staff - This part of the metric is now solely a comparison between the engagement score for Disabled staff and non-disabled staff. ?*



Staff with a disability: Responses 260 Staff without a disability: Responses 1,016

What it shows us – the trend lines indicate an increase in engagement scores for both staff groups. The 2021 scores are comparable with the national community healthcare benchmarking scores, 7.0 for staff with disabilities and 7.4 for non-disabled staff.

WDES Metric 9b - *Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard? Some examples*

Example 1: During Covid-19 pandemic, held open supportive conversations with staff who were "shielding" (held virtually), due to Covid-19 Pandemic

Example 2; Health and Wellbeing Working Group, with members who have a disability who can help shape the support the Trust can offer.

Example 3: Disability and Wellbeing Forum – virtual lunch and learn sessions, Compassionate & Inclusive Leadership sessions and Reasonable Adjustment Awareness training.

Example 4: Open conversations around "mental health and wellbeing"

Example 5: Freedom to Speak up Guardian promotion on Trust's Feel-Good Pledge intranet page.

Example 6: Mental Health First Aiders' drop in sessions

Example 7. Time to Talk campaign - as an accredited Time to Change Employer, promoted National Time to Talk Day

Example 8. Signed up to "Check-in campaign - Campaign to promote a wellbeing culture by normalising conversations around suicide and mental health, as well as providing resources and signposting for support

WDES Metric 10 - *Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting*

Disabled Board members in 2019	Non-disabled Board members in 2019	Board members with disability status unknown in 2019	% points difference (+/-) between Disabled Board members and Disabled staff in overall workforce	Disabled Board members in 2020	Non-disabled Board members in 2020	Board members with disability status unknown in 2020	% points difference (+/-) Between Disabled and non-disabled Board members in 2020	Disabled Board members in 2021	Non-disabled Board members in 2021	Board members with disability status unknown in 2019	% points difference (+/-) between Disabled Board members and Disabled staff in overall workforce
Exec = 0	Exec = 100%	Exec = 0	**Total Board = 13**	Exec = 0	Exec = /	Exec = 70%	**Total Board = 11**	Exec = 0	Exec = 17%	Exec = 83%	**Total Board = 12**
Non-exec = 0	Non-exec = 100%	Non-exec = 0	**Overall workforce = 3031**	Non-exec = 9%	Non-exec = /	Non-exec = 81%	**Overall workforce 3175**	Non-exec = 0	Non-exec = 0	Non-exec = 100%	**Overall workforce 3349**
Voting = 0	Voting = 100%	Voting = 0		Voting = 9%	Voting = 27%	Voting = 64%		Voting = 0	Voting = 22%	Voting = 78%	
Non-voting = /	Non-voting = /	Non-voting = /	**Difference = -5 %**	Non-voting = /	Non-voting = /	Non-voting = /	**Difference = +4%**	Non-voting = /	Non-voting = /	Non-voting = 100%	**Difference = -5%**

What it shows us – 83% of the Trust Board's disability status is unknown.

What are we doing - this has been discussed in the Workforce directorate and it has been identified that where staff are not recruited via NHS jobs, there is no automatic transferring of personal data from recruitment stage onto ESR. An alternative process will be implemented to improve equality data quality.

What we are doing

Health and Wellbeing group - during the pandemic a more informal group was formed which flexed and responded to what staff needed at that time, by designing and implementing a wide range of emotional, psychological, physical, and social interventions. We are now at a place, where we need to engage with staff to determine what they want/need from us in terms of HWB, moving forward. We will do this by re-purposing a HWB Engagement Group and HWB Steering Group, with formal Terms of Reference, with the appropriate level of governance to provide assurance to the Board.

A Non-Executive Wellbeing Guardian has been secured which will ensure HWB remains of equivalent importance to the Trust Board as clinical performance.

Speaking up - Maintaining and improving a culture of speaking up with the freedom to speak up guardian cultivating transparency and confidence in staff and showing that the Trust is committed to support staff where incidents of harassment and bullying in the workplace may occur.

Staff networks – The Trust's disability and wellbeing forum is in its infancy but does have a number of individuals who contribute and share their lived experiences which are published on MyLCH. The aim is to grow and evolve this network to become a key influencer on this agenda within the Trust.

Training and development - Reasonable Adjustment Awareness Sessions have been designed and were delivered to a variety of groups of managers and staff throughout 2019/20; these have been well received with additional support provided more informally to those that need it.

During the Covid-19 Pandemic, whilst there has been a pause to the "formal action plan" we continue to respond positively and at pace, with targeted health and wellbeing support for specific communities including our disabled staff, some examples are given below.

- Shielding staff – continued engagement with staff who are shielding
- BAME staff – significant support around assessment of risk for individual staff, and developing the role of BAME speaking up champions
- Working from Home staff – further support continues and results from a survey for this population are currently being analysed

- Support for Neighbourhood, who have experienced significant demands around delivery of End-of-Life care
- Drop in “virtual” sessions for Clinical Staff hosted by Director of Nursing, supported by ODI & Clinical Psychologist

Conclusion - The WDES reporting process has highlighted a number of areas where action is needed to maintain and improve the working lives of our disabled staff, which currently account for 5% of the workforce.

Recommendations

The Trust Board is recommended to:

- Note the progress made over the last 12 months and to confirm they are assured that the WDES action plan 2021/22 will progress workforce disability equality in the Trust.

- Approve the WDES action plan 2021/22 and its subsequent publishing on the Trust's external website

WDES Action Plan 2021-22

Objective	Task	Target date	Desirable Outcomes	Measure	Review date	Responsible Team	National links	Workforce Strategy
Actions to progress disability equality relating to organisational culture								
A workforce that is aware of the WDES and their contributions to it	Design and implement a revised WDES communication plan	31.10.21	Increase awareness of the WDES by staff at all levels of the Trust	Staff Survey	31.10.21	EDI	WDES	We are much more representative of our communities
LCH can demonstrate compliance with the Equality Act general duties	Design and implement a management process to ensure that recording of staff applications for and outcomes of the application for non-mandatory training can be accessed through the ESR	2.4.22	Provide robust data to inform the WDES action planning Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion increases.	Annual report to contribute to the annual WRES report	2.4.22	ODI	Equality Act 2010 MWRES	LCH managers are consistently inclusive, capable, put people before process and are aligned with LCH values. We support our existing and aspiring leaders to achieve this.
LCH to become a truly inclusive organisation	Promote the current range of reasonable adjustment and support that is available to staff and managers to Increase the percentage of Disabled staff confirming that LCH has made adequate adjustment(s) to enable them to carry out their work. (Currently at 79%, a 5% year on year target up to 94% by 2024)	31.3.24	Disabled staff say that their employer has made adequate adjustment(s) to enable them to carry out their work	Improved staff experience – quarterly pulse and annual NHS staff surveys	31.3.24	EDI HR & ODI		LCH managers are consistently inclusive, capable, put people before process and are aligned with LCH values. We support our existing and aspiring leaders to achieve this.
	Identify key stakeholders and collaborative opportunities	31.12.21	To ensure all voices are heard to inform our actions around staff disability	Improved staff experience – quarterly pulse and annual NHS staff surveys	31.12.21	EDI		
	Develop the Health and Wellbeing Group to test the appetite for a formal Support Network.	31.3.22	We will be able to better understand, and incorporate staff lived experience and diverse employee needs into our organisational approaches and policies	Improved staff experience and engagement – quarterly pulse and annual NHS staff surveys	31.12.21	HWB Group		

Actions to progress disability equality relating to bullying and harassment								
Improve staff feedback	Continue to promote the city wide Zero Tolerance approach ***#notinadayswork***	Ongoing	Show the wider impact that abuse and aggression have on the NHS including: •Physical and emotional harm to staff. •Potential harm to other patients and visitors •Diversion of staff away from their clinical duties to deal with incidents. •Temporary restriction of access to physical locations; and •Time and resources spent attending court cases.	Improved experience for all colleagues measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports	31.3.22	Comms	Leeds wide initiative	We look after our people through improved psychological, physical, and financial wellbeing, leading to best-ever attendance, capability & satisfaction
	Anti-Bullying and Harassment/Respect and Civility Policy revision/implementation	31.12.21	An equitable experience for staff with and without a disability Provide a positive working environment free of bullying, harassment, and intimidation	Improved experience for all colleagues measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports	31.12.21	ADoW	NHS People Plan	Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.
Actions to progress disability equality relating to recruitment and selection **A number of tasks identified in this section are the "High Impact Actions" set down in the NHS People Plan. Each action is currently being piloted by an NHS Trust in our region. LCH will use the findings from the pilots to prioritise and refine its own planning, timing and implementation of these actions, with engagement from key stakeholders ***								
*	Promote the equality self-service function on ESR and promote the case to declare/update equality data to reduce the percentage of unknown/not declared on ESR .currently 13%.	31.3.22	Improve data quality to better inform WDES actions and decisions		31.3.22	EDI and WFI	NHS People Plan	We maximise our workforce capacity by fully exploring all options available to us
Overhaul the recruitment and promotion practices to make sure that LCH staffing reflects the diversity of our community	Conduct an equality analysis of the recruitment and selection data held on NHS Jobs	31.12.21	Data to help 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	NHS Jobs data (historical) Improved staff experience – quarterly pulse and annual NHS staff surveys	31.12.21	EDI	Equality Act 2010 (PSED)	Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.
	Organise talent panels to: a) Create a 'database' of individuals by system who are eligible for promotion and development opportunities such	31.3.22	To increase diversity of talent pools to increase likelihood of appointing candidates from diverse backgrounds to post	Improved staff experience – quarterly pulse and annual NHS staff surveys		Clinical Education Team ODI	NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us

	as Stretch and Acting Up assignments must be advertised to all staff b) Agree positive action approaches to filling roles for under-represented groups c) Set transparent minimum criteria for candidate selection into talent pools		To embed accountability and make workforce diversity an organisational priority to increase likelihood of appointing candidates from diverse backgrounds to post Provide evidence for the CQC "Well Led" domain that we have made real and measurable progress on equality, diversity, and inclusion – and that we are able to demonstrate the positive impact of this progress on staff and patient We are much more representative of our communities. Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled			Project Management Talent Pool Team		
* Overhaul the recruitment and promotion practices to make sure that LCH staffing reflects the diversity of our community	Introduce a system of 'comply or explain' to ensure fairness during interviews This system includes requirements for diverse interview panels, and the presence of an equality representative who has authority to stop the selection process, if it was deemed unfair.	31.3.22 31.3.22 31.3.22			31.12.21 31.12.21 31.12.21	Resourcing Team EDI	NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us
	a) Provide training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used. b) Ensure adoption of values-based shortlisting and interview approach c) Consider skills-based assessment such as using scenarios	31.3.22	To close/reduce inequality gaps during interviews to increase likelihood of appointing candidates from diverse backgrounds to post		31.12.21	Resourcing Team	NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us
Actions to progress disability equality relating to leadership								
* Overhaul the recruitment and promotion practices to make sure that our staffing reflects the diversity of our community	Enhance EDI support available to: a) Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies b) Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interview	31.12.21	Meet the requirements of the NHS People Plan Provide evidence for the CQC "Well Led" domain that we have made real and measurable progress on equality, diversity, and inclusion – and that we are able to demonstrate the positive impact of this progress on staff and patient We are much more representative of our communities. Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled		31.12.21	EDI Resourcing Team	NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us
*	Ensure Board members own the	31.3.22	To reduce/eliminate impact of		31.12.21	EDI	NHS People	Disparities in

Overhaul the recruitment and promotion practices to make sure that our staffing reflects the diversity of our community	agenda, as part of culture changes in organisations, with improvements in representation of staff with disabilities, as part of objectives and appraisal		unconscious bias during interviews to increase likelihood of appointing candidates from diverse backgrounds to post				Plan (High impact action)	employee experience have substantially reduced; with any remaining disparity actively tackled.
We become an employer of choice.	Review the Disability Confident Leaders self-assessment	30.4.22	LCH retains Disability Confident Leaders Accreditation	Completed review submitted to *WeArePurple*, our Disability Confident partner	31.1.22	EDI	Disability Confident accreditation (DWP) Equality Act 2010	We maximise our workforce capacity by fully exploring all options available to us

Trust Board Meeting held in public: 1 October 2021

Agenda item number: 2021-22 (73b)

Title: Workplace Race Equality Standard (WRES) annual report and 2021-22 Action Plan

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Category of paper: Assurance/Approval
History: SMT, REN, Business Committee.

Responsible director: Director of Workforce, OD & System Development

Report author: EDI Lead (Workforce)

Executive summary

The purpose of this report is to outline the WRES actions and progress made over the last 12 months, and to provide assurance that the WRES action plan 2021/22 will progress workforce Race equality in the Trust and is based on ESR data extracted on the 31 March 2021. (*WRES technical guidance*)

Main issues for consideration based on the recent WRES data

- Under representation of BME staff at AfC Band 6 and above (Clinical and non-clinical)
- BME candidates are not being disadvantaged at the "shortlisting to appointment" stage of the recruitment process
- Over a fifth of BME staff and almost a quarter of White staff who completed the (NHS Staff Survey), experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months
- BME staff experience in WRES indicators 6-8 (NHS Staff Survey) are worse than white staff

Some highlights of progress made during the last 12 months to progress race equality include

- The Trust has embraced both the city wide #Zerotolerance initiative and the ICS led #RootOutRacism campaign
- The 3rd cohort of the Race Equality Allyship Programme began in July 2021 and is due to finish in December 2021. A 4th cohort four will be launched in February 2022.
- The Trust is delivering an initial Race Equality Allyship Programme for Harrogate & District Foundation Trust staff. It is worthy of note that a second cohort of the programme has been commissioned before the completion of the first which endorses the impact and quality of the Trust Race Equality Allyship Programme.
- Having delivered cohorts 1 & 2 we continue the delivery of the 3rd cohort of the Reverse Mentoring programme with a 4th being launched in January 2022. This programme has been the subject of interest across the NHS.
- The REN launched and have continued to promote & support the "I can be me" campaign.

Recommendations

The Trust Board is recommended to:

- Note the progress made over the last 12 months and to confirm they are assured that the that the WRES action plan 2021/22 will progress workforce race equality in the Trust.
- Approve the WRES action plan 2021/22 prior to subsequent posting on the Trust webpage

1 Introduction

Workplace Race Equality Standard (WRES) 2021

The Workforce Race Equality Standard (WRES) was introduced in 2015 as part of the NHS standard contract. It was the first-time workforce race equality had been made mandatory in the NHS.

The WRES was introduced to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. Evidence shows a motivated, included, and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations.

The WRES encourages the development of a more diverse, empowered, and valued workforce and implementing it supports NHS organisations in complying with the provisions of the Equality Act 2010. All staff should be able to look at their leaders and see themselves represented, and patients deserve the same.

The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- to improve BME representation at the Board level of the organisation.

The WRES requires every NHS Organisation to publish data annually against a set of nine WRES indicators based on;

- Four Indicators relate specifically to workplace data – which is taken from ESR either as a snapshot on 31 March 2021 or as data for the year up to this date

- Four Indicators are based on data from the national NHS staff survey – which is taken from the 2020 NHS staff survey

- One considers black and minority ethnic (BME) representation on the Trust Board.

Reporting criteria and time-table April 2021 - March 2022

	NHS Staff survey year	Reporting period	Local extraction date	Date to upload onto national system	Date to publish report/action plan on LCH webpage
WRES	2020	April 2020 – March 2021	31 March 2021	30 August 2021	31 October 2021

Medical WRES (MWRES)

Whilst the Workforce Race Equality Standard was launched some years ago, it has long been recognised that the medical workforce has several challenges which set it apart from the rest of the healthcare profession and so a bespoke set of 11 indicators have been developed that have fulfilled the following criteria;

- Broadly like the standard WRES indicators in terms of the dimensions of ethnic inequalities.
- They cover developmental opportunities, career progression, treatment by patients and employing organisations and representation.
- Based on data already collected and published, which could reliably be assessed annually, thus enabling monitoring of trends over time.

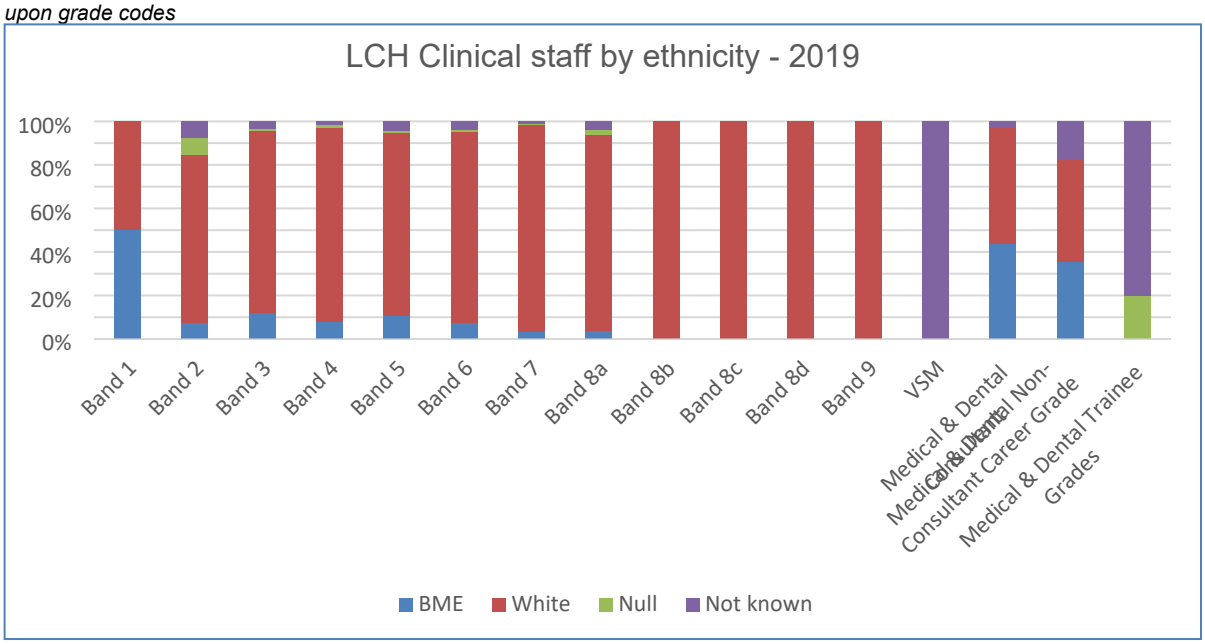
NHS E/I have published their inaugural MWRES data analysis report which provides an overview of the data on all eleven medical indicators providing a baseline on which to build future improvements. The report will be shared at Septembers JNC to start the discussion and seek views on how they wish to engage.

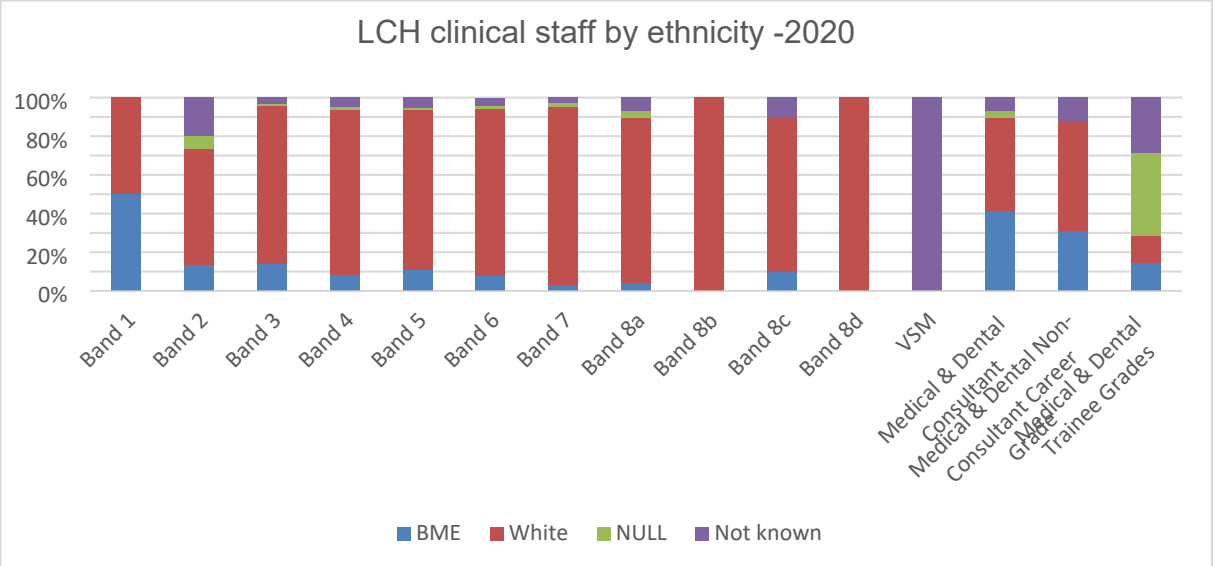
2 Workforce Race Equality data as at 31 March 2021

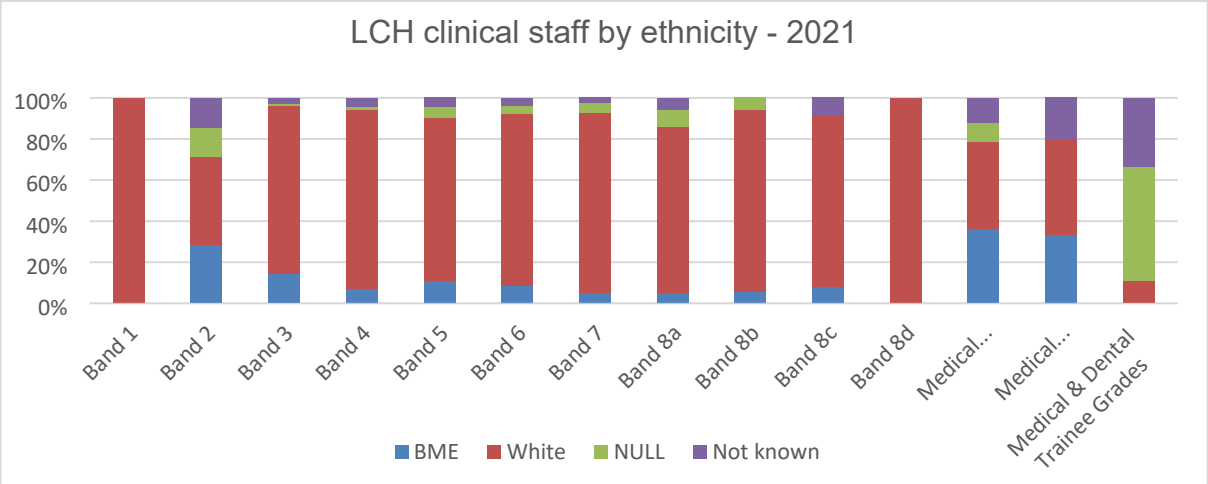
WRES Indicator 1 - *Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:*

- *Non-Clinical staff*
- *Clinical staff - of which*
- *Non-Medical staff*
- ***Medical and Dental staff*

Note: Definitions are based on Electronic Staff Record occupation codes except Medical and Dental staff, which are based upon grade codes







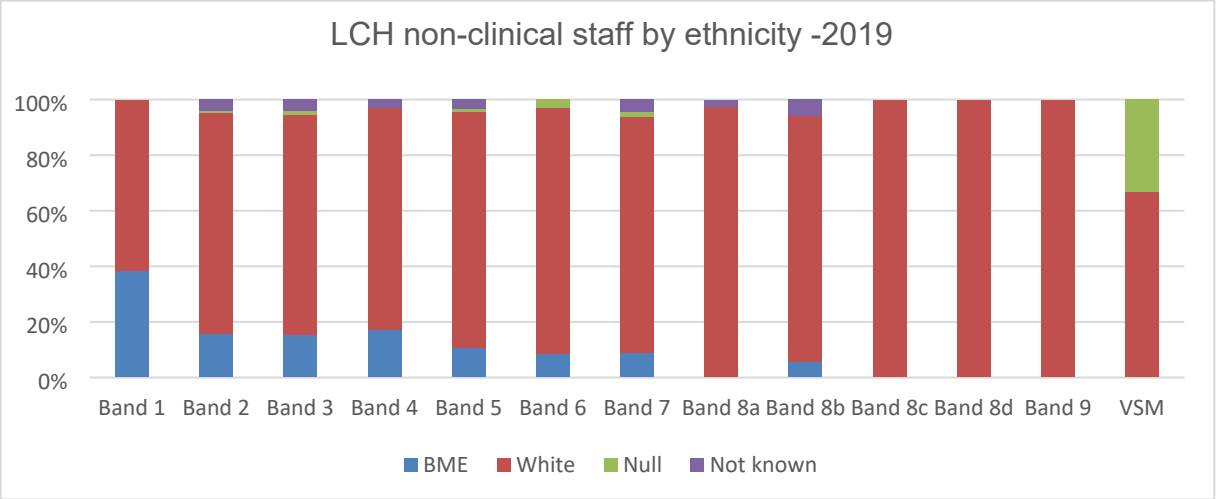
What it shows us - over a three-year period 2019 -2021 there has been an increase in BME staff in clinical posts at all AfC bands except for band 4 which has remained static over the reporting period. *(As shown above)*

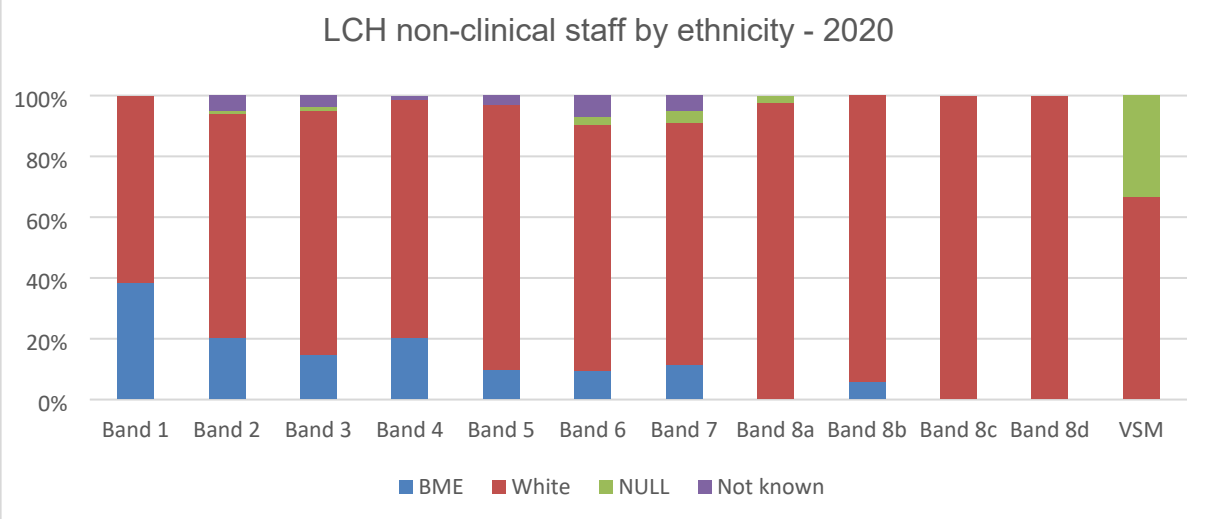
LCH now has increased BME representation at senior clinical positions with an increase in BME staff in post at band 8a and since 2019 band 8c and now in 2021 at band 8b.

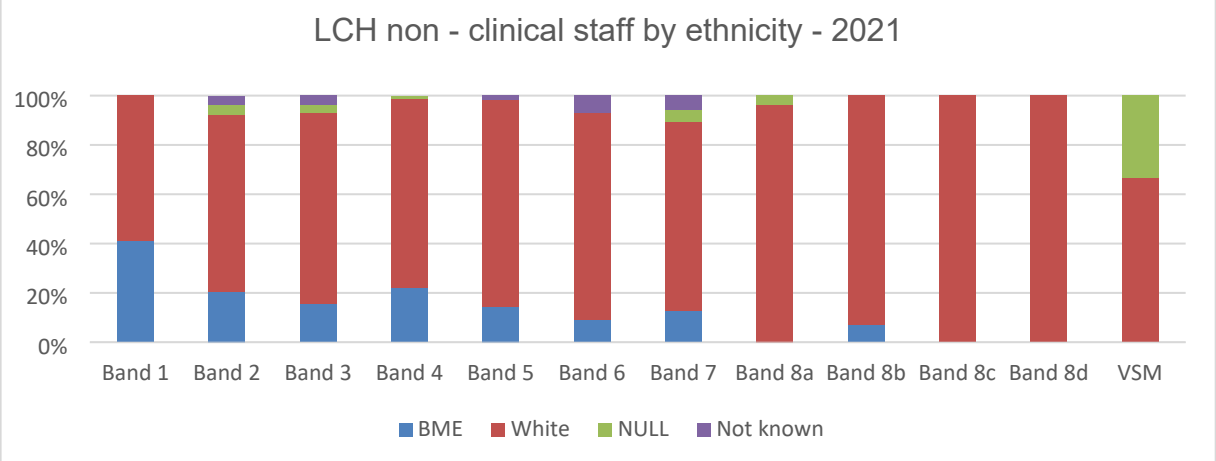
As at the 31 March 2021, 51 LCH staff, bands 7-8d, and 140 from bands 1-6 either chose not to disclose their ethnicity or did not provide a response.

What we are doing - The workforce information team have created and shared, a simplified process for all staff to update their equality details on ESR.

Since April 2021 the Business Committee performance report has included BME aspirational goals to increase representation in all AfC grades for the workforce to 14% by 2023 and 18% by 2028. However, these will be reviewed once the ONS Census21 data is made available in later 2022.







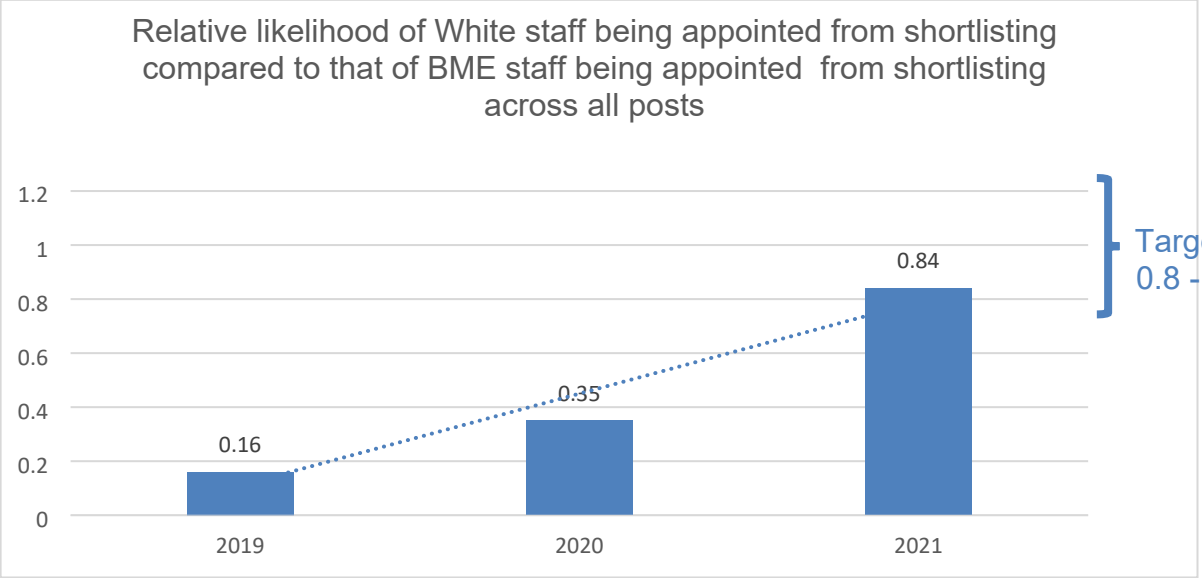
What it shows us - over a three-year period 2019 -2021 there has been an increase in BME staff in non-clinical bands 2-7.

Even though there has been an increase over the reporting period in the number of band 8a posts, there remains no BME representation in non-clinical band 8a posts.

At band 8b non-clinical grade there remains over the 3-year period a BME representation of 1 out of a total of 15 posts at that grade, in addition there has not been any BME representation at band 8c, 8d or VSM.

As at the 31 March 2021, 3 LCH staff, bands 8-8d, and 46 from bands 1-7 either chose not to disclose their ethnicity or did not provide a response.

WRES Indicator 2 - *Relative likelihood of staff being appointed from shortlisting across all posts*



Note: This refers to both external and internal posts, a figure below "1" would indicate that white candidates are less likely than BME candidates to be appointed from shortlisting.

What it shows us - As a group, BME candidates are not being disadvantaged at the "shortlisting to appointment" stage of the recruitment process. To be able to demonstrate equity at this stage of the process the score must be between 0.8 and 1.2 (*WRES Annual Report 2020*)

What we are doing - Implementing the NHSEI *6 High Impact Actions* designed to overhaul the recruitment & promotion process to underpin the NHS People Plan and help to make sure that LCH staffing reflects the diversity of our community

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*

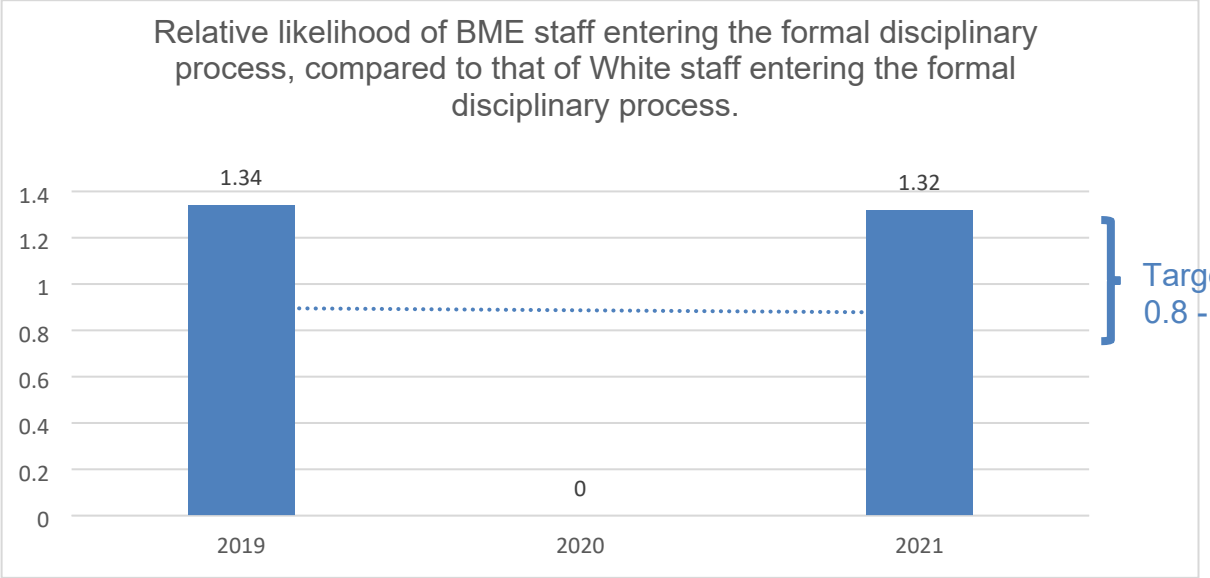
These actions are aimed at closing the inequalities gap in our recruitment and promotion pathway which has been further highlighted by staff experiences during the coronavirus pandemic.

We have completed an equality analysis of LCH NHS Jobs equality data for a three-year period 2019-21 and identify that there was a lower percentage of BME applications received for vacancies, than white applications, specifically from Pakistani and Bangladeshi heritage candidates – future equality analysis of the LCH NHS Jobs equality data is included in the WRES action plan.

Currently, we are scoping out a resourced action to encourage and support applications from Bangladeshi and Pakistani heritage applicants which will include community engagement via community partners, and mentorship.

As SMT directed in 2020, all recruitment panels for band 7 and above must have a diverse membership.

WRES Indicator 3 – *Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*



Note - Data from a two-year rolling average of the current year and the previous year – means data from whichever two previous 12month periods (i.e. 2 years) have been used as the basis of the reported data. A figure below "1" would indicate that BME staff members are less likely than white staff to enter the formal disciplinary process

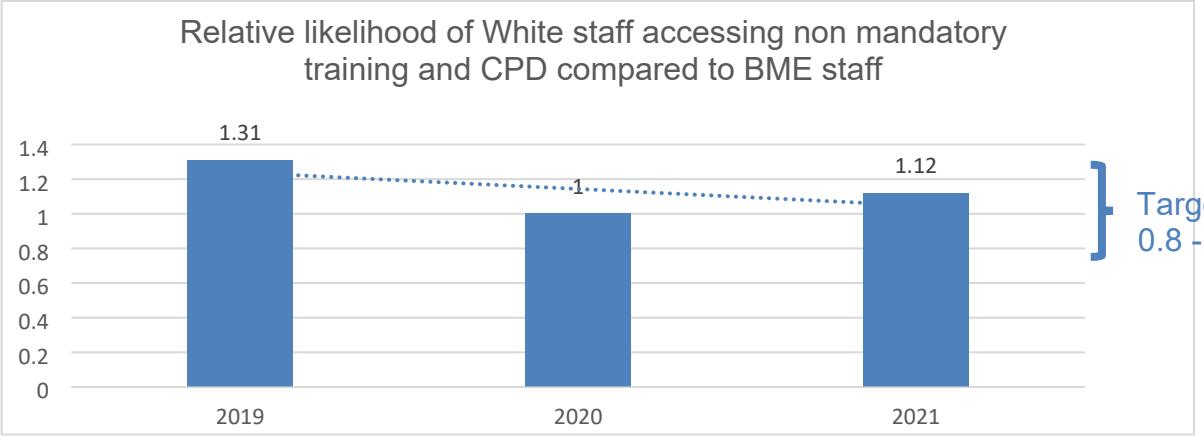
Entering the formal disciplinary process as measured by entry into a formal disciplinary investigation, this refers to staff who have entered a formal investigation as prescribed by the LCH Disciplinary Policy.
WRES data collection criteria determine staff who have been subject to an investigation, but for whom no further action was taken should be counted and cases where mediation has taken place rather than any kind of formal investigation or disciplinary action are not counted.

What it shows us - the scores in the graph for 2020 and 2021 above equate to:

- 2020 - 6 White, 0 BME and 1 unknown
- 2021 - 11 White, 2 BME and 0 unknown

What we are doing - The EDI team is working with HR Business Partners and the Race Equality Network (REN) to look behind these figures. REN membership has suggested that by only recording staff entering the formal disciplinary process as defined by WRES above, further work is required to gather information around concerns raised by BME staff who are being "informally" performance managed, to provide an accurate picture.

WRES Indicator 4 - *Relative likelihood of staff accessing non-mandatory training and CPD*



A figure below "1" would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.

What it shows us - the direction of travel over the reporting period shows improvement in this metric, LCH now falls within the 0.8 – 1.2 target score (*WRES annual report 2020)*

What we are doing - The Learning & Development budget has now been centralised and sits with Workforce ODI team. A simplified process has been implemented that will provide a consistent & transparent approach to the allocation of L&D resources to individuals in LCH. This will enable the extraction of equality data to facilitate the monitoring of all received applications and successful applications by protected characteristics for "long course" funding.

Analysis of the Long Course successful applicants for 2019/20 was conducted and revealed an over representation of successful Asian delegates and under representation of successful Black delegates. Equality analysis of "2021/22 will be carried out and results shared at the Diversity & Inclusion Hub meeting for further scrutiny.

Two years of data will assist identifying and implementing actions to increase representation of underrepresented groups in the application and successful applicant stages.

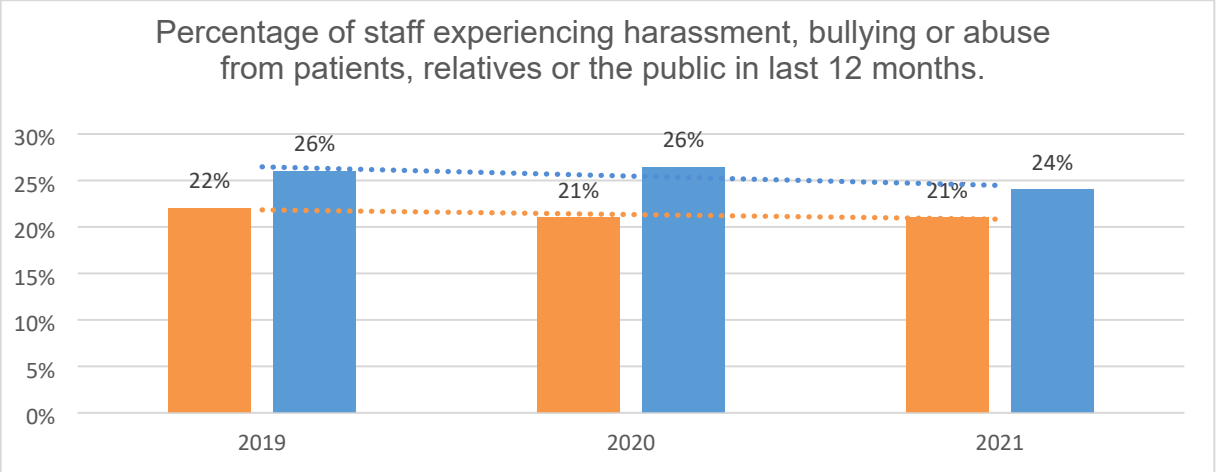
WRES Indicators 5-8

For each of the next four NHS staff survey Indicators, a comparison of the outcomes of the responses for white and BME staff is undertaken. This information has been extracted from our 2020 staff survey results, which was 45% overall completion rate this comprised of.

- 91.1% White background
- 1.8% Mixed/multiple ethnic background
- 3.8% Asian/Asian British background
- 3% Black/African/Caribbean/Black British background
- 0.1% Other ethnic group background

A summary of "what are we doing" for WRES indicators 5-8 is included at the end of this section.

WRES Indicator 5 - *Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months*



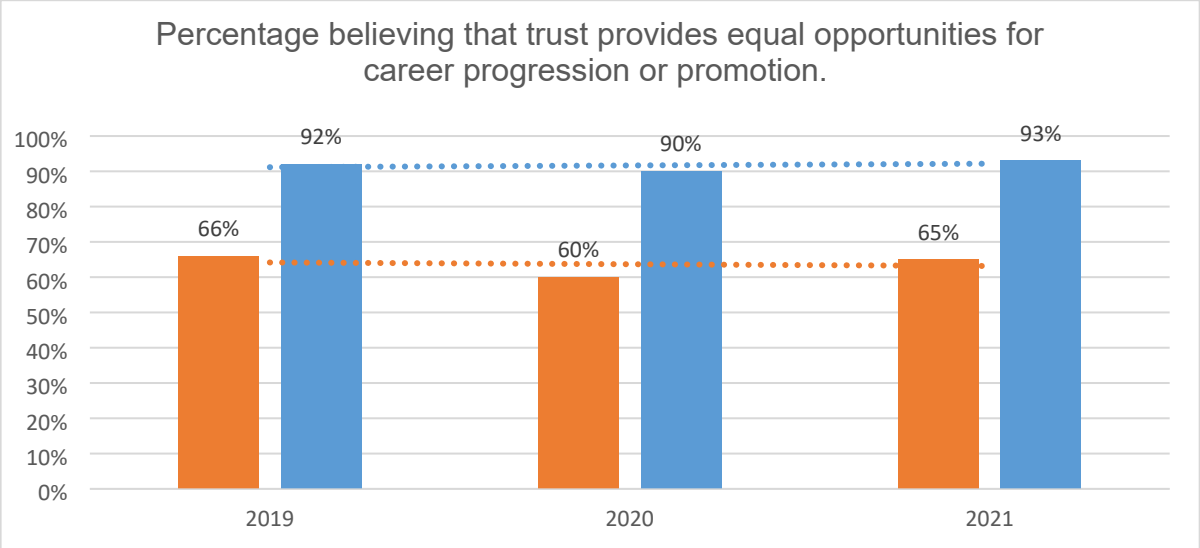
What it shows us – Whilst the trend line in the graph above provides an indication of improvement for both white (Blue) and BME staff (Orange), of concern is that over a fifth (21%) of BME staff and almost a quarter (24%) of white staff, who completed the staff survey had experienced harassment, bullying or abuse from patients, relatives of public in the last 12 months.

Over the reporting period the LCH percentages for white staff have been above the 22% white benchmarking average and for BME staff they have been below the 23% BME benchmarking average. *(Benchmarked against Community Trusts)*
(It is worth noting that in 2017 the figure was 25% for white staff and 31% for BME staff).

WRES Indicator 6 - *Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months*

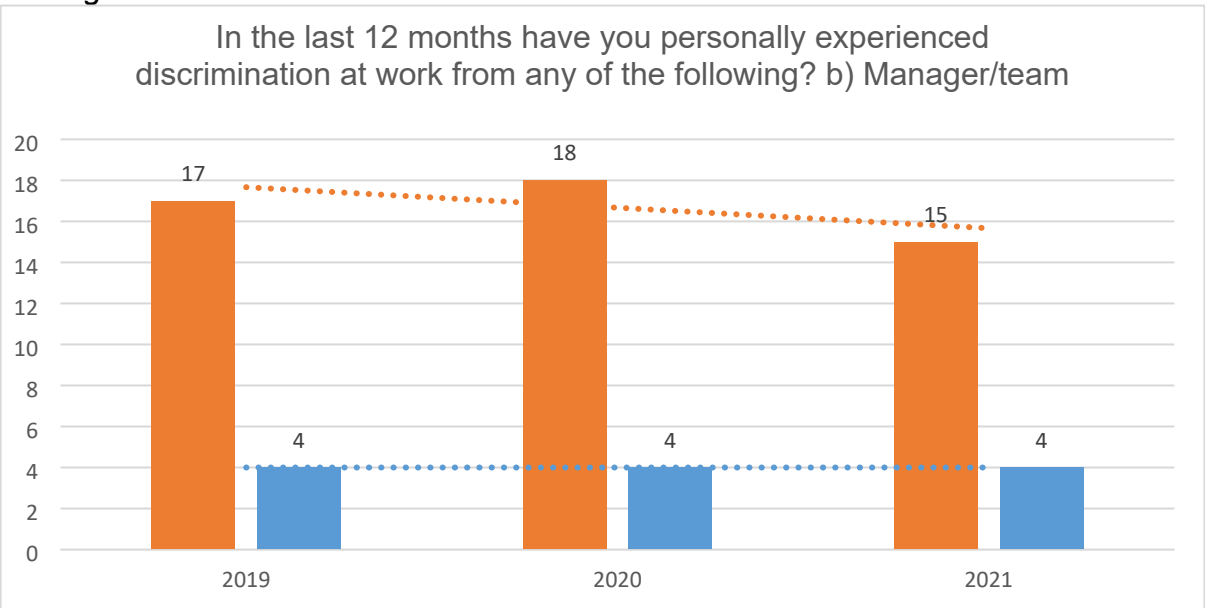
What it shows us -The trend line indicates that for BME staff (Orange) there has been an increase in experiencing harassment, bullying or abuse from staff over the reporting period, this had decreased slightly for white staff, which results in the difference in experience in this metric is getting wider.
Over the reporting period the LCH percentage for BME staff is above the 23% BME benchmarking average and below the 17% benchmarking marking average for white staff. (*Benchmarked against Community Trusts)*

WRES Indicator 7 - *Percentage believing that trust provides equal opportunities for career progression or promotion*



What it shows us - the gap, identified by the trendlines, between white and BME staff's *belief that the trust provides equal opportunities for career progression or promotion* has widened by 2% to 28% over the 3-year period compared to an average 15% gap for the benchmarking group. *(Benchmarked against Community Trusts)*

WRES Indicator 8 - *In the last 12 months have you personally experienced discrimination at work from any of the following? (b) Manager/team leader or other colleagues*



What it shows us - The trend line identifies that experience for BME colleagues is gradually improving whereas the percentage of White colleagues experiencing discrimination remains static. The LCH percentage score for white staff (Blue) reflects the 4% white benchmarking average however LCH BME staff are above the 14% BME benchmarking average score. *(Benchmarked against Community Trusts)*

WRES Indicators 5-8, what we are doing

1. In April 2020 LCH launched the *#notinadayswo*rk campaign alongside the Leeds Teaching Hospitals NHS Trust, and the NHS Leeds Clinical Commissioning Group to show people the wider impact that abuse and aggression has on the NHS.

2. In September 2020 the Adult Business Unit, supported by the FTSUG, EDI team and REN, started their *Open Conversations – supporting BME staff in ABU* initiative which included the following themes/workstreams

    - Expectations with patients and families
    - Expectations for staff
    - Reporting process
    - Escalating concerns
    - Communications- promoting this work.
    - Local Conversations at service and team level.
    - Promote reverse mentoring at service and team level
    - Promote BAME Freedom to Speak up guardians within services and teams
    - How can BAME staff network support people with line management/leadership roles?
    - Access to Training and Development – barriers
    - Sharing health and wellbeing resources
    - Together with the REN, the co-creation and launch of the *What you can expect from us* poster which underpins the Leeds city wide #notinadayswork zero tolerance campaign.

3. In June 2021 LCH signed up to an anti-racism movement #RootOutRacism, which was co-created by over 100 West Yorkshire and Harrogate Health and Care Partnership ethnic minority colleagues to proactively challenge racism across all aspects of society, the movement is part of an ongoing commitment to tackle structural and institutionalised racism, as well as addressing health and social inequalities across the area. The *#RootOutRacism* will be officially launched in August 2021 and will include the LCH REN Chair.

4. The third cohort of the Allyship Programme began in July 2021 and due to finish in December 2021. Cohorts 1 & 2 have come together to share good practice at the 6 monthly LCH Allyship forum.

5. Continued delivery of the 3rd cohort of Reverse Mentoring programme

6. The REN launched and have continued to promote & support the "*I can be me*" campaign.

7. 9 BME Freedom to Speak up Champions were recruited during the pandemic for BME staff who had a concern or would like to speak to someone in confidence.

8. Promotion of development opportunities for BME staff both internally and externally. It is anticipated that what we are doing for WRES Metric 2, implementing the NHSEI 6 High Impact Actions designed to overhaul the recruitment & promotion will positively impact on WRES Metric 7
9. Promotion of religious and cultural observances including Black History month, South Asian Heritage Month.

10. The EDI team supporting conversations in BU teams to become *comfortable with the uncomfortable.*

11. Delivery of the Compassionate and Inclusive Leadership sessions

12. Establish a 6 monthly EDI forum to begin in September 2021

WRES Indicator 9 - *compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce*

What it shows us - the data held on ESR as at the 31 March 2021 shows that the Trust Board comprises of 6 people who have declared themselves as white (4 voting & 2 non-voting) and 6 who's ethnicity is either unknown or null.

What we are doing - this has been discussed in the Workforce Directorate and it has been identified that where staff are not recruited via NHS jobs, there is no automatic transferring of personal data from recruitment stage onto ESR. An alternative process will be implemented to improve equality data quality.

A WRES action plan for 2021/22 (Appendices A) has been written, in partnership with the REN. Although each action has a team allocated to it, everyone in the Trust has a responsibility to progress Race Equality. The role of the EDI Team and REN is to hold up a mirror up to the organisation, ensure voices are heard and drive progress so the Trust can become an anti-racist and so become a truly inclusive organisation.

Recommendations

The Trust Board is recommended to:

- Note the progress made over the last 12 months and to confirm they are assured that the that the WRES action plan 2021/22 will progress workforce race equality in the Trust.

- Approve the WRES action plan 2021/22 , for subsequent posting on the Trust webpage.

WRES action plan 2021/22

Objective	Task	Target date	Desirable Outcomes	Measure	Review date	Responsible Team	National links	Workforce Strategy
Actions to progress race equality relating to organisational culture								
A workforce that is aware of the WRES and their contribution to it	Design and implement a revised WRES Communication Plan	31.10.21	Increased awareness of the WRES by staff at all levels of the Trust		13.10.21	EDI team	WRES Staff Survey	We are much more representative of our communities.
LCH can demonstrate compliance with the Equality Act general duties	Design and implement a management process to ensure that recording of staff applications for and outcomes of the application for non-mandatory training can be accessed through the ESR	31.3.22	All staff have the equality of opportunity for development	Annual report to contribute to the annual WRES report	31.12.21	ODI Team	Equality Act 2010 MWRES	LCH managers are consistently inclusive, capable, put people before process and are aligned with LCH values. We support our existing and aspiring leaders to achieve this.
A compassionate, inclusive and Anti-Racist organisation	Process and outcome evaluation of Cohort 3 Reverse Mentoring programme	31.10.21	The aims and objectives of the programme were met Evaluation of the programme helps inform delivery of future Reverse Mentoring programmes.	Improved experience for BME colleagues measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports	13.10.21	EDI Team	NHS People Plan High impact action	We look after our people through improved psychological, physical and financial wellbeing, leading to best-ever attendance, capability & satisfaction Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.
	Commence delivery of Cohort 4 Reverse Mentoring	30.11.21	Educate the workforce about Race issues, by exposing them to challenging dialogue, which they might otherwise never encounter.		31.10.21	EDI Team	NHS People Plan High impact action	
	Delivery of Cohort 3 Race Allyship programme	31.12.21	Improved insight into the issues affecting our 'Other than white" colleagues White ethnic colleagues adding their voice to those of their Black ethnic colleagues (as a whole) Increase number of staff's self-awareness of Race Inequality.		13.10.21	EDI Team	NHS People Plan High impact action	
	Deliver Cohort 4 of the Race Allyship programme	31.1.22			31.12.21	EDI Team	NHS People Plan High impact action	
	*Increase the numbers of staff who have signed a pledge to be part of the **I can be me*** – campaign pledge	Ongoing	Staff are open to conversation Staff have a commitment to equality and inclusion Staff will play their part in bringing us all together		31.12.21	Race Equality Network	Equality Act 2010	

	#WYHRootOutRacism – anti racist campaign	Ongoing	The objective of the Anti-Racism Movement is to unite WY&H HCP and communities in challenging racism by rooting it out and by standing together to take action.	Improved experience for BME colleagues measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports #RootOutRacism pledges by LCH colleagues	31.12.21	Race Equality Network EDI Team		We look after our people through improved psychological, physical and financial wellbeing; leading to best-ever attendance, capability & satisfaction
Overhaul the current LCH recruitment and selection process.	Continue to support and deliver The Race Equality Allyship Programme The Reverse Mentoring Programme The Compassionate and Inclusive Leadership sessions Promotions of external opportunities to develop cultural competences	31.12.21	A culturally informed workforce	Improved experience for BME colleagues measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports MyLCH inclusion hub “hits” data	13.10.21	EDI Team	NHS People Plan	
Actions to progress race equality relating to bullying and harassment								
Provide a safe space to explore and find solutions for disproportional trauma experienced by BAME staff	Promote the “Space to heal” peer support sessions, led by qualified CBT Therapist, Launch the pilot Evaluate the pilot.	31.10.21 30.11.21 30.6.21	Staff are provided with a service to address their individual and community response to cultural and racial trauma.	Increased engagement with staff via quarterly pulse and national NHS staff survey.	31.12.21	Race Equality Network	NHS People Plan High impact action	We look after our people through improved psychological, physical and financial wellbeing, leading to best-ever attendance, capability & satisfaction

Improved staff experience	Continue to promote the city wide Zero Tolerance approach ***#notinadayswork***	Ongoing	Show people the wider impact that abuse and aggression has on the NHS including: •Physical and emotional harm to staff. •Potential harm to other patients and visitors •Diversion of staff away from their clinical duties to deal with incidents. •Temporary restriction of access to physical locations; and •Time and resources spent attending court cases.	Improved experience for all colleagues measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports	31.12.21	Communications Team	Leeds wide initiative	We look after our people through improved psychological, physical and financial wellbeing; leading to best-ever attendance, capability & satisfaction
	Anti-Bullying and Harassment/Respect and Civility Policy revision/implementation	31.12.21	Provide a positive working environment free of bullying, harassment and intimidation		N/A	ADoW	NHS People Plan	Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.
Continue to provide a culturally appropriate point of contact for individuals who require advice, to inform them of the options available, whether informal or formal and to direct individuals to the support available in support to the *Freedom To Speak Up Guardian*	Continue to promote and build the capacity of the REN Freedom to Speak Up Champions	Ongoing	Building BME colleagues' confidence to speak up. Improved experience for BME colleagues	Improved experience for BME colleagues measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports	31.12.21	Race Equality Network	NHS People Plan	Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.
LCH to become a truly inclusive organisation	Delivery of compassionate and inclusive leadership sessions	Ongoing	Create an inclusive culture in LCH led by inclusive leaders at all levels	Improved experience for all LCH colleagues, measured by the quarterly pulse surveys, annual NHS staff survey and FTSUG reports Improved recruitment and retention figures Increased diversity at all levels of the organisation Improved patient outcomes	31.12.21	ODI Team		LCH managers are consistently inclusive, capable, put people before process and are aligned with LCH values. We support our existing and aspiring leaders to achieve this.

Actions to progress race equality relating to recruitment and selection ***The tasks identified in this section are the "High Impact Actions" set down in the NHS People Plan. Each action is currently being piloted by an NHS Trust in our region. LCH will use the findings from the pilots to prioritise and refine its own planning, timing and implementation of these actions, with engagement from key stakeholders***								
Overhaul recruitment and promotion practices to make sure that LCH staffing reflects the diversity of our community	Organise talent panels to: a) Create a 'database' of individuals by system who are eligible for promotion and development opportunities such as Stretch and Acting Up assignments must be advertised to all staff b) Agree positive action approaches to filling roles for under-represented groups c) Set transparent minimum criteria for candidate selection into talent pools	31.3.22	To increase diversity of talent pools in order to increase likelihood of appointing candidates from diverse backgrounds to post		31.12.21	Clinical Education Team ODI Team Project Management Talent Pool Team	NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us
	Overhaul interview processes to incorporate: a) Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used. b) Ensure adoption of values-based shortlisting and interview approach c) Consider skills-based assessment such as using scenarios	31.3.22	To close/reduce inequality gaps during interviews to increase likelihood of appointing candidates from diverse backgrounds to post		31.12.21		NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us
	Introduce a system of 'comply or explain' to ensure fairness during interviews This system includes requirements for diverse interview panels, and the presence of an equality representative who has authority to stop the selection process, if it was deemed unfair.	31.3.22	To embed accountability and make workforce diversity an organisational priority in order to increase likelihood of appointing candidates from diverse backgrounds to post		31.12.21		NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us

Overhaul recruitment and promotion practices to make sure that LCH staffing reflects the diversity of our community	Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews	31.3.22	To embed accountability and make workforce diversity an organisational priority in order to increase likelihood of appointing candidates from diverse backgrounds to post		31.12.21		NHS People Plan (High impact action)	We maximise our workforce capacity by fully exploring all options available to us
	Conduct an equality analysis of the recruitment and selection data held on NHS Jobs for 2021/22	29.4.22	Any disparity of equality of opportunity in the process is identified and potential actions to address are considered for inclusion in the WRES action plan 2022/23	NHS Jobs data (historical) Improved staff experience – quarterly pulse and annual NHS staff surveys	N/A	EDI Team	Equality Act 2010 (PSED)	Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.
	Increase the equality (Race) declaration rate by working to reduce the percentage of unknown/not declared recorded by staff on ESR	31.3.22	Improved data quality to better inform WRES actions and decisions		31.12.21	EDI & WFI Team	NHS People Plan	We maximise our workforce capacity by fully exploring all options available to us
The LCH workforces is representative of the communities that it serves	In partnership with 3rd sector organisations and the PET engage with Bangladeshi and Pakistani communities that are underrepresented at the application stage of the LCH recruitment process.	31.12.21	Increased number of applications from candidates from a Bangladeshi and Pakistani heritage	NHS Jobs equality data	30.11.21	EDI, PET & Resourcing Teams	NHS People Plan	We are much more representative of our communities.
Actions to progress race equality relating to leadership								
Overhaul recruitment and promotion practices to make sure that our staffing reflects the diversity of our community	Enhance EDI support available to: a) Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies	31.3.22	To make workforce diversity an organisational priority in order to increase likelihood of appointing candidates from diverse backgrounds to post		31.12.21	NHSEI EDI Teams	NHS People Plan (High impact action)	We are much more representative of our communities.
	Ensure Board members own the agenda, as part of culture changes in organisations, with improvements in BAME representation (and other under-represented groups) as part of objectives and appraisal by: a) Setting specific KPIs and targets linked to recruitment. b) KPIs and targets must be time limited, specific and linked to incentives or sanctions	31.3.22	To reduce/eliminate impact of unconscious bias during interviews to increase likelihood of appointing candidates from diverse backgrounds to post		31.12.21			

Leeds Community Healthcare NHS Trust

Public Board Meeting: 1 October 2021

Agenda item number: 75

Title: Infection Prevention and Control Annual Report 2020-2021

Category of paper: for assurance
History: Quality Committee 27 September 2021

Responsible director: Executive Director of Nursing and Allied Health Professionals
Report author: Head of Infection Prevention and Control and Deputy DIPC

Executive summary

To inform the Board of the achievements made by the Infection Prevention and Control Team in 2020-21 and to comply with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

The report covers the period 1st April 2020 to March 31st, 2021 and provides information on:

- IPC activities undertaken within the organisation and collaboratively with partners across the healthcare economy inclusive of the cooperation partnership agreement and additional commissioned services.
- Description of the (IPC) arrangements.
- Healthcare Associated Infections (HAI) statistics and surveillance.
- Forthcoming IPC programme 2021/22.

The following are key elements of the infection prevention activity and performance during the period of April 2020 to the end of March 2021.

- The Trust has had 1 MRSA assigned bacteraemia case during the year.
- The Trust has had no assigned Clostridium difficile cases during the year.
- The Trust has achieved 92% of all staff members being up to date with infection Prevention and control training.
- The Trust achieved 75% of front-line staff vaccinated against influenza.

Considerations:

- The continuation of provision in relation to the global pandemic: Covid-19 and the enhanced delivery of IPC throughout the Leeds system.
- Expansion to the cooperation partnership agreement between LCH and LCC for IPC provision and restructuring of the IPC Service.
- The continuation of evolving health inequalities throughout the population we serve that impact on the health promotion in relation to IPC.

- Continuation of the collaborative working that IPC have made with partners across the city and wider, inclusive of the Partnership Cooperation Agreement with Leeds City Council.
- The continuing difficulties that the team face in achieving the 90% target for the seasonal staff influenza programme.
- The burden of needle stick injuries throughout LCH and inappropriate use of needle safety equipment sometimes resulting in harm.
- Work completed around antimicrobial resistance and sepsis prevention.

Recommendations

The Board are recommended to note the contents of this report and approve its publication.

Report summary

This document forms the Infection Prevention and Control (IPC) annual report on Healthcare Associated Infections (HAI) within Leeds Community Healthcare NHS Trust (LCH).

The aim of this report is to provide information and assurance to the Board that the Infection Prevention and Control Team (IPCT) and all staff within the Trust are committed to reducing HCAI and that LCH is compliant with current legislation, best practice and evidenced based care inline with Care Quality Commission (CQC) criterion and the Health and Social Care Act (2008).

The report provides information on:

- IPC activities undertaken within the organisation and collaboratively with partners across the healthcare economy during Covid-19.
- Description of the (IPC) arrangements.
- HAI Surveillance.
- Forthcoming IPC programme 2020-21.

However, the biggest challenge for Infection Prevention and Control this year is one that we will continue to face for the next few months at least, the COVID 19 pandemic.

Key Achievements

During the past year the Trust has maintained and achieved in the following areas:

- Increased activity of work in relation to the Covid-19 pandemic, supporting services citywide, including the provision of testing and Covid-19 vaccination.
- Continuing compliance with the CQC criterion relating to Infection Prevention and Control (IPC).
- Successful collaborative working across the healthcare system and working towards the Partnership Cooperation Agreement with Leeds City Council.
- Increased funding capacity and restructuring of IPC service provision.
- Vaccinating 75% of frontline staff in the Seasonal Staff Influenza Campaign as well as a successful vaccination programme for Leeds City Council staff in adult and children's social care and care home settings.

Key Risks

- Major infection/outbreak/pandemic – this is a risk for any service. There were several outbreaks of infection this year throughout the healthcare economy including TB, Hepatitis A and the ongoing heightened activity in response to the Covid-19 pandemic, which focused our attentions on isolated staff outbreaks as well as wider provision of specialist knowledge in relation to workplace outbreaks.
- Ensuring that the correct systems and processes are in place to reduce where possible the risk of needle stick injuries to staff throughout LCH. To work with neighbourhoods and teams in identifying causation behind injuries, and where appropriate deliver training on needle safety devices and potentially evaluate equipment in use.
- During Covid-19 whilst the IPC have continued the surveillance around the Gram negative Blood Stream Infection (GNBSI) agenda it has been difficult to engage with the public to health promote, whilst many services such as luncheon clubs were closed during lockdown.

Key plans for 2021/22

The IPC programme aims to continuously review and build on existing activity. This is driven by local needs, whilst incorporating and complying with the latest Department of Health (DH), Public Health England (PHE) and relevant strategy and/or regulation(s).

- From July 2020 expansion to the Partnership Cooperation Agreement with Leeds City Council as a result of the increased work in relation to Covid-19, including track and trace, outbreak support, testing provision and vaccination support. This will result in moving to a seven-day service, increased staff and restructuring the skill mix of the service.

- Continued education on the standards relating to antimicrobial stewardship guidance in line with the UK's five-year national action plan – 'Tackling antimicrobial resistance 2019–2024 from the Department of Health'.

- Coordinate the provision of the service in line with the World Health Organisations (WHO) IPC Core Competencies, including leadership, education, leadership, workforce and HAI's.

- Staff development and enhanced knowledge base delivered through appropriate educational courses, which will result in the upskilling of staff members and enable succession planning.

- Support the resetting of services and embracing new ways of working whilst maintaining compliance from an IPC perspective.

- Co-ordinating the seasonal staff influenza campaign to vaccinate 90% of frontline staff and ensuring that staff are fully briefed on the prevention, detection and management of Influenza. Due to the pandemic there will not be a Commissioning for Quality and Innovation (CQUIN) payment attached to this target, however as an organisation we will continue to strive for a high uptake amongst frontline staff.

- Collaborate with the Leeds Healthcare economy on the implementation of a work plan to reduce the number of Gram-negative E. coli bacteraemia and aim to reduce incidence by 10% in accordance with Department of Health and NHS England / Improvement programme. We continue to maintain a zero tolerance to preventable healthcare associated infections such as MRSA and Clostridium difficile.

- Continue to promote knowledge and compliance with hand hygiene practice and other standard infection control precautions through education, increased audit activity, risk assessment and planned action in relation to environmental or cleanliness issues.

- Work collaboratively across the Leeds Healthcare Economy to support staff to identify correct detection, reporting and management of sepsis: with an emphasis on improving awareness of sepsis signs, symptoms and management, with the implementation of RESTORE.

- Continued support and guidance provided to font line staff in the use of sharp safety devices and the prevention of needle related incidents. This requires continued engagement with all business units particularly adults and specialists.

Annual Infection Prevention and Control Report

1. Background

This report is a requirement under the 'Code of Practice' of which Criteria 1 states *that 'the nominated Director for Infection Prevention and Control (DIPC) is to prepare an annual report on the state of HCAI in the organisation for which he or she is responsible and release it publicly.*' This report has been produced by the Head of Infection Prevention and Control and Deputy DIPC on behalf of the DIPC.

Leeds Community Healthcare NHS Trust recognises the obligation placed upon it by the Health Act 2006, (updated 2008, 2012, and 2015), that the prevention and control of infection continues to be a high priority for the Trust. There is a strong commitment throughout the organisation to prevent all avoidable healthcare associated infections (HAIs).

- Reporting requirements for the annual report are pre-set by the Department of Health.
- The Trust has registered with the CQC as having appropriate arrangements in place for the prevention and control of healthcare associated infections.
- Significant input from the IPCT to support this year's influenza campaign with improved uptake of vaccine in staff groups.

The Trust supports the principle that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection are provided within the Trust.

In 2020/2021 the Covid-19 global pandemic was the most significant issue faced in relation to Infection Prevention and Control (IPC) in the Trust and across the NHS. There was a first wave which lasted from April 2020 to August 2020. This was followed by a second wave which impacted across the Trust form the end of September 2020 and continued, though this was abating, at the end of March 2021.

2. Covid-19 Pandemic Response

During 2020/2021 the IPC team have worked tirelessly in response to the Covid-19 pandemic. It was based on reasonable assumption that the transmission characteristics of Covid-19 are similar to those of SARS-CoV another novel respiratory virus. The transmission of Covid-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces.

Health and social care organisations in England are being advised by PHE and the Trust has been applying the principles of their guidance locally. The infection prevention actions to reduce the risk of transmission to patients and staff are multifaceted. Limiting transmission of Covid-19 in the healthcare setting requires a range of IPC measures and hierarchy of controls including;

- Early recognition and triaging of cases
- Effective communication strategies
- The IPC team will continue to provide support, guidance and training to reduce the risk of healthcare transmission of Covid-19 in line with government guidance and the board assurance framework.

Due to the amount of preparation and on-going management required for Covid-19, the IPC team enacted the business continuity plans, actions included;

- Postponing the IPC audit programme
- Postponing formal post infection reviews (all patients with alert organisms still received the necessary IPC input)
- Suspending the planned transition work as part of the cooperation partnership agreement.

3. Performance

3.1 Surveillance of Healthcare Associated Infections (HCAIs)

This section of the annual report provides insight into the current Healthcare Associated Infection (HAI) burden actions taken to improve practice and patient safety linked to:

- Clostridium difficile infection (CDI)
- Meticillin resistant Staphylococcus aureus (MRSA) blood stream infections (BSI)
- Gram Negative Bacteria (GNB) specifically E. coli

Clostridium difficile Infection (CDI)
All community apportioned CDI cases are reviewed by the LCH IPCT. This review process involves the collection and analysis of patient care information and the subsequent identification of potential contributing factors for C diff acquisition.
This information is jointly reviewed by the CCG Medicines Optimisation Team, who directly link to the respective GP practices. A Post Infection review (PIR) is undertaken in situations where the episode of infection is identified as part of an outbreak, a contributing factor in the death of the patient or when the patient is identified within a LCH in-patient facility. From April 2015 an enhanced process of CDI review is being undertaken. The primary aim of this is to provide insight into the contributing factors for infection in cases where clear causation is not apparent. Due to the global Covid-19 pandemic it was decided that GP questionnaires would no longer be requested, in this instance patient care information was sourced from SystmOne and Leeds Care Record. Although information was considerably limited for patients whose GP practice use EMIS patient records, the number of EMIS practices identified was minimal.

Clostridium difficile community apportioned cases Q1 – 4, 2020/21
The following table outlines the number of community apportioned CDI cases identified and reported to the IPCT during this period.

	Quarter 1 2020 – 21			Quarter 2 2020 – 21			Quarter 3 2020 – 21			Quarter 4 2020 – 21			Year Total
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Cases attributed to wider community healthcare economy	5	4	4	13	7	8	8	7	2	3	8	5	74
Community onset community associated	3	3	3	6	4	8	7	5	2	2	7	2	52
Community onset intermediate association	2	1	1	7	3	0	1	2	0	1	1	3	22
Cases attributed to LCH	0	0	0	0	0	0	0	0	0	0	0	0	0

Figure 1 shows there has been an annual decrease of 17 cases in comparison to last year, however, Figure 2 shows July, September, October, November and February 2020/21 saw higher numbers of cases than the same months in 2019/20.

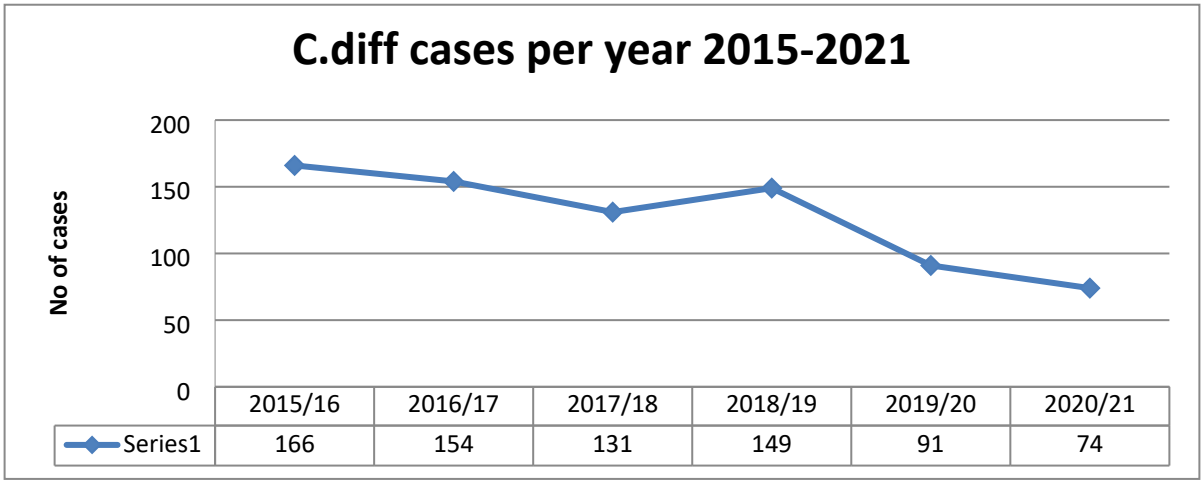


Fig 1. Comparison of C. diff cases per financial year 2015 – 2021

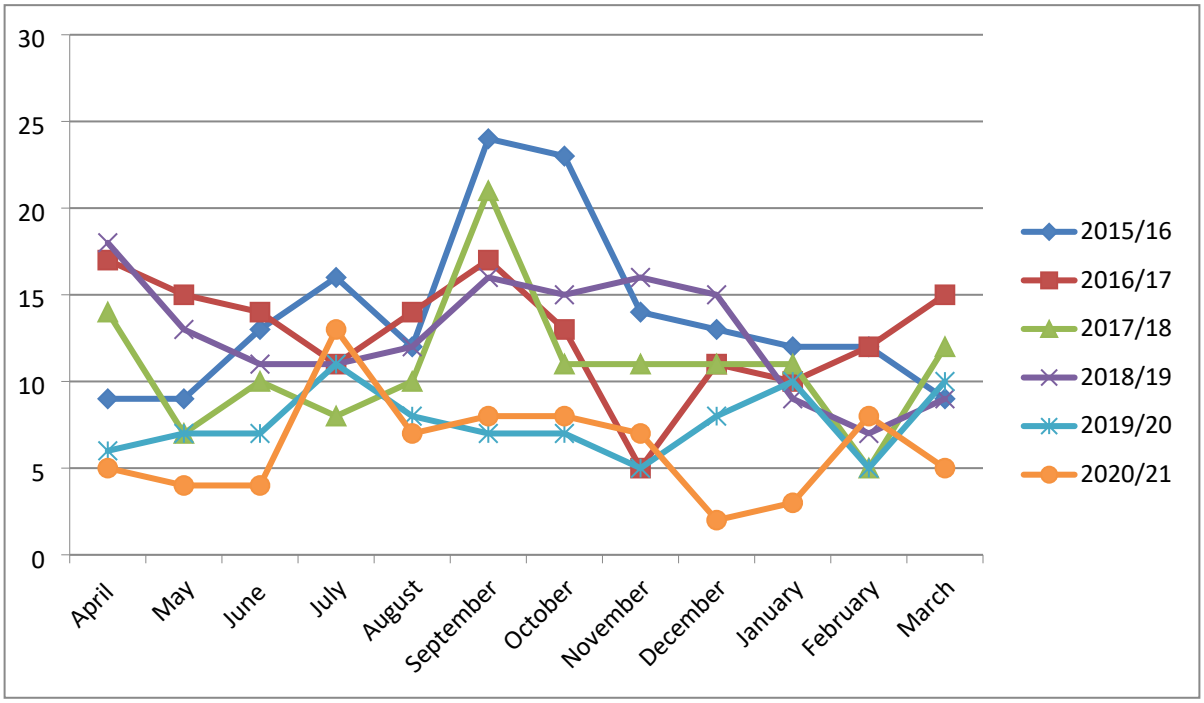


Figure 2. Comparison of C. diff cases per month 2015 – 2021

Key themes Identified

Antibiotic Usage: For cases where prescribing patterns have deviated from guidance, a full review is undertaken by the Primary Care Locality Lead Pharmacist. Learning identified during this review is shared both locally and where appropriate throughout the respective organisation. Prescribing which does not follow the Leeds Health Pathways guidance occurred in only 5 cases this financial year

MRSA Blood stream infections cases (MRSA BSI)

There is local requirement for all Post Infection Review's (PIR) to be undertaken within 14 working (21 full) days of notification. The principal purpose of the PIR is to deliver zero tolerance on MRSA BSI, to identify how each case of MRSA BSI occurred and to identify actions that will prevent it reoccurring in the future. Unfortunately, due to the increased pressures across the health economy and prioritisation of the novel Covid-19 virus pandemic, it has been not been possible to undertake PIR meetings within the 14 day time period, however all LCH investigation timelines have been completed in this time frame.

The outcome of the PIR determines clinical learning and relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA BSI.

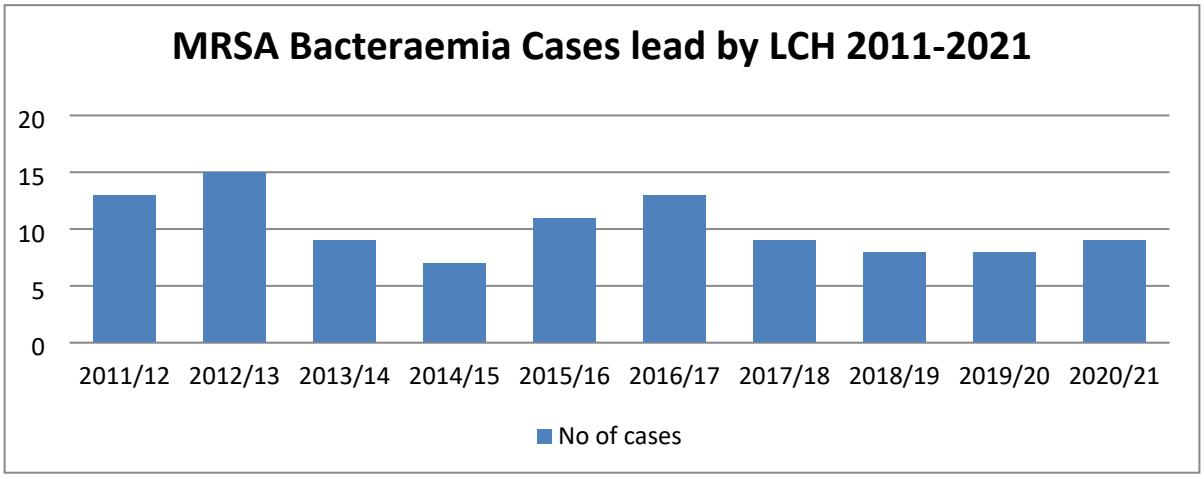


Figure 3. MRSA BSI led by LCH 2011 – 2021.

From April 2020 to March 2021 there has been 1 case of MRSA Bloodstream Infection (MRSA BSI) attributed to LCH, this case was added onto Datix and investigated.

Figure 3 shows during the reporting period for 2020/21, 9 MRSA BSI was notified to LCH that required joint exploration with stakeholders. LCH was also notified of 5 collaborative cases at LTHT.

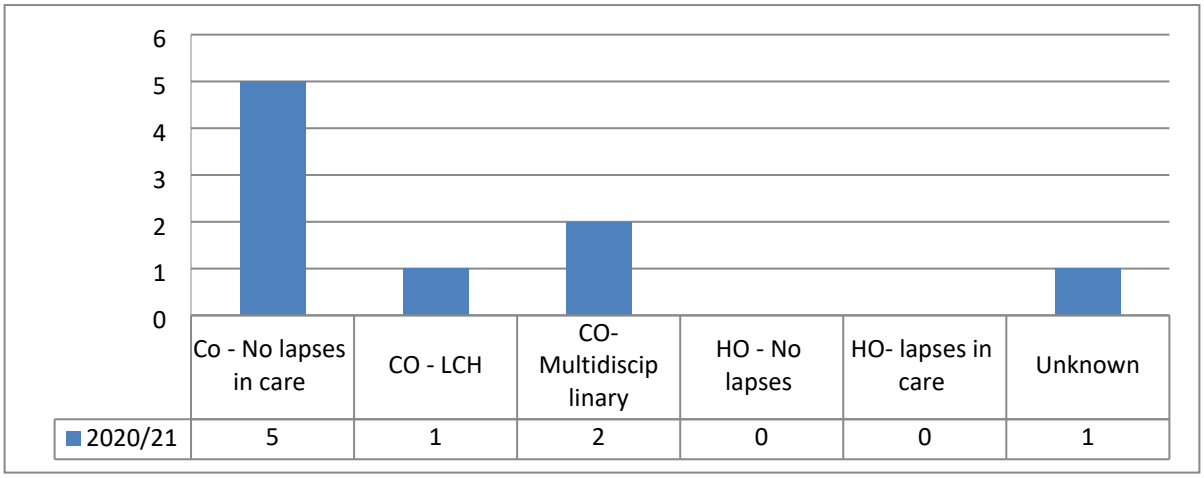


Figure 4. Attribution of cases 2020- 2021

Figure 4 shows assignment system, during the 2020/21 period. One case would have been assigned to LCH care, 2 cases to wider multiagency and 5 cases to Community onset but no lapses in care. One case involved a child for whom a PIR is not conducted, this case is represented as unknown in the figure.

Gram Negative Blood stream Infections (E. coli BSI)

All community apportioned E. coli BSI cases which are identified within LTHT are reviewed by the LCH IPC team. The LCH IPC Nurses then complete a RCA for 10 cases. This RCA process involves the collection and analysis of patient care information, using GP questionnaire and healthcare records including SystmOne, and Leeds Care Record, and the subsequent identification of potential contributing factors for E. coli BSI acquisition

For patients who E. coli bacteraemia is listed as a cause of death (either 1a or 1b) and the case is an inpatient in an LCH area, a full multidisciplinary PIR, similar to that for MRSA BSI will be undertaken.

Some community cases which were identified through LTHT laboratories and all cases from other outlying acute trusts such as Bradford, Harrogate, Mid Yorkshire and York are still not

being appropriately identified to LCH. Therefore, to ensure accuracy all community cases are cross checked with the Data Capture System routinely. Cases which are identified in acute trusts other than LTHT are not subject to the RCA process but do count towards the monthly and annual total.

	Quarter 1 2020 – 21			Quarter 2 2020–21			Quarter 3 2020–21			Quarter 4 2020 – 21			Year Total
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Community E. coli cases	24	39	28	48	52	42	33	34	32	38	34	42	446
Community Klebsiella cases*	2	11	10	9	6	12	11	9	11	5	3	8	97
Community Pseudomonas cases*	2	1	1	4	3	2	1	1	3	3	0	1	22

*Community acquired pseudomonas and klebsiella cases are currently not acted on in line with service specification.

The table above outlines the number of community apportioned E. coli BSI cases identified and reported to the IPCT during this period, showing a total of 446 Community E.coli cases for the financial year 2020/21. This is a reduction of 14% on 2019/20.

All patient/ public facing work remains on hold due to the Covid-19 pandemic, the vulnerability of lunch club attendees and the need for social isolation. However, it is hoped discussion can commence in the near future.

Due to the pandemic 'The Gram Negative Collaborative Working Group' were unable to meet throughout the 2020/201 year however; these meetings will be recommenced in the new financial year. This group continues to involve professionals from across all Leeds NHS trusts and other partners including LCC, GP confederation, private, and voluntary care sectors.

3.2 PPE Provision

In April 2020 the PPE team was formed comprising of IPC Nurse for advice alongside specialists from business logistics and procurement. A dedicated email address was opened for staff members to post any question they had in relation to PPE. This proved to be a very popular service offering huge value, as well assurance to the trust board.

As the current Covid-19 pandemic developed, the Trust found itself in a position where unprecedented levels of PPE were being required. As centralised PPE push stock commenced, the IPC team were being relied upon to ensure stores were being distributed throughout the Trust.

The group quickly took control of the issue, initialised a stock reporting tool allowing real time scrutiny of stock levels, minimum requirements and having the ability to effectively plan for any supply issues.

Fit testing

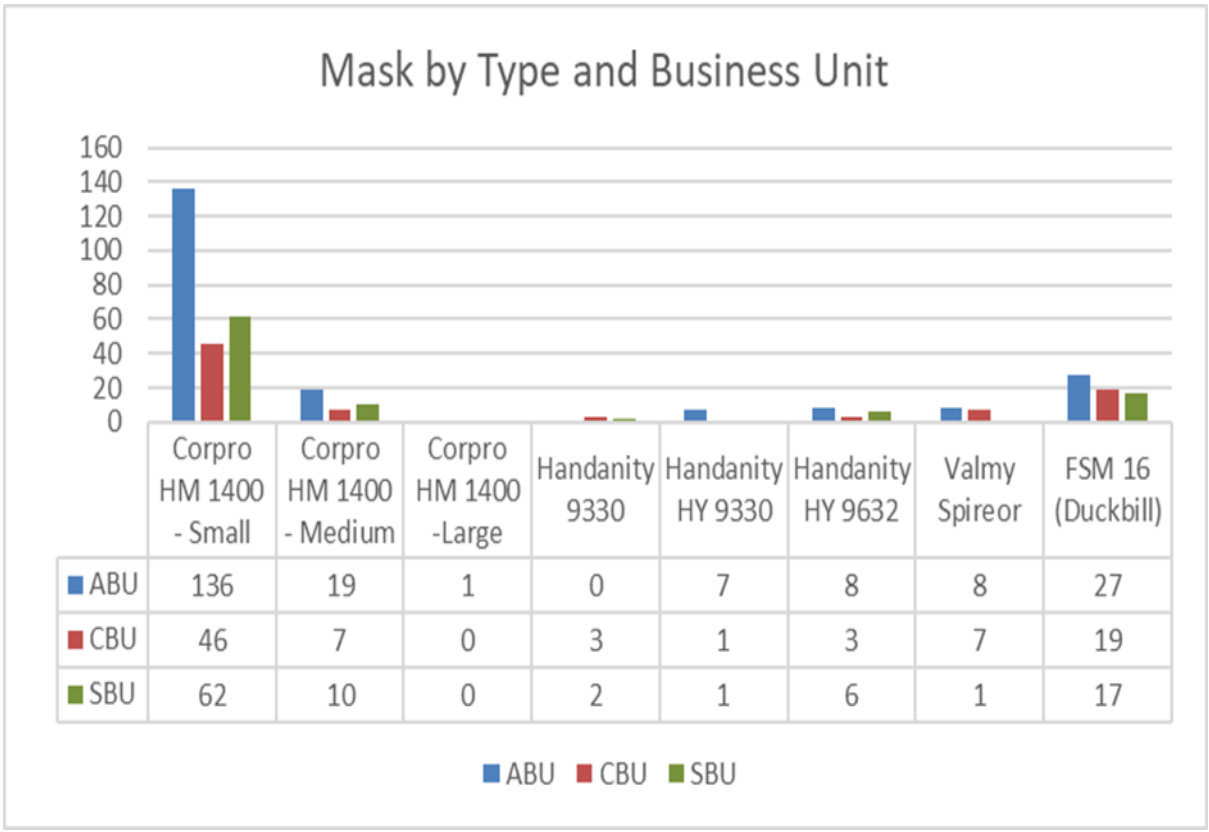
The IPCT have continued supporting the PPE working group in providing specialist clinical advice. Throughout this reporting period, there have been difficulties accessing a single standard FFP3 mask due to the nature of supply. For that reason, the Trust has continued

down the route of issuing out reusable Corpro half masks. As can be seen from the table below, the vast amount of respiratory protection is now managed via these reusable options.

At the time of writing, the Trust have 6 FFP3 options (1 reusable and 5 single use) but it is worthy of note that the FSM16 will be the next option to be removed from stock once supplies run out.

Toward the end of this period the PPE working group dissolved their ownership of fit testing, transferring the management back to the IPC team. Since then, the IPC team have delegated the role of qualitative (hood and Bitrex) fit testing to teams within their respective business units. This is supplemented with the IPC team conducting quantitative (computer based) fit testing for those who are unable to pass using the Bitrex method. It was hoped that this distributed method would improve service members gain access to a timelier service.

A large amount of work has been conducted to ensure there are appropriately trained personnel across all business units to undertake this tasking. To meet this demand, external trainers were brought into the Trust who have delivered Fit2Fit accredited training which is recognised as being the industry standard.



	Corpro HM 1400 - Small	Corpro HM 1400 - Medium	Corpro HM 1400 -Large	Handanity 9330	Handanity HY 9330	Handanity HY 9632	Valmy Spireor	FSM 16 (Duckbill)
ABU	136	19	1	0	7	8	8	27
CBU	46	7	0	3	1	3	7	19
SBU	62	10	0	2	1	6	1	17

The vison going forward:

The IPC team will become an independent Fit2Fit accredited centre in its own right and assurance across the whole fit testing piece is improved.

The accreditation will ensure:

- Reduction of the financial burden associated with bringing in external contractors as and when further training is required.

- Quality control is maintained.
- The IPC team can support the business units in a more individualised way.

The assurance will:

- Identify all clinical staff requiring respiratory protection and prompt their compliance.
- Identify which personnel is on which mask.
- Identify which individuals require re-fit testing and prompt them to organise.
- Identify those on a reusable mask and prompt any maintenance.

3.3 Hand Hygiene and PPE Compliance

Part way through the year it was decided to assurance all clinical staff had against hand hygiene, PPE and AGP PPE compliance. A tool comprising 3 sections was introduced and teams were expected to audit all staff quarterly.

There has been a varied response across the Trust to these audits, and it has been difficult to quantify compliance in any meaningful way leaving any assurance less than optimal.
It has been agreed that a more structured approach be investigated with a sample being audited on a quarterly basis with the emphasis on added value.

3.4 Leeds Health Care Record / PPM+

In November 2019 the reporting of laboratory specimen results migrated from the IC Net system to Leeds Care Record (LCR). All MRSA positive and Clostridium difficile (CDI) positive samples for patients in the LCH community setting are reported to the IPC team on a daily basis through this electronic platform.

Each result was processed by adding a high priority alert/reminder on SystemOne. An IPC information task was sent to any LCH services currently involved with the patient, identified by any services with an open referral. The result was flagged up to the patient's GP by either a task on SystemOne, or a telephone call to those using a different healthcare record system, requesting that the patient be reviewed in light of the result. If the patient was a resident in a care home or nursing home the facility was contacted to inform of the result and offered appropriate infection control advice. GPs were signposted to the MRSA decolonisation guidance, available at Leeds Health Pathways.

Leeds Care Record is a joined-up digital care record which enables clinical and care staff to view real-time health and care information across care providers and between different systems. It is a secure computer system that brings together certain important information about patients who have used services provided by their GP, at a local hospital, community healthcare, social services or mental health teams.

All MRSA positive and C.diff positive lab results are reported to the LCH IPC team on a daily basis via a customised IPC nurse tasks list on the LCR system.

Each result was processed by adding a high priority alert/reminder on SystemOne. An IPC information task was sent to any LCH services currently involved with the patient, identified by any services with an open referral. The result was flagged up to the patient's GP by either a task on SystemOne, or a telephone call to those using a different healthcare record system, requesting that the patient be reviewed in light of the result. If the patient was a resident in a care home or nursing home the facility was contacted to inform of the result and offered appropriate infection control advice. GPs were signposted to the MRSA decolonisation guidance, available at Leeds Health Pathways.

In addition to the task generated on LCR, LCH IPC received a weekly report from LTHT listing any patients who have had samples taken during hospital admissions, outpatient appointments and surgical assessments that have returned MRSA positive. These were similarly processed as for the LCR IPC nurse task list.

Particular focus was given to the MRSA positive cases identified with urinary catheters, wounds and/or invasive devices due to the high risk of developing a bloodstream infection. In such cases the GP may be prompted regarding antibiotic prophylaxis prior to catheter change/removal or to review the current antibiotic therapy.

All CDI cases whether 'toxin detected' or 'toxin NOT detected' were reported to us in the same way as for MRSA – either via the daily LCR IPC nurse task list or the Community CDI list

sent weekly from LTHT IPC team. They were similarly processed with a reminder added on S1; other services informed as appropriate and GPs prompted to review the patient (PPIs, antibiotic therapy etc).

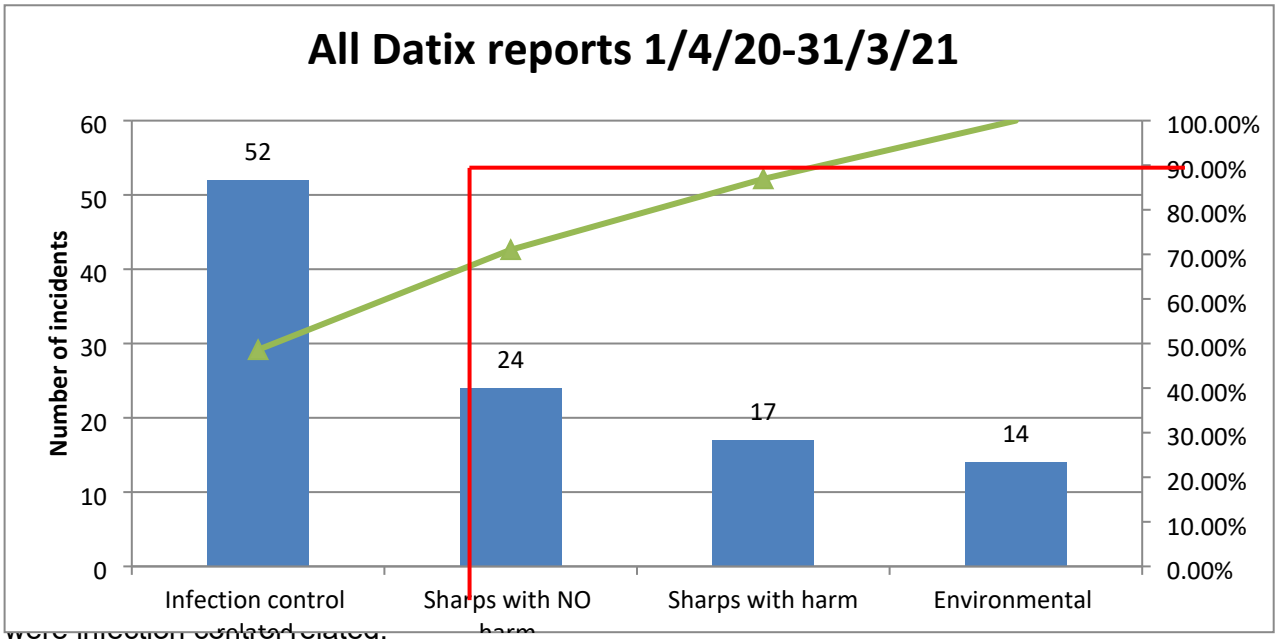
If the patient resided in a care home, the home was contacted to inform of the result and to reiterate standard infection control precautions.

The above measures were taken as a proactive measure with the aim of reducing the spread of MRSA and CDI within the community and minimising the risk to the affected individuals.

An accurate figure for the number of results reported during the 2020-2021 period has been difficult. Furthermore, the numbers on the task list constantly refresh as new results are added on the system. A daily log of numbers suggests an average of 21 cases per day consisting of approximately 60% MRSA and 40% CDI. Out of area results received was 10.

3.5 Incident reporting

Every incident (clinical/ non-clinical) or near miss within LCH should be reported to the Risk Management Team via the online electronic reporting system Datix. IPC act as subject matter experts incident reports, their cause and any identified themes and trends for 2020/21 in respect to infection prevention and control including sharps injuries and other identified related incidents. Any identified learning is shared both locally and organisationally where appropriate.



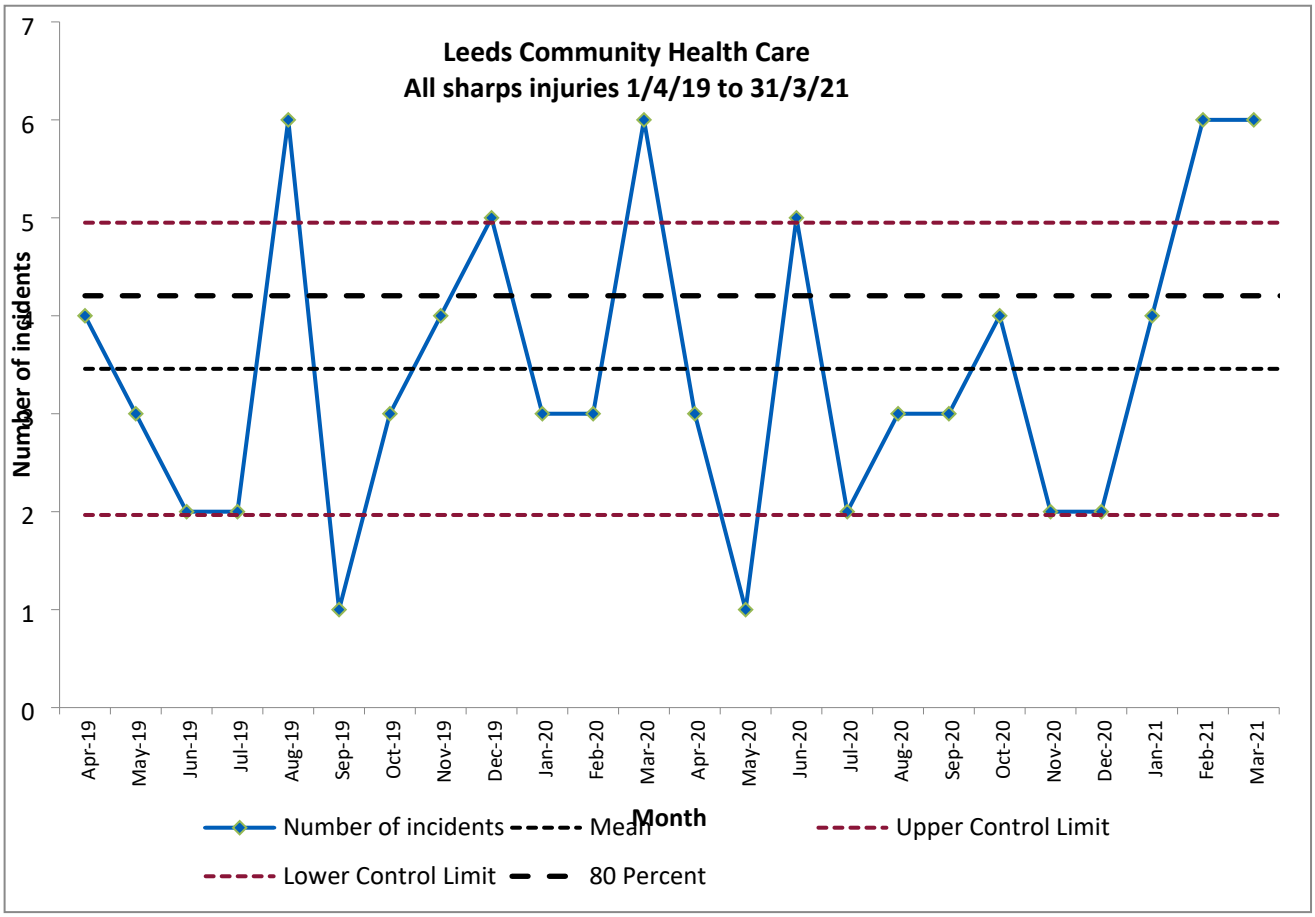
were infection control related.

Please see below a breakdown of incidents by type:

- Sharps incidents Total: 41
  - Sharps with harm: 17
  - Sharps with no harm: 24
- Infection control related: 52
- Environmental issues: 14

As highlighted in the above Pareto Chart, 48% of all incidents reported from 1st April 2020 until 31st March 2021 were IPC related incidents. This includes Covid-19 exposure, PPE related incidents such as incorrect donning/ doffing, incorrect disposal of PPE or breaches/ misunderstanding of ever-changing national guidance.

The SPC Chart below demonstrates the trends in sharps injuries between 2019-2021.

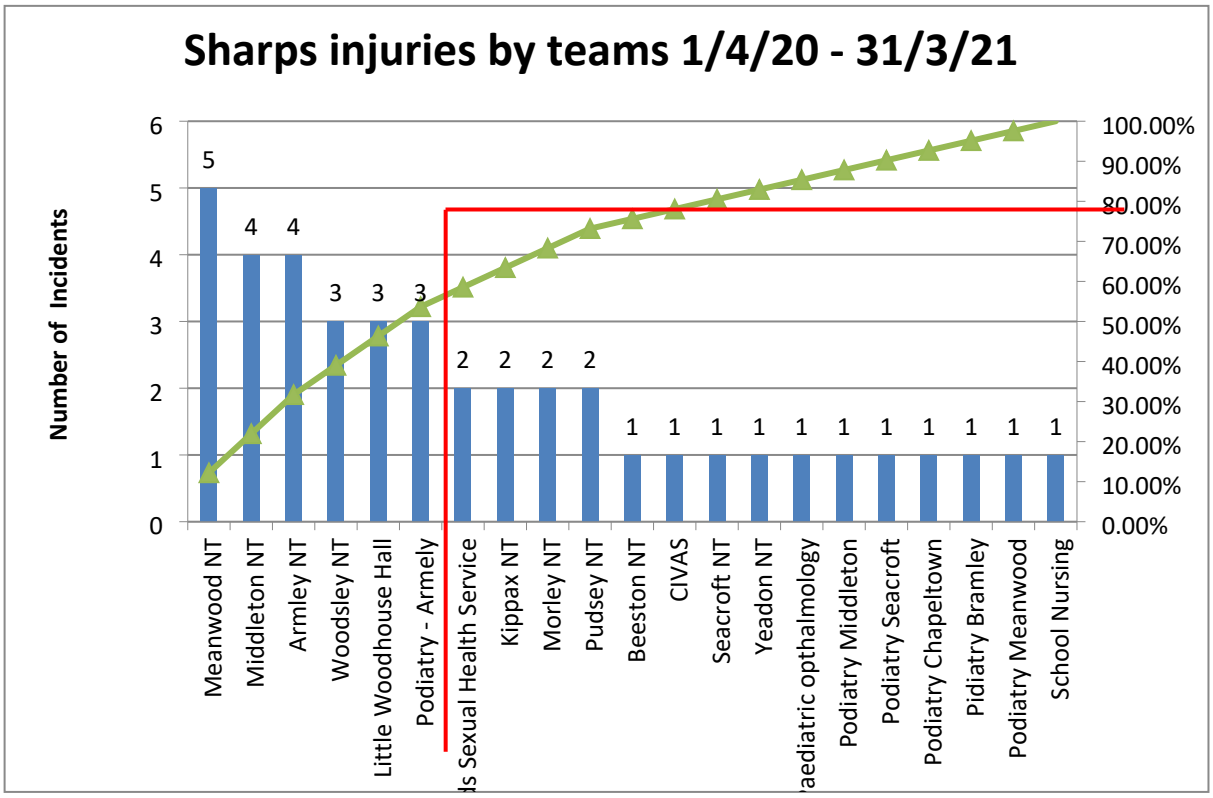


Sharps incidents

There have been 41 sharps related incidents reported via the Datix® reporting system during 2020/2021; (42 sharps related incident in the previous year 2019-2020).

17 of these being sharps with harm, which equates to 41% of all sharps incidents reported. Compared to the previous year's 50%, this shows another substantial decrease from 80% 2018-2019.

The following Pareto chart demonstrates all the reported sharps incidents and the number of incidents within that team. This demonstrates that out of the 21 teams who reported sharps related injuries, 60% were reported within adult business unit, 27% within specialist business unit and 12% within children's business unit.



Discussion and Actions

The incidents reported under each subcategory have been investigated and actioned accordingly as advised by the Datix® team;

- Sharps safety remains a prominent topic within the mandatory IPC training sessions.
- All community staff are advised to carry a 'sharps safety kit' with them when visiting patients in case the stock is not available in the patient home, including a sharps bin.
- The IPC team have worked tirelessly to provide advice, up to date guidance and training to the teams within LCH throughout the pandemic
- The team identified a sharp increase in infection control related incidents and so worked to produce waste posters, donning and doffing training, PPE guidance and regular comms to keep staff up to date with guidance.

4. Outbreaks and other Communicable Disease Control (CDC)

4.1 Significant outbreaks with IPC response

An outbreak is categorised when there are two or more cases in the same area that are displaying the same/similar symptoms or microbiological confirmation of the organism. All outbreaks are reported to Public Health England (PHE) and discussed at the IPCC meeting.

Covid-19 Pandemic

In December 2019 an emerging virus was identified in Wuhan, China resulting in a global pandemic which remains ongoing.

This is the first pandemic that LCH has had to manage (since the Swine Flu Pandemic in 2009) and preparedness for the evolving virus commenced in February 2020. Initially, this was lead via Infection Control and Emergency Planning but by March 2020 the international situation dictated a Trust wide response.

The Trust response was led by the Incident Management Team. Patient and staff safety was at the forefront of the pandemic.

We have adapted to suit the needs for this new virus and the complexities that it creates. Personal Protective Equipment (PPE) supplies remained good over the past six months however this has been closely monitored by a dedicated PPE Group chaired by the Executive Finance Director. Staff support remains ongoing and at the time of writing the annual report routine patient services are re-starting.

Challenges that we have encountered have been around;

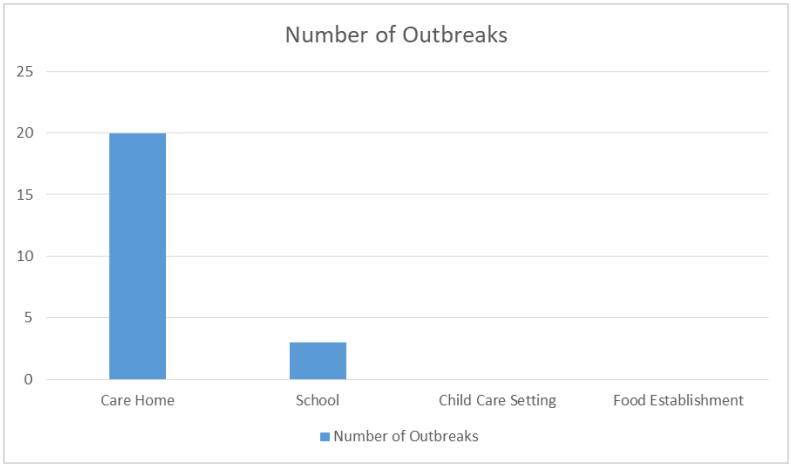
- Capacity within the IPC team in response to the number of care homes that encountered an outbreak.
- Fit testing requirements.
- The frequent changes experienced in national guidance
- Being unable to complete normal service delivery leaving potential gaps in assurance.
- Swabbing requirements to support wider Leeds healthcare economy.
- Increase in reactive advice required citywide.

4.2 Communicable Disease Control (CDC)

The CDC Team is a collaborative approach between Leeds City Council (LCC) Environmental Health Food and Health Team and IPC. The team's purpose is to investigate, act and report on all individual cases and larger outbreaks of notifiable gastric diseases within the population of Leeds. The team investigate confirmed and suspected food poisonings and also manage outbreaks of viral gastroenteritis within any establishment including care homes, childcare settings, schools, day centres, etc.

The team work closely with partner agencies including Leeds City Council and Public Health England (PHE) and have continued to work with PHE and West Yorkshire local authorities to review and standardise key principles of managing Gastrointestinal illnesses across West Yorkshire.

Establishments reporting outbreaks of gastrointestinal illness 1/4/20 to 31/3/21
Total outbreaks



The graph above provides an overview of the types of facilities that have reported outbreaks of gastrointestinal illness during the reported period. Each of the 23 identified outbreaks have been visited, advised and managed by the CDC nursing team. The graph shows that outbreaks of gastrointestinal illness have only been reported in Care Homes and Schools in the reporting period. Despite faecal samples being submitted there has been no causative organism identified in any of the outbreaks.

The reduction in the number of outbreaks (compared to 75 in the year pre Covid) and no causative organism being identified, is likely to be a result of the Covid pandemic. There has been a reduction in visitors, particularly to Care Homes, increased personal and environmental hygiene and social distancing.

Schools and childcare facilities have had restricted attendance (for key worker children for much of the reporting period) introduced support bubbles and again increased hygiene practices and social distancing which has aided the reduction in outbreaks of gastrointestinal illness.

Suspected food poisoning 01/04/2020 to 31/03/2021

There were 272 reports of suspected food poisoning which were reported either electronically, via the FSA, or LCC self-service reporting systems. All suspected food poisoning reports are reviewed each day by the CDC nurse to detect any potential food poisoning outbreaks, and cases are responded to accordingly. The Covid pandemic there has resulted in a reduction in the number of suspected food poisoning reports from the public (375 in the year pre Covid) and this may be due to the closure of “dine in” restaurants and travel restrictions to and within the city. Business support replied initially via email to all 272 complainants and 12 cases responded which required follow up by the CDC nurses.

Organisms identified through Notification of Infectious Disease Reporting 1/4/20 to 31/3/21

The table below incorporates the confirmed isolates identified via faecal testing at LGI microbiology laboratory and Colindale Central Surveillance Centre.

Organism	Number of Cases
E.Coli (STEC)	7
Typhoid/Paratyphoid	2
Cryptosporidia	20
Shigella	8
Salmonella	46
Campylobacter	663
Listeria	2
Giardia	45
Clostridium Perfringens	1
Yersinia	3
TOTAL POSITIVES	797

There has been a reduction in the number of positive isolates reported compared to 1293 in year pre Covid, which may be due to several reasons.

- There is generally an increase in confirmed food poisoning isolates over the summer months when people are holidaying. However, the Covid pandemic has seen a restriction in travel both abroad and in the UK.
- People have also been unable to meet in gardens for social activities such as BBQ's and garden parties
- Restaurants have been closed for "dine in" meals
- Reinforced media advice reiterating the importance of personal and environmental hygiene

The Covid-19 pandemic resulted in a temporary change of working for approximately 4 months during which time Environmental Health Officers (EHO's) managed the CDC element of the Food Safety Team. This was manageable due to a reduction in the public's social activities, travel restrictions, the closure of many restaurants, a reduction in face to face working and restricted/reduced work activities carried out by the Environmental Health Officers.

The team continues to work towards a paper lite service but again the Covid pandemic has resulted in difficulty with meetings via "teams". Face to face has always been the preferred option to demonstrate the requirements of the service to colleagues and departments who are not aware of the logistics involved.

4.3 Head Start Service

The IPC Team continues to provide a specialist service for the management of head lice infestations within the community. The service offers advice and support in cases of

persistent head lice infestation. The main sources of referrals come through school staff, with additional referrals via school nurses, health visitors, social workers and pharmacists.

The Headstart service has seen very little activity during the 2020/2021 period with few enquiries and only 3 referrals throughout the year. The COVID-19 global pandemic and associated measures implemented to reduce the spread of the virus have resulted in schools being closed for most of the year, with only vulnerable children and those of key workers attending.

The service continues to encounter complex and challenging cases where children can present with severe head lice infestation in addition to other issue and safeguarding concerns. These families are often hard to engage and repeatedly fail to manage their child/children's head lice. These cases can be hard to resolve. It can be very difficult to get all family members together and frequently adult members of the family are reluctant to have their hair checked.

Access to free Hedrin via the Pharmacy First Minor Ailments Scheme continues to be highly significant in reducing the number of referrals by removing the financial barrier to obtaining treatment, while also directing parents for first-line advice to their local pharmacist rather than attending their GP Practice. Reports of pharmacies saying they do not participate in the provision of Hedrin as part of the Minor Ailments Scheme have ceased following CCG communication with the pharmacies.

Headstart visits continue to take place predominantly in the school environment wherever possible. This facilitates better engagement with parents/guardians and closer collaborative working with the school staff, particularly the learning mentors/child protection leads, who are the main source of referrals into the service. Visits are conducted in the home only in special cases when we are specifically requested to do or when this is the only remaining option available.

5. Environment

5.1 MEG Auditing Tool

In November 2020, a new electronic auditing system – MEG was introduced. This is a single digital platform that has enabled, timesaving, mobile working for the auditing assurance process. The tool can be used for auditing LCH premises and specialities including: Care homes, specialist schools and prisons/custody suites all of which come under the LCH provision.

Compliance scores can be generated and any areas of concern are easily highlighted and clearly visible. Action plans can be generated and shared with the relevant responsible teams e.g. cleaning lead or Buildings Managers. There is a process for action plans to be returned within the 3-month timeframe. Future plans are that the platform will be shared with the service leads that will have most input into the action plans to provide improved assurances.

The implementation of the system is still in its infancy but going forwards it is anticipated that it will be rolled out to help teams perform and engage with hand hygiene and PPE audits with greater ease.

5.2 Environmental Audits

A rolling programme of IPC audits using a modified version of the Department of Health/Infection Prevention Society Quality Improvement tool has been conducted and embedded into the MEG auditing system.

The objectives of the audits are to inform services of their level of compliance to the standards, policies and procedures and allow improvements to be made based upon the findings. Audit is a requirement of the Health and Social Care Act 2008, Code of practice for registered providers on the prevention and control of health care associated infections and related guidance. Concerns from the auditing process are escaled via the Infection Prevention and Control Group to the Quality Assurance and Information Governance Group (QAIG).

The code states that registered providers must audit compliance to key policies and procedures for infection prevention. Data from the LCH auditing activity is used to applaud good practice, identify concerns and themes which is used to improve LCH environments, services and staff performance.

The aim for 20-21 was to audit 61 LCH premises which comprises of:

- 29 health centres/clinics
- The Community Neurological Rehabilitation Unit,
- The Continence Urology and Colorectal service suites at Rutland Lodge
- Leeds Sexual Health Centre
- Hannah House Children's with Complex Health Needs Residential Unit
- St Georges Centre for Musculoskeletal (MSK) and Children's Out patients
- Leeds Assisted Living Centre
- Wetherby Young Offenders Institute and Adel Beck Secure Children's Home (HMP's)
- The 14 Police Custody Suites (which are currently open) for East, North, South and West Yorkshire
- 4 Special inclusion learning centre (SILC) schools
- 3 recovery hubs
- 3 MSK units at Wharfdale Hospital, Chapel Allerton Hospital and Sunfield Medical Centre
- Thornton Medical centre clinical rooms

However due to the Covid-19 pandemic the audit activity was interrupted, and a reduced number of IPC audits was performed for 2021. Nevertheless, the team continued to have a presence in many of the premises. This included Covid-19 outbreak advice and premises inspections/visits in the 3 recovery hubs, Wetherby young offenders Institute and Adel Beck. Hannah House also received visits for donning and donning training, fit testing and visits for other clinical advice and support.

During 20-21 the IPC team audited 50 premises which was:

- 11 Health Centres/clinics
- The Neurological Community Rehab Unit
- MSK at Wharfedale Hospital
- 4 SILC schools
- Hannah House
- 14 Custody suites
- Wetherby Young offenders and Adel Beck Secure Children's home
- Leeds Sexual Health Centre

Findings
Findings in the premises varied across the locality. An example of compliant and non-compliant areas a listed below:

Compliant areas:

- 4 SILC schools had clean clinical environments
- The custody suites showed good practice with PPE and sharps management
- Hand hygiene basins with replenished liquid soap dispensers and paper hand towels and alcohol dispensers widely available in clinical areas
- In the health centres the staff appeared compliant in wearing face masks, the waste bins were foot operated and lidded, there were no waste sacks stored in corridors, couches were of good condition, water coolers were supplied with potable water and curtains and blinds were clean.

Non-compliant areas:

- Non-clinical areas in the SILC schools were dirty (cleaning is the responsibility of the local authority who have since been given advice on cleaning by the IPC team)
- The LCH staff in Wetherby Young offenders and Adel Beck Secure Children's home were confused around PPE (i.e. wearing gloves and aprons when not required and typing with gloves on)
- Cleaning standards for equipment were poor in some custody suits (which was related to lack of clinical staff and cleaning staff awareness of who is responsible for cleaning what equipment
- In the health centres there was evidence of staff drinking beverages in the cleaner's cupboard, staff cups and beverages were stored in clinical room cupboards, some toys were dirty, some work surfaces were dirty and cluttered, some patient chairs were non-wipeable and sharps bins did not have their temporary closure mechanism activated.

Follow up

The IPC team share the MEG audit action plans with the relevant service and department leads who are responsible for improving non-compliant areas (i.e. building managers, the cleaning lead and service clinical leads). Action plans should be completed after 3 months. However, audits with lower compliance scores also receive a 3 month follow up visit by the IPC team**.** Audits with lower compliance scores received a 3 month follow up.

The IPC team plan to audit all 61 areas for 21-22. Due to restructuring the team we anticipate that the pandemic will not disrupt this.

5.3 Patient Led Assessment of Care Environment 2019

The PLACE inspections during 2020-2021 were postponed due to Covid-19.

6. LCH business unit overview

6.1 Children's Service Annual Report

The Infection Prevention and Control Team have continued to foster positive working relationships with the teams working within the Children's Service. Some of the key achievements include:

- Working with the School Inclusion Nursing Service to monitor and improve standards within Specialist Inclusion Learning Centres. The IPC Team have worked with partners to achieve significant upgrades to the care environment at Penny Fields and Broomfield schools.
- Establishment of an Infection Prevention Champions Group within the 0-19 Service.
- Contributed to the planning and development activities related to the proposed new CAMHs unit to replace Little Woodhouse Hall.
- Collaborative work has been undertaken to ensure the ongoing maintenance of high standards of IPC practice at Hannah House. Significant improvements have also been noted within this area over the past year.
- Undertaken Patient Led Assessments of Care Environments (PLACE) inspections of the two Children's in-patient areas, with positive comments being provided by the inspectors.
- Work has been done to increase the awareness of SEPSIS amongst both staff and parents/carers. Information has been distributed to families to both inform and raise awareness of this distressing condition.

The IPCT have worked with the Outpatients Service Team to ensure a smooth transition to their relocation to new facilities at the Reginald Centre.

6.2 Specialist Business Unit Report

The Infection Prevention team continue to work closely with the teams within the specialist business unit, particularly during the Covid pandemic to support them with any outbreaks and general IPC support and advice. The IPC team have also recently increased in size which has allowed more input from the IPC team which has included:

- Yearly audits of all Police Custody suites to ensure compliance with IPC standards and to offer support and guidance on environmental issues. The LCH staff work within a police custody suite building and alongside non healthcare staff which can be a barrier to good IPC practice. This has shown in some areas where the cleaning was found to be inadequate and is under review by the Clinical Lead with support from the IPC team.
- Yearly IPC environmental audits have been undertaken in Adel Beck and WYOI; Adel Beck continues to have a good standard of compliance and cleanliness. It is obvious that LCH clinical staff take ownership of IPC in their environment. WYOI show good compliance with IPC, however there was some cleaning issues that have been picked up on previously which were highlighted. WYOI staff take good responsibility of IPC and complete monthly cleaning audits which are actioned by the clinical lead and supported by the IPC team.
- IPC have worked closely with WYOI and Adel Beck to prevent and control outbreaks alongside wider Leeds Healthcare Economy colleagues. A good relationship has been built with the staff working in these areas and IPC which will promote and ensure good IPC compliance long term.
- Recent outbreak reported at Adel Beck was managed well and spread was limited following good communication and staff working together to make changes to IPC practice.
- Bi-yearly dental water tests are now to be carried out by the Dental team and overseen by the IPC and Water Safety Group. This is to be reviewed in 12 months. However, following installation of the steril straw system to all areas, it was found this does not work in areas which the dental cart is not used as regularly. WYOI had

out of range results on a number of occasions which was resolved by going back to using Milton and this has since resolved.

- CNRU continue to run an outpatient only service and their inpatient unit continues to be closed.
- Podiatry services have recently reported an increase of sharps incidents, relating to removal of blades. No injuries occurred as a result of this and this has been investigated by Podiatry which have linked it to a number of locum staff/students not knowing the correct procedure. IPC continue to monitor and will visit Podiatry if this continues to review current procedure.
- A visit to Steris decontamination unit is planned to follow up four Datix reports originating from podiatry.
- SBU staff continued to have a good completion rate for the PPE& HH auditing tool.
- Collaborative workplace visits between Environmental Health colleagues & the IPC team have taken place across the Leeds Community. A mixture of proactive, supportive visits & outbreak visits have occurred throughout the Covid pandemic, facilitating closer working relationships with the wider community and other public health professionals.

6.3 Adult Business Unit

IPC continue to work closely with the teams within the adult business unit, particularly during the Covid pandemic to support them with maintaining services within the neighbourhood teams. The IPC team has been involved with the following:

- ABU have been supporting fit test trainers/ champions across all of the business units. This has meant we have provided support during preliminary fit test sessions, advice and troubleshooting to enable teams to deliver fit testing to their own staff.

- ABU has always worked closely with IPC and the PPE team to ensure a constant supply of PPE and have kept up to date with constantly changing guidance. The ABU coordinator attended weekly meetings throughout the pandemic with the PPE/ IPC team so that information could be cascaded to the teams in ABU.

- The IPC team have always run quarterly IPC champions events, due to the Covid19 pandemic these were stopped as face to face events but changed into online 'teams' events. The champions requested that these were changed to monthly events which still continue to run and have a good uptake.

- The IPC team encouraged all staff in the adult business unit to have their seasonal flu vaccine. This was supported by the CLASS and IPC nurses visiting each base to ensure the jab was accessible.

- Supporting the HCAI work when colleagues have undertaken a PIR which involved care provided from a neighbourhood team. This has meant improved communication with the neighbourhood team, highlighting good practice and shared learning.

7. Commissioned services – Care Homes

In 2010 the IPC team commenced a face to face audit programme auditing approximately 40 care homes with nursing over a 3-year rolling programme. In April 2019 the IPC team

increased their auditing activity to auditing approximately all 152 care homes (which included residential homes) over a 2-year rolling programme. The programme included 40 face to face audits and 40 care home self-assessment audits per year.

Due to the Covid-19 pandemic the auditing activity in 20/21 was disrupted and only a small number of care homes was audited. Nevertheless, additional support to care homes was provided for 20-21 which included:

- Covid-19 outbreak visits
- Locally produced Covid-19 IPC resources (such as posters and an outbreak check list)
- Free IPC care home Covid-19 training
- Availability of telephone/email advice for IPC and Covid-19 queries

The purpose of the audits is to appraise and gain an insight into the environment and IPC practices which are measured against national standards. This enables the audit programme to:

- Highlight areas of good practice and also identify areas which need more work
- Provides care homes with a structured action plan listing evidenced based recommendations for improvements
- Provides or signposts to IPC resources and national guidance
- Helps care homes keep practice up to date
- Helps link in care homes with other teams and services in the wider health and social care economy

Number of audits completed 2020/21

During the summer months (when there was less COVD19 outbreaks in the care homes) the IPC team audited:

- 9 care homes
- 8 care homes (as a follow up audit visit)

Covid-19 outbreak visits

After the initial national lock down period the IPC team commenced visits to care homes with Covid-19 outbreaks. The aims of the visits were for the IPC team to support care homes during an outbreak, identify areas of good practice and also identify areas that needed development. Each care home received an action plan for areas of development and the action plans were shared with the local authority and CCG contracts managers. The team outbreak visit during year 20/21 included:

- Visiting 62 care homes with an outbreak

(Due to the recovery hubs being at increased risks of outbreaks (from high client turn over), each hub also had an unannounced IPC visit after the national lockdown period was lifted).

Findings of outbreak visits

Compliance with national COVID19 guidance during an outbreak varied across the care homes. There was also common areas of good practice and common areas that need development.

Good practice included:

- awareness of the correct isolation time periods and the need to isolate for longer if symptoms persisted
- touch point cleaning and touch points being cleaned more often than twice daily
- care home cleanliness appeared to a good standard in many of the care homes
- block booking agency/bank staff to work in the care home only and also during the pandemic
- staggered staff breaks to maintain safe spaces for social distancing
- Kitchen staff remained in the kitchen only during the outbreak
- Staff cohorted to work with either positive or non-affected residents (or if not possible, positive residents cared for last when possible)
- Positive rooms cleaned last by the cleaner or by care staff during care episodes
- Visitors to the care home only allowed in exceptional circumstances

Areas for development

- staff seen in close contact with each other (when not required to be in close contact)
- staff not aware of the correct doffing procedure
- staff performing hand hygiene only after doffing all pieces of PPE (and not between doffing each piece of PPE)
- staff doffing gloves and aprons used in isolation rooms after they had left the isolation room
- surgical masks worn incorrectly (i.e. pushed down under chin or not covering nose)
- staff wearing the same pair of gloves continually (i.e. when doing a drinks round)
- shortages of foot operated and lidded clinical waste bins (and scarcity of foot operated and lidded bin supplier availability)
- staff with medical mask exemption not risk assessed and not redeployed (staff continued to work with, or near residents and other staff whilst not wearing a mask)
- not using a 2 step cleaning procedure (and using a disinfectant only for cleaning)
- non wipable sofas and arm chairs being used (and care home not aware to regularly steam clean these)

Additional IPC support provided to care homes

Care home staff flu vaccinating
For the 3rd year running the IPC team has worked with the local authority in delivering free on site flu vaccines clinics for 580 Leeds health and social care providers. This is done to enhance existing opportunities for staff to get vaccinated. For 20-21 the team provided vaccines to:

- 14 care home sites
- 279 care home staff

Care Home Managers Forum
In October 2021 a member of the IPC team attended the Care Home Managers Forum to discuss the national care home PPE guidance

Free IPC care home training
In May 2020 the national care home Super Trainers programme commenced. The IPC team worked with the CCG and played a key role in the programme. This included an IPC nurse becoming a super trainer and also the IPC team co-ordinating the training for the nominated 22 city wide health and social care staff trainers.

At the end of the programme:

- all 151 care homes had been offered training

- 75 care homes had had face to face super training
- 23 care homes had had virtual super training

Through June to early April 2021, the IPC team also provided virtual Covid-19 IPC training for care homes and supported living providers which was:

- Over 15 virtual training sessions
- Attended by 60 different care home or supported living providers
- Attended by 450 staff

From late January 2021 the IPC team re-commenced face to face training for health and social care providers which includes care homes. (The numbers of care home who received face to face IPC training is included in the IPC team 20-21 training report).

Bronze Support to Care Homes/Providers Meeting and provider bulletin
Throughout the pandemic the IPC team attended the city wide Care Home Bronze meetings and were included as a standing agenda item. The team has also periodically produced articles for the health and social care city wide provider bulletin which includes advice on PPE for aerosol generating procedures, and also advice and how to outsource fit testing.

Outbreak spread sheet and local Care Home Covid-19 Incident Management Meetings
Throughout the pandemic the IPC team has maintained a daily spread sheet of Covid-19 outbreaks in Leeds care homes. This allowed the IPC team to be in daily contact with care homes with outbreaks and determine which care homes required outbreak visits.

The spread sheet was also shared to city wide partners and provided valuable monitoring and surveillance to teams such as PHE, CCG and local authority contracts managers. The IPC team also attended City wide incident management meetings for when individual care home outbreaks were of concern.

Local Covid-19 outbreak advice, outbreak resource pack and local resources
When each care home developed an Covid-19 outbreak, the IPC team rang the care home to give support and advice on managing the outbreak. The team also developed a resource pack which included a Covid-19 outbreak check list and local Covid-19 posters (such as advice on correct mask wearing and advice on ventilation). The pack was emailed to the care home after the telephone advice had been given.

IPC care home web page
Throughout the pandemic the IPC team maintained the care home IPC resource web page. A new section has been created to include local COVID19 IPC resources and links to key care home national COVID19 guidance. A snapshot of users of the web page showed that for 3 months (between mid-March 2021 and mid May 2021) showed that 178 unique users had used the web page.

Care home swabbing
Before the care homes had been provided with their own Covid-19 swabs and swabbing procedures the IPC team commenced city wide swabbing of symptomatic/suspected care home residents. Between March and June 2020, the IPC team swabbed 102 residents from 26 care homes.

Future developments
The IPC team are leading a city-wide steering group on the roll out of the RESTORE2 physical deterioration and escalation tool in Leeds care homes. The impact of the tool in other national areas has helped residents get the right care, at the right time and in the right place, and has

reduced care home 999 calls and hospital admissions and has saved resident lives. The IPC team plan a key role in the roll out.

Plans for 2020-21

For 20/21 the IPC team plan to continue supporting the 152 registered care homes in Leeds which includes:

- Annually face to face auditing (with follow up visits as required) each care home
- Attending and contributing to relevant groups and meetings such as the local Care Home Focus Group, the local City-Wide Sepsis group and the national Infection Prevention Society Care Home Special Interest Group,
- Maintaining the Covid-19 care home outbreak spread sheet, outbreak telephone advice and resource pack, and outbreak visits when there are care home outbreaks
- Maintaining the care home IPC resources web page
- Inviting care homes to attend IPC educations programmes and events hosted by the team
- Including care homes in sharing relevant IPC updates and learning cascades.
- Being a key member of the RESTORE2 roll out in Leeds

8. Policies and guidelines

The IPC team continued to review and revise the Trust's IPC policies / clinical guidelines during 2020-21 in line with their review dates. This also takes into account any changes to national publications, however due to the speed in which guidance was updated by PHE and NHS England / Improvement the standard precautions policy was updated in September 2020 to reflect changes in guidance around PPE. The policies are aligned to the Leeds Healthcare Pathways which is accessible through LCH and Primary Care.

Policy Development Overview:

Policy	2020	2021	2022
Infection Prevention and Control Overarching Policy PL305	**Sep-20**		
Management of Blood and Body Fluid Exposure Incidents including Needle Stick Injuries Policy and Procedures PL322		**Mar-21**	
Local Decontamination of Reusable Medical Equipment Policy PL331		**Mar-21**	
Diagnostic and Screening Procedures including Safe Sampling, Handling and Transportation of Specimens Policy PL332		**Oct-21**	
Healthcare Waste PL341 Included in IPC Manual		**May-21**	
Standard Precautions Policy (includes Hand Hygiene, Personal Protective Equipment and Management of Spillages in the Community PL227	**Oct-20**		
Isolation Policy and Procedures for Leeds Community Healthcare NHS trust In-patient Areas PL306	**Dec-20**		
Transmissible Spongiform Encephalopathy: Prevention of Cross Infection Incidents Policy PL319			**Feb-22**
Linen and Laundry Management Policy PL314	**Nov-20**		
Food Safety PL299	**Mar-20**		
Respiratory Virus Policy PL294	**Jan-20**		
Deceased Patient PL330			**Mar-22**
The Management of Communicable Disease Outbreak within the Community Setting Policy PL261			**May-22**
Management of Patients with Meticillin Resistant Staphylococcus aureus (MRSA) in Community Health and Social Care Settings Policy PL343			**May-22**
Aseptic Non-Touch Technique (ANTT) Policy PL338			
Prevention and Management of Multi-Resistant Bacteria (including Carbapenemase Producing Enterobacteriae (CPE), Glycopeptide Resistant Enterococcus (GRE) and Extended Spectrum Betalactamases (ESBL's)) PL351	**Oct-20**		
Prevention and Control Measures for Specific Infections in the Community Policy PL345			**Jul-22**
Clostridium Difficile PL288			**Sep-22**
Guideline for the Management of Toys in the Community GL037	**Mar-20**		

Guidelines for the Management of Animals in Community In-patient Healthcare Premises GL022			**Nov-22**
Guidelines for the Management of Scabies GL086			**Nov-22**
Guidelines for the Management of Headlice			

9. Education and Training

The Health and Social Care Act (2008) identifies the importance of effective education and training for all staff members. The continued development and implementation of an effective mandatory training programme remains central to the LCH infection prevention strategy. As a result of challenges associated with the COVID pandemic, the majority of internal mandatory training was undertaken remotely. In situations where strict social distancing was possible, small group events were facilitated by the team. This included preceptorship training and informal bespoke sessions within care delivery teams.

Training compliance rates were on average 92% at year end and this demonstrates a significant increase from the 70% noted during the previous report period 2019-20.

Towards the latter part of the year, LCH has provided an additional 0.6 WTE Band 7 IPC Nurse Specialist role to enhance education and training within the wider care economy of Leeds. The initial primary focus of this project has been to work with care facilities providing both nursing and residential care, Working Age Adult Care Teams, Third Sector providers, Mental Health Providers and the local authority Adult Social Care Team.

Collaboration and support has also been provided to the LCC Adults and Health Directorate to develop and facilitate an education programme related to improving understanding and uptake of the COVID Vaccination programme.

Support has also been provided to the LCC Children and Families Team to develop a Keeping Safe and Well virtual training sessions for school age children. This programme is about to be launched after the Easter Break 2021. Further work is planned for the development of a bespoke training programme for schools, nurseries and other childcare providers. The aim of this initiative is to complement and supplement currently existing resources and to have the flexibility to provide specialist education and support to areas potentially struggling with outbreaks of transmissible infection.

10. Campaigns and further achievements

10.1 Seasonal Staff Influenza Campaign 2019/2020

The Code of Practice (2012) for the prevention and control of healthcare associated infections (HCAI) emphasises the need for NHS organisations to ensure that its frontline health care workers are free of and protected from communicable infections (so far as is reasonably practical). Influenza is a highly contagious illness which can be serious, particularly for older people or those with other health conditions. Health and social care workers care for some of the most vulnerable people in our communities and 50% of staff may carry flu and may unknowingly pass flu onto others.

Health care staff are also at increased risk of transmission of infections. Therefore, it is important that staff help protect themselves (and their families) and the patients that they care

for by receiving annual flu vaccinations. Staff vaccination also results in lower rates of influenza-like illness and mortality in healthcare settings and helps to ensure vital business continuity in the health and social care sector (by reducing staff flu related illness).

Results 2020/21

At the end of January 2021, LCH had vaccinated ***75.1% of health care workers involved with direct patient care*** and closed the Immform data reporting tool in total 3797 vaccines have been administered by LCH for: LCH staff, LCC staff and local care home and hospice staff. Numbers of vaccinated staff for each of these three areas are broken down further below:

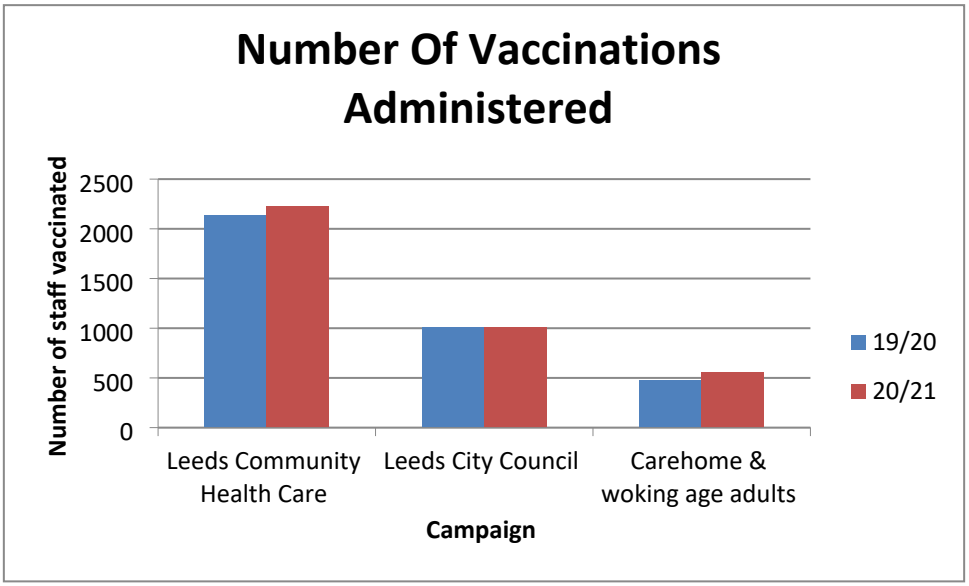
LCH Staff: 2230 staff vaccinated: • 1583 of these staff were clinical staff • 332 received the vaccine elsewhere of this 249 staff are clinical
LCC Staff: 1012 Leeds city council staff were vaccinated during the campaign
Care home & hospice staff: 555 staff from local care homes, hospice staff and working age adults were vaccinated during the 20/21 season

Challenges

Throughout the 20/21 campaign the team faced a number of challenges, the immunisation schedule had to be amended late in the planning stage to support a phased delivery schedule of vaccinations from the supplier and to enable us to comply with government guidance relating to PPE and social distancing. We introduced an electronic appointment booking system to support social distancing guidance. We had to reduce the numbers of venues we were vaccinating in due to the pressures of Covid and therefore only vaccinated in 4 Covid secure buildings, this made accessing the vaccination very difficult for some staff members as they were working from home and didn't live in Leeds.

The bulk of the immunisations were delivered via our ClaSS staff but additional support was needed from IPC team members for the ad hoc sessions and to support with continued myth busting relating both the influenza and COVID vaccinations whilst still attending to other IPC work streams and increased responsibilities due to COVID.

IPC will continue to work closely with stakeholders to ensure the sustainability and success of future campaigns. We will continue to work in conjunction with business intelligence and workforce to ensure we have accurate data.



Future plans

The delivery of future flu campaigns may be very different in light of the Covid-19 pandemic. IPC will continue to work closely with stakeholders to ensure the sustainability and success of future campaigns. We will continue to work in conjunction with business intelligence and workforce to ensure we have accurate data. Due to social distancing guidelines currently in place we will be implementing a booking system for LCH staff and LCC staff. We will also be circulating a survey monkey to the trust to see how we can make accessing the vaccination easier given that staff are not in base as much, this may be that we purchase vouchers for staff that are working from home and do not live in Leeds. We will also ensure we hold several vaccination clinics in all LCH buildings throughout the campaign.

There will be a consideration for an enhanced peer to peer program to support the campaign with myth busing and spreading the positive messages about getting why it is important to be vaccinated. We will also be working with service managers to ensure they are actively encouraging and supporting staff to receive the vaccination.

The future of the campaign is lie more centrally to the business unit and whilst initial coordination will be led by IPC, there is to be a stronger emphasis on teams being held to account for overall uptake. This will triangulate with the work completed by business intelligence and workforce with an enhanced way of working across the organization and duty of care held by all.

10.2 Conferences

During 2020-21 all conferences were postponed due to commitments around Covid-19. Plans will be considered to hold a conference early 2022 in relation to healthcare associated infections and learning from the pandemic in relation to Infection Prevention.

11. IPC team structure and celebrations

In 2020 the IPC team went under significant restructuring due to the increase in funding through the cooperation partnership agreement. At the start of the pandemic due to the citywide provision, it was recognised early on that the skill mix we had was insufficient to deal with the demand required.

The ‘Lead IPC Nurse’ Liz Grogan was promoted to ‘Head of IPC’ and as part of the restructuring Matt Shipley started as the newly appointed ‘Lead IPC Nurse’ in January 2020.

In July 2020 Louise Popple was awarded Infection Prevention and Control Nurse of the Year at the British Journal of Nursing Awards for her outstanding work around the ‘I-Spy E.coli Campaign’. In December the IPC Team were award ‘System Team of the Year’ in Leeds for the teams outstanding contributions through the healthcare economy in response to the Covid-19 pandemic and Liz Grogan was awarded ‘Highly Commended Leader of the Year’ in LCH.

Steph Lawrence, Executive Director of Nursing and Allied Health Professionals who nominated the team said: *“The IPC team at LCH are already an award winning team, but they deserve this award for the exceptional support and expertise they have provided to the Trust during the Pandemic. The team has worked as one to ensure the Trust has the support and guidance it has needed at all times during what has been an exceptional and challenging time for them.”*

“The team has built relationships across the Trust and externally with partners including the local authority, the Clinical Commissioning Group (CCG) and care homes to ensure the whole system got the support it required.”

The team were also nominated by Carolyn Nelson, Head of Medicines Management and Controlled Drug Accountable Officer who said: “In 2020, two hundred years since the birth of Florence Nightingale, the work of the IPC Team has never been more important. The role of the small, but mighty IPC Team has been well and truly thrust into the spotlight.”

“The work of the Team is so much more than COVID. Despite the pandemic the team has continued to: deliver statutory and mandatory training, investigate health care acquired infections, delivered the annual staff 'flu vaccine campaign, ensured water quality for dental procedures, audited environments where care is delivered, trained Care Home staff and have continued to promote hydration to reduce the impact of E-coli. Team IPC - you are the best - second to none.”

12. Challenges and forward plan 2020/2021

Forward Plan 2021 - 2022

- IPC will continue to be a high priority for the Trust and the team have set out an ambitious but flexible programme of work over 2021-22.

- There will be a continued focus on the resetting of services during the Covid-19 pandemic and IPC will start to deliver increased work priorities of the cooperation partnership agreement as we recruit an increased skill mix to deliver the objectives. IPC will start to audit, to monitor compliance with IPC guidelines and policy, and on targeted education programmes to ensure staff knowledge.

- A stronger focus around Quality Improvement to be implemented by IPC and to embed training by NHS Improvement into the team. Focus our attentions around the WHO IPC Core Competencies and provide a bespoke training update the IPC Team on RCA/PIR/SI process.

- Re focus our attentions around the collaborative HCAI Improvement Group and the AMR agenda.

- Implementation of the National Standards of Healthcare Cleanliness (April 2021), with enhanced assurance mechanisms in place and demonstrating the organisation is inline with the Cleaning Charter.

- Build engagement with the ICS for West Yorkshire for IPC.

Challenges for 2021-22 will include:

- Delivering the undulating response to Covid-19 with specific emphasis on track and trace in workplace settings and care homes throughout the Leeds healthcare economy.
- Increased preventative measures in response to Covid-19 in nurseries, schools and universities.
- Achievement of the HAI objectives.

The partnership cooperation agreement and annual IPC plan will be monitored through quarterly cooperation review meetings with a governance structure in place, as well as the Infection Prevention and Control Committee (IPCC) and the Quality Assurance and Improvement Group (QAIG).

13. Conclusion

2020-2021 has proven to be a very successful year for the Infection Prevention and Control team. We have delivered successfully on the first fiscal year of the partnership cooperation agreement with Leeds City Council.

This report demonstrates the continued commitment of the Trust and evidences successes and service improvement through the leadership of a dedicated and proactive IPC team. It is also testimony to the commitment of all LCH staff dedicated in keeping IPC high on everyone's agenda.

The year has been dominated by Covid-19 and the IPC Team workload increased dramatically as a result. Keeping staff and patients safe was priority during this time, as well as the system wide working through the city of Leeds. It is fair to say that the working day of an IPC Nurse and others in the team was unpredictable and often very stressful.

Throughout this time the IPC team has dedicated their time to the management of the pandemic and should be acknowledged for their unwavering hard work. I personally would like to thank my team for their dedication, tenacity and continuation of their positive spirit during a very challenging period of time.

Report compiled by Liz Grogan Deputy DIPC and Head of IPC – September 2021 and contributions were made by members of the Infection Prevention and Control Team.

Leeds Community Healthcare NHS Trust

Agenda item 2021-22 (76)

Version 3: 23 09 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 Inc COVID 19		X Inc COVID 19	X Inc Covid 19	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 -blue box		X
Staff survey	annual	DW				X					
Safe staffing report	2 x year	EDN&AHPS			X				X -blue box		
Seasonal resilience	annual	EDO	X taken at Board Workshop Nov 2020							X	
Business Coninuity Management Policy	As required	EDO					Taken in the Private session			Taken in the Private session	
Serious incidents report	2 x year (Feb and August)	EDN&AHPS		X	X				X -blue box		
Patient Safety Report	2 x year (Feb and August)	EDN&AHPS			X				X -blue box		
Patient experience: complaints and concerns report	2 x year (Feb and August Annual report)	EDN&AHPS			X Six monthly report				X Blue box 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	X -Q1 blue box		XQ2
Third Sector Strategy	2x year (Feb and Aug)		X First report		X Deferred		X		X -blue box		
Estate Strategy	2xyear (March and October)	EDFR			X					To be taken at a Board workshop session November 2021	
Digital Strategy	2x year	EDFR	X			X				X -blue box	
Engagement Strategy	2 x year (Mar &Oct from 2020)	EDN&AHPS	X			X				X -blue box	
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											
WDES -annual report and action plan	annual									X	
WRES - annual report and action plan	annual									X	
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 -blue box		
Infection prevention control assurrance framewrok	2x year(October and March)					X				X -blue box	
Infection prevention control annual report	annual	EDN&AHPS	X							X will move to May from 2022	

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: 1 October 2021

Agenda item number: 2021-22 (79)

Title: Engagement Strategy Six Monthly Update Report

Category of paper: For information
History: Quality Committee

Responsible director: Executive Director of Nursing and Allied Health Professionals
Report author: Quality Lead

Executive summary

Purpose of the report

The purpose of this report is to provide an update to the Quality Committee on the Leeds Community Healthcare NHS Trust (LCH) Engagement Strategy.

The LCH Engagement Strategy was approved by the Trust Board in October 2019. An Operational Plan for Year 2 of the strategy was presented and agreed at Quality Committee in March 2021 and an update on Operational Plan progress requested in September 2021.

This paper provides an update on the work to date as part of the Year 2 Operational Plan in 3 out of the 6 priority areas.

Main points

Progress has been maintained on implementing the Engagement Strategy Operation Plan despite difficulties presented throughout the Covid-19 pandemic. Objectives have been met according to agreed timescales.

Consideration is being given to the review process of the current Engagement Strategy as part of the Year 3 Operational Plan development.

Recommendations

- Note the actions of the year two Operation Plan against the 3 priority areas of the Engagement Strategy that were presented.
- To approve the development of a Year 3 Operational Plan to be presented to Quality Committee in March 2022.

Engagement Strategy Update

1 Introduction

1.1 The Patient Engagement Strategy provides a framework for Patient Experience and Engagement work within the Organisation for the years 2019-2022.

1.2 A Year 2 Operational Plan was discussed and agreed in March 2021 by Quality Committee.

1.3 This report provides an update summary against 3 of the 6 priority areas as agreed at the last Quality Committee, these being:

- Listening to everyone's voice
- We are ALL experts
- How we do what we do

2 Background

2.1 The Engagement Strategy 2019-22 was approved by the Trust Board in October 2019. The Strategy describes an overarching aim of ensuring that through genuine engagement Leeds Community Healthcare NHS Trust is able to deliver the best possible care in all our communities, adapting and responding to feedback, engaging the communities we serve and responding to requirements, challenges and opportunities. The strategy aims to strengthen our approach to Engagement with a focus on six priority areas.

2.2 In March 2021 Quality Committee received an update on the following 3 of those 6 priority areas, these being:

- Culture of Engagement
- Working with others
- Leadership

3 Current position

3.1 A summary of progress in the other three areas is below. See Appendix 1 for the full Operational Plan.

3.2 Listening to everyone's voice: We will listen openly to a diversity of voices and consider how we learn from each and every experience

3.3 The Trust's Patient Experience: Dealing with Compliments, Concerns and Complaints Policy (PL302) has been reviewed and issued to all services and staff in July 2021. The policy helps to ensure we learn from each and every experience by:

- encouraging and welcoming all patient and carers feedback, compliments, and concerns and complaints
- making it easier for patients and /or their carers to tell us about their experiences
- providing a clear framework for providing responses to voiced concerns and complaints
- being honest when mistakes are made or identified
- using feedback to learn and take action to improve services

3.4 The planned revised training programme to support the revised policy was put on hold due to the pandemic but is recommencing in November 2021. The Patient Experience Team have provided 1 to 1 or small group training, development and ongoing support to service mangers and concern/complaint investigators throughout the pandemic.

3.5 A new "How to Guide" for managing concerns and complaints is being tested with one service with the aim of rollout across all services by the end of December 2021. A monthly audit of complaint numbers and timescales is now in place reporting through the Trust's Performance structures, including reporting of performance indicators. From January 2022 using the Trust's digital feedback platform, complainant's will be asked to give feedback on their experience of the complaint process. This will help further inform procedures and development of training programmes on managing complaints and concerns.

3.6 A task and finish group led by the Patient Experience and Engagement Lead has supported the implementation of the Accessible Information Standards (AIS) across services. This has included development of a range of tools for managers and staff explaining the requirements and rationale for implementation; the provision of development workshops for staff; the introduction of the new SystmOne Communication Template and its reporting on PIP. The new template states that all staff must ensure there is a discussion with patients regarding their communication needs as part of their initial assessment and this is recorded for other clinicians to see. Usage of the template will be reported through performance processes. Staff have identified the need for the same approach for parents and carers, which will be progressed by the LCH Carers Group.

3.7 We are ALL experts: We recognise the skills and experience that each person can bring

3.8 The Trust's Patient Engagement Champions Network has continued to meet virtually throughout 2021. In June there was a successful Celebration and Sharing Learning Event Day for Champions providing an opportunity for services to share service-based initiatives. This was alongside workshops delivered by the NHS Improvement Always Events Team and members of the LCH Youth Board. The content of network sessions is based on needs identified by champions and services through appraisal and development reviews, with the September session based on peer support. Additionally, the Patient and Engagement Officer delivers bespoke development sessions to services based on identified need.

3.9 The Trust contributes to several city-wide groups as part of its commitment to interagency working, for example being part of the How Does it Feel Working Group, led by HealthWatch. One key outcome has been a series of videos with users, with long term conditions, sharing their experiences. All these videos are available on YouTube. One video story "Gemma", describes their positive experience of LCH Podiatry Services.

3.10 Training and development supporting staff to work with carers and young carers has been rolled out across the Trust, supporting our commitment to carers. These sessions are led by Carers Leeds and Family Action and bespoke to LCH services. Due to the positive evaluation of these sessions

Carers Leeds and Family Action are developing similar programmes for other health organisations.

3.11 How we do what we do: We have efficient systems and processes in place to maximise the potential of our engagement and the influence of the people's voice

3.12 An Engagement Toolkit has been available for Patient Engagement Champions and Services since December 2020. The toolkit is reviewed every quarter with new resources added based on requests from services. The newest addition (October 2021) will contain information on involving service users including young people in recruitment processes and holding virtual resolution conversations. A more formal review and evaluation will take place in December 2021 to seek the impact of the toolkit on staff members and asking what needs to be removed and added to support their work.

3.13 Patient and carer experience is being used to support changes in service delivery, for example:

- Community Neurology Rehabilitation Service are having focus groups with people who have or who care for people who have experienced a stroke, Parkinsons Disease, Multiple Sclerosis (MS) or have suffered a brain injury. These groups have been hosted by Voluntary Action Leeds. The service has also developed a survey to gather insights round what matters most to people when accessing the service.
- The MSK Team have had a focus group to help develop its new website, exploring how easy it is to access, is the information clear, would they use it and what would make it even better
- The 0-19 PHINS Participation Group, has a Facebook presence, hearing parents and young people's experience of services and what might make things better ensuring users views are central to possible changes from the beginning of the process
- The CAMHS ADHD Parents Group which meets monthly providing peer support and an opportunity to share personal stories and influence service change

4.0 Priorities for Year 3 of the Engagement Strategy

4.1 A key priority in Year 3 will be a review of the current engagement strategy, focusing on the impact it has and developing priority areas for the new strategy. A secondary objective will be to identify specific staff training needs to enable delivery of effective patient engagement and experience and a programme to meet these needs. The aims of the new strategy will be co-produced with service users and their carers, stakeholders, and staff. Colleagues from Healthwatch Leeds, Forum Central and Leeds Beckett University will be commissioned as partners in this work, working LCH colleagues and representatives from LCH Patient Participation and engagement groups.

4.2 Health inequalities will remain a key underpinning thread for year 3 recognising that engagement with those at greatest risk of health inequality is key to positive health outcomes. A key area of focus will be learning from patients/users and their carers how we increase access to services.

4.3 Ensuring patients/users and their carers are heard as part of Reset and Recovery will remain a priority. The Year 3 operational plan will continue to support services to engage with their patients/users and their carers and communities to review how we deliver our services; to identify areas for change and improvement; and work with people to create services that are effective and meet the needs of the people who access them. It will also include working closely with Business Intelligence and the Outcome team to use the data we collect to identify gaps in services to be able to work with communities to improve access and encourage uptake or self-management where appropriate.

4.4 Building on the achievements delivered in Year 2, the current Priority Areas objectives will be reviewed and influence Year 3's plan. There is no expectation that objectives described in the Year 2 plan will not be achieved.

5.0 Conclusion

5.1 Progress has been maintained on implementing the Engagement Strategy Operational Plan with priority areas 3 – 6 objectives met according to agreed timescales in the plan. It continues to be key that we ensure the voices of all communities are heard and influence service delivery and access, and how we work as an organisation and as a city to improve access, reduce inequalities, encourage self-management, and give patients, carers and the public a much louder voice.

5.2 To support the momentum it is appropriate to start thinking now about the how we will engage with patients, carers and the public for the next 3 years. As part of our strategy review process we will ensure that the Year 3 Operational Plan links to other action within the Trust around equity, working with partners including the 3rd sector, and supporting our staff in "ALL being experts".

6.0 Recommendations

The Committee is recommended to:

- Note the actions of the year two implementation plan against the 3 priority areas of the Engagement Strategy that were discussed.
- To approve the development of a Year 3 Operational Plan to be presented to Quality Committee in March 2022.

Appendix 1- Year Two Engagement Strategy Operational Plan Priorities

1: CULTURE OF ENGAGEMENT: Engagement will be embedded within our culture and underpins everything that we do					
Priority Objective		**How**	**Who?**	**By when?**	**Outcome Measure**
The people's voice drives our organisation	We will implement processes to hear the people's voice within all areas of the organisation We will develop an infrastructure that enables this voice to have a much bigger influence We will measure the impact of the people's voice	- An Always Event Workplan is developed in the AE Oversight Group Meeting - The Always Event process is followed to support the identification of Always Events within all Business Units; this involves patients, carers and staff - Develop a plan to Identify service specific measures for FFT	Patient Experience Team AE Oversight group Patient Experience Team		- AE Oversight Group Meeting Workplan aims are completed - Action plan developed and agreed through the QAIG (Quality Assurance and Improvement Group).
We listen to people and learn from their experiences	- We will create opportunities to reflect on feedback and this will be embedded within our processes - We will proactively challenge and strive to continuously improve - We regularly audit to measure how learning is sustained				- We have fostered an open, honest and reflective culture for patients and staff –the staff survey and feedback reflect this - There is evidence to show that our learning from experience makes things better

2: WORKING WITH OTHERS: We work to improve the whole patient journey; working with people to maximise their strengths, reduce health inequalities and link with our partners across the city					
Priority Objective		**How**	**Who?**	**By when?**	**Outcome Measure**
Establish our approach to a People's network within the Organisation	We will define the aims and objectives of an LCH people's network	- Review Friends of LCH member's network	Patient Experience Team Comms/		- Membership is reviewed and communication sent to all members

2: WORKING WITH OTHERS: We work to improve the whole patient journey; working with people to maximise their strengths, reduce health inequalities and link with our partners across the city					
Priority Objective		**How**	**Who?**	**By when?**	**Outcome Measure**
	We will work closely with existing networks in the city We will develop our offer for involvement	- Review our approach to an LCH people's network; Aims and purpose	Clinical Leads/ Quality Leads/ PET		- Our approach and aims of an LCH Network are published on the LCH website
Develop and sustain links with our partners across the City	By building positive working relationships with key partners across the city We will feed into city-wide developments as part of the Leeds Plan We will work together to improve the patient journey in the city				- Partner relationships are effective and productive and support positive outcomes - We are linked to all city-wide developments - Our patient feedback captures the whole patient journey

3: **LEADERSHIP: There will be leadership from every voice, we are accountable to our citizens as well as the Trust board.**					
Priority Objective		**How**	**Who**	**By when?**	**Outcome Measure**
The people's voice has influence throughout the organisation	We have representation of the people's voice within our quality and assurance frameworks; at the Patient Safety and Engagement Group Meeting (PSEGG) and at our Public Board Meetings	- Establish a process to ensure the People's voice forms part of each governance meeting - The people's voice will form part of the Quality Committee membership; through the Youth Board, PSEGG and the Engagement Staff Champion Group - Healthwatch Leeds will become a regular membership of Quality Committee	LCH Trust Board members/ Patient Experience Team CBU Involvement Lead/ PET/ Engagement Staff Champions/ PSEGG Executive Director of Nursing and AHPs		- The People's voice is represented at the Patient Safety, Experience and Governance group meeting - The Youth Board, PSEGG, Engagement Staff Champion Group are having regular contact with Quality Committee - Healthwatch Leeds are a member of the Quality Committee
Engagement will be role-modelled and embedded across the organisation	Dedicated staff roles; central PE Team and within Business units	- Implement processes to ensure that Engagement is a standing team meeting agenda item within all service team meetings; Support offered by PET, and this feeds into the Engagement Staff Champion meetings on a bi-monthly basis	Team Leads/ Engagement Staff Champions		- The Engagement Staff Champion role contributes to Objectives within appraisals, and is measured through performance reviews and the appraisal process

4: LISTENING TO EVERYONE'S VOICE: We will listen openly to a diversity of voices and consider how we learn from each and every experience					
Priority Objective		**How**	**Who**	**By when?**	**Outcome Measure**
We learn from all experiences	We will review our complaints, concerns and compliments processes to ensure learning from this feedback is implemented and shared	- Review Complaint policy and process - Review Concern process - Review Compliment process - Patient experience audit of complaint process - Embed the Datix 'Action tab' function across all complaint investigators	Patient Experience Team; Complaint manager, Patient Experience and Engagement Lead	July 2021 Full use of action tab on Datix by end of Q3 3 2021/22	- The revised complaint policy is signed off by the Policy Group and uploaded to the website and intranet - The revised concern and compliment processes are agreed at the PSEGG meeting, and shared Organisation-wide. These are uploaded to the website and Intranet - Complaint, concern and compliment training is developed and delivered - Complaint process audit is completed - Completed actioned plan on Datix
Our services are accessible to all	We will review the patient experience information we use to make sure this is in line with the Accessible Information Standards Working with our partners and community groups to increase our reach Our networks and groups will reflect the communities we serve	- Measure all service against the Accessible Information Standards and guidance to establish a current position - Work with services to implement the Accessible Information Standards	Patient Experience Team supported by • SystmOne Team • IG • Business Intelligence • Quality Leads and Clinical Leads	June 2021: Working Group established July 2021: New SystmOne Communication Template in place July 2021: Training for staff made available along with additional resources to support staff August 2021: Data available for services on PIP and reported via Performance structures	- Completed audit of Accessible Information Standards for all services - Regular updates are provided to Healthwatch - The data we collect reflects a much wider audience demographically - We are engaged with relevant community groups - The information/correspondence we produce is available in different languages and formats when required - We promote inclusivity through our information sharing; this is accessible to everyone

4: LISTENING TO EVERYONE'S VOICE: We will listen openly to a diversity of voices and consider how we learn from each and every experience					
Priority Objective		**How**	**Who**	**By when?**	**Outcome Measure**
We engage at every opportunity.	Engagement will be embedded within organisation-wide policy, process and approach, e.g., Business development	- Establish a plan to ensure the People's voice contributes to and is embedded within service developments and redesign - Work in conjunction with the Business Development Team to agree an approach to engagement	Patient Experience Team Patient Experience Team/ Business Development Team	December 2020	- Action plan developed and agreed through the Patient Safety, Experience and Governance Group Meeting (PSEGG) - A plan is agreed with Quality Improvement Team - Key links with QI are made and sustained

5: WE ARE ALL EXPERTS AIM: We recognise the skills and experience that each person can bring					
Priority Objective		**How**	**Who**	**By when?**	**Outcome Measure**
Our staff have the skills, knowledge and confidence to engage	- Staff training needs are identified - Training is delivered across the organisation as required and available - Learning is shared through engagement forums, newsletters, within team meetings and at other relevant forums - We use city-wide forums to share learning with our partners	Part of Trust appraisal and development systems (role modelled by the Patient Experience Team)	Patient Experience Team Services	Throughput the strategy period and reviewed monthly in terms of Patient Experience work planning	- Annual and six-monthly appraisals and review, monthly one-to-one meetings - Training and development to services following identification of need - Bimonthly Patient Engagement Champions Forum with representation from all services with a development component in each session - Ongoing attendance and contribution to city-wide forums; the People's voices group, Complaints sub-group and others

6: HOW WE DO WHAT WE DO: We have efficient systems and processes in place to maximise the potential of our engagement and the influence of the people's voice					
Priority Objective		**How**	**Who?**	**By when?**	**Outcome measure**
Effective systems	Review our data collection approaches Ensuring our systems are robust and fit for purpose to capture experience and feedback Our reporting structures enable us to showcase our engagement activity	- Scope what feedback methods are currently being used within each Business Unit - Work in conjunction with the Quality Improvement Team to agree a plan to build a set of quality improvement tools that enable the collection and analysis of quality data used to inform service improvement approaches	Patient Experience Team/ Clinical Leads/ Quality Leads Patient Experience Team/ Quality Improvement Team	December 2020 December 2020	- Completed scoping exercise across Business Units; Adults, Children and Specialist - A plan is agreed with Quality Improvement Team - Key links with QI are made and sustained - There will be an increase and variation of our data collection - We will have an increased capacity to capture the people's voice
We have a protected resource to support experience and engagement activities	Development of an engagement toolkit Each business unit will utilise an engagement budget, with clear guidance on expenses and reimbursements	Develop tool kit, test and implement across the organisation Review after 12 months use Processes identified in each unit, which includes supporting FFT	Patient Experience Team With • Patient Champions • Quality and Clinical Leads BU General Managers and Clinical Leads	December 2020 December 2021: To review and update October 2021	- There will be an increase in engagement activity Trustwide across a wider scope - Staff are confident and have what they need to lead engagement in services - There is consistency in how we engage - Experience and engagement activity has a clear rational and is meaningful to all involved

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 1 October 2021

Agenda item number: 2021-22 (80)

Title: Digital Strategy Update Report

Category of paper: for assurance

History: Business Committee 29 September 2021

Responsible director: Executive Director of Finance and Resources

Report author: Assistant Director of Business Intelligence

Executive summary (Purpose and main points)

The purpose of this report is to provide an update on the implementation of the Digital Strategy with the opportunity to review the proposed refresh of the strategy in the light of the revised operational landscape which has resulted through COVID and further digital developments and maturity.

This report has two purposes. Firstly, to provide an update on progress made on implementing the priorities identified in the current Digital Strategy. Secondly to signal a direction of travel for a refreshed Strategy.

The current Strategy focussed on essential infrastructure and digital security upgrades. Detail is provided in the report.

The focus of the updated Digital Strategy is to support improved patient communications, with tools to help patients understand and manage their care better and to support our own staff to provide the best possible care via the use of digital technologies. The intention here is to demonstrate how the Trust will change over time through the adoption of new and continued use of existing digital tools.

It will be presented in a more visual “roadmap” style, which is intended to illustrate what impact various digital tools and services will have for staff, patients and the organisation. This will be supplemented by a series of “patient stories” which describe how a patient will utilise the various digital services along their pathway of care. This approach is intended to make the Strategy more meaningful to the readership.

Recommendations

The Board is recommended to:
To note the revised approach of presenting the strategy through a roadmap supported by patient stories and note the progress which has been made with the major projects embedded within the current strategy

1. Purpose of the Report

This report has two purposes. Firstly, in Section 2, to update the Committee on progress made on implementing the priorities identified in the current Digital Strategy. Secondly, in section 3, to signal a direction of travel for a refreshed Strategy.

2. Digital Strategy 2020-23: Progress Highlights

This section of the report focuses on the achievements of those projects which were identified in the Digital Strategy 2020-2023 and were developed to improve the capability, security, and resilience of the LCH Digital systems, services or estate.

2.1 Cyber / Security Related

A key priority was to ensure the LCH digital estate was as secure and resilient as possible by decommissioning outdated and unsupported 'on-premise' file servers with replacement technologies that were hosted in the Microsoft Azure Cloud Infrastructure. A project supported by the Leeds City Digital Team enabled this migration to take place in January 2021, where 17 out of 41 servers were migrated to the Azure Cloud infrastructure.

The servers which remain on the LCH estate are either:

- still supported and so it would be uneconomic to retire them so early, or
- running systems which are to be retired (such as the IT Helpdesk System) and where migrating to the Cloud would not make sense.

The 'on premise', out of data hardware on which LCH relied upon for services such as file storage and print have now been retired and the vulnerability threat they posed no longer exists.

With the file servers migrated to a fully supported hardware infrastructure, there remains a number of software upgrades to be performed to ensure each file server in Azure is running a fully supported version of the Microsoft operating software. It should be noted that an advantage of using the Microsoft Azure cloud-platform is that even unsupported versions of software will continue to receive essential security patches which allows LCH to maintain software compliance. We intend to have completed all software upgrade work by 31st December 2021

As part of the Trust's continued compliance with the General Data Protection Regulation (GDPR), a system for collating "event logs" from our systems was required to ensure we can investigate any alleged misuse brought about under GDPR. A Security Incident and Event Management System (SIEM)was delivered in March 2021 and will provide an ongoing valuable resource to track how our staff use our systems.

2.2 Software Upgrades

Always On Migration: The “Always On” software, provides an updated secure remote access route to the LCH network to support remote working and will replace the CISCO VPN solution which was rapidly expanded in March 2020 to meet the demands caused by COVID. The new software brings advantages to users in so far as there are no PIN numbers or one-time passwords to use and the limit of 1,100 concurrent users is removed. To date, the hardware and software to support all Trust users has been installed and approximately 100 users have been trialling Always On for several months with no significant issues reported. The IT team will push the required digital certificates and software during October 2021 to all network users in the background to ensure all devices are capable of connecting to the service, before releasing instructions to users on what they need to do to use the new software. The intention will be to migrate all users to Always On by 31st December 2021 and to retain the CISCO VPN solution for partners in the LMWS service who connect to LCH clinical applications via this method. CISCO VPN can also act as a backup to Always On should a future technical problem occur.

Office 365 Migration: Driven by the requirement to use only software which continues to be fully supported from a security perspective and to provide the best experience to users, the Trust has been deploying the latest suite of Microsoft products (Word, Excel, PowerPoint, Teams and Outlook) since Autumn 2020 to replace the Office 2010 family of products. The final stages of deployment are now taking place with the following completion rates noted at the end of August.

CBU 100%

SBU 90%

ABU 80%

Corporate 80%+

From the 16th August 2021 Office 365 was deployed to those devices which have not yet received the new software to help enforce compliance. The project remains on track to complete by 31st October 2021

Windows 10 Migration: This project was required to replace all unsupported Windows 7 software and completed in line with the deadline of the 31st March 2021. An IT policy is now in place to prevent any legacy Windows 7 devices from connecting to the network.

2.3 Electronic Patient Record

Electronic Patient Record (EPR) Optimisation Adult Business Unit – plans to accelerate the rate of deployment of the EPR Optimisation unit in the Neighbourhood Teams were brought forward. The project has since grown considerably in scope and scale with Digital services becoming part of a much wider piece of transformational work within the service. The main priorities will be to establish the NTs to access SystmOne Live in a mobile environment and to implement Allocation Software (to optimise visits) in 2022/23.

2.4 Service Improvements:

Telephony Upgrade: A project is in progress in collaboration with Virgin Media to deploy an upgraded telephony system with the first services expected to transfer and go live in October 2021. Whilst requirement gathering workshops were held as part of the specification development a requirement for call recording was missed from the original specification and whilst the capability can be included the financial costs of incorporating this are being assessed and will be limited to those services with a justification to do so. In the next phase, the project will need to assess the consequences of bringing the Sexual Health Services into scope, who currently use the Leeds Teaching Hospitals telephony system to manage calls to the service.

Helpdesk Services: The implementation of single telephone number was completed in April 2021 which was the first step towards a more streamlined way for a user to raise a request for support. The launch of My-LCH has allowed for the review and consolidation of self-help resources for staff to use and prevent the need to call or email the IT Helpdesk. Additional recruitment to IT helpdesk and administrative positions have completed facilitating quicker access to IT support services and by the end of September 2021, an additional 2 Whole Time Equivalents above the baseline position of April 2021 will be in post. The scheduled implementation of a new helpdesk system, using the new Intranet (My LCH) platform is scheduled by the end of this financial year. The new solution will allow staff to log calls and for the IT, Clinical Systems and Workforce Information teams and will help to manage and track requests for support.

E-Learning Solution: The Digital Strategy Implementation Group approved a pilot to enable the Clinical Systems Team to purchase and develop training content which can be accessed by staff on-line and this work is continuing for using PCMIS (LMWS new starters) and one for the Love Your Laptop initiative supporting the ABU Optimisation. The content will go live after a technical issue has been resolved with the supplier.

3. Revised Vision for the Strategy

The report will now go on to describe how the Digital Strategy will be updated to reflect the changed landscape within which LCH is now operating.

The vision for the new Digital Strategy is to make it more accessible and relevant to clinicians and patients. The Strategy will describe how the investments we have made and are continuing to make in technology and digital services will make a difference to the way in which care can be provided and how digital methods of communication can support care and to allow the patient more control and understanding of the services they receive.

The revised strategy will be presented in the form of a roadmap and supporting information which provides the reader with more detailed information of the digital tool or service. A draft of the roadmap and an example of supporting information can be found in Appendix One.

Supporting the roadmap will be a series of “patient stories” which describe various scenarios taken from each Business Unit and how the patient would be able to use digital services to support their own care, interact with clinicians and administration services, with the intention to bring the strategy to life for staff by explaining what difference the adoption of new digital services will make to the way in which care can be provided and how patients can interact with the service. An example patient story using a Patient Communication Portal is included in Appendix two.

The approach of using a roadmap, supplemented with patient stories has been tested with Digital Strategy Implementation Group (DSIG) on the 3rd September 2021, who were supportive of the approach. The intention is to consult further, including here at Business Committee before taking the draft strategy to a future Board workshop.

4. NHS X – “What Good Looks Like” (WGLL)

WGLL has been introduced by NHS X to inform NHS leaders of what should be in place at both an ICS and organisational level to meet the standards expected to support digital and data transformation.

There are seven success measures, which can be seen in the diagram below and the framework includes the actions which the Trust are expected to take:

The 7 success measures of What Good Looks Like

Through DSIG, an assessment of the actions and activities required to implement the WGLL framework will be made through DSIG in October and then fed back to Business Committee. The response to WGLL will also support the revised Digital Strategy.

5. Next Steps

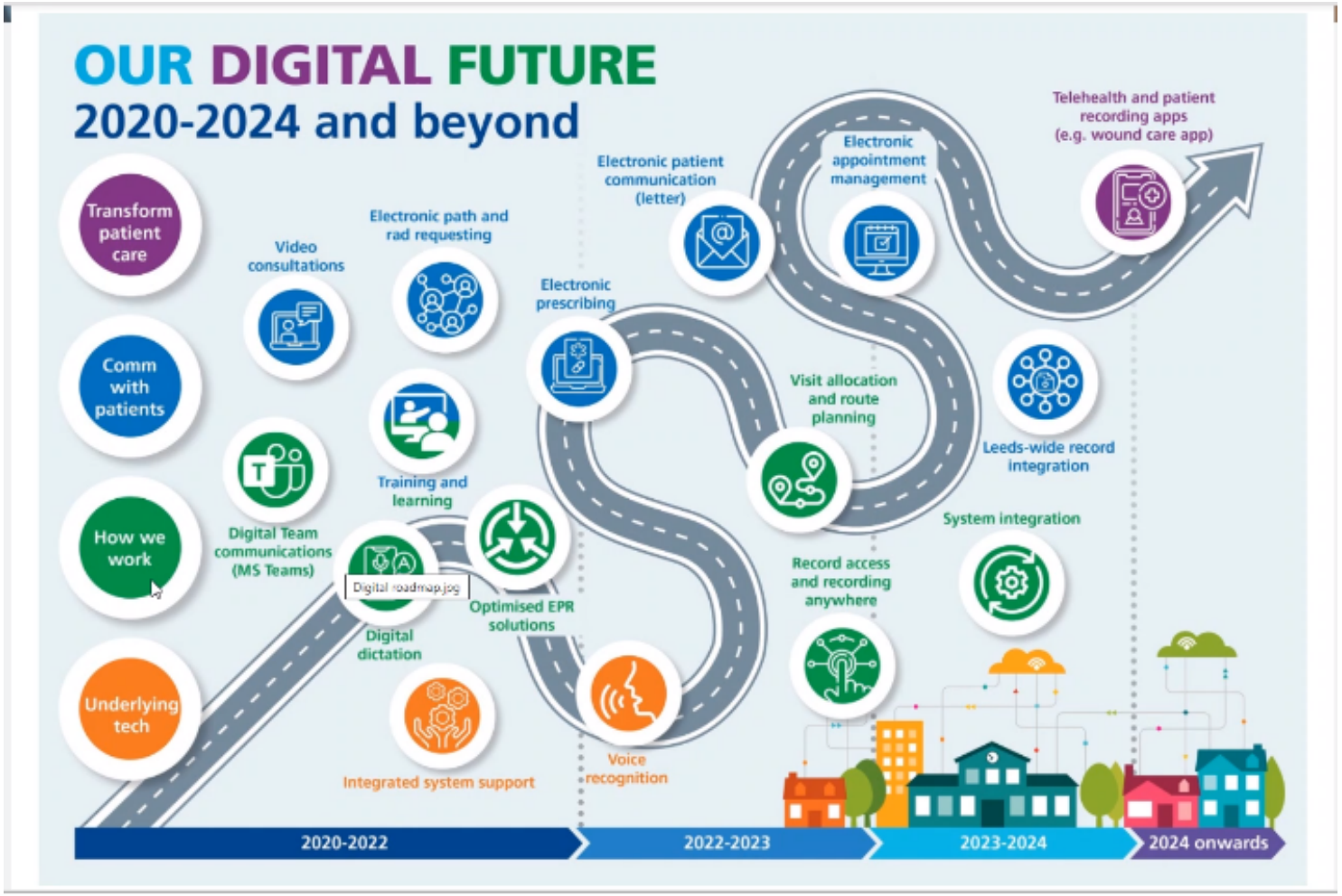
The next steps are

- To continue to deliver the Digital Strategy Implementation Plan and monitor progress through Digital Strategy Implementation Group
- Launch the revised “vision” to the organisation through the use of Roadmaps and Patient stories, promoting thorough My LCH, Leaders Network, service meetings between now and December 2021.
- Establish the next set of “must be done’” actions which includes the re-contracting of SystmOne, as the current extension period expires in July 2023.

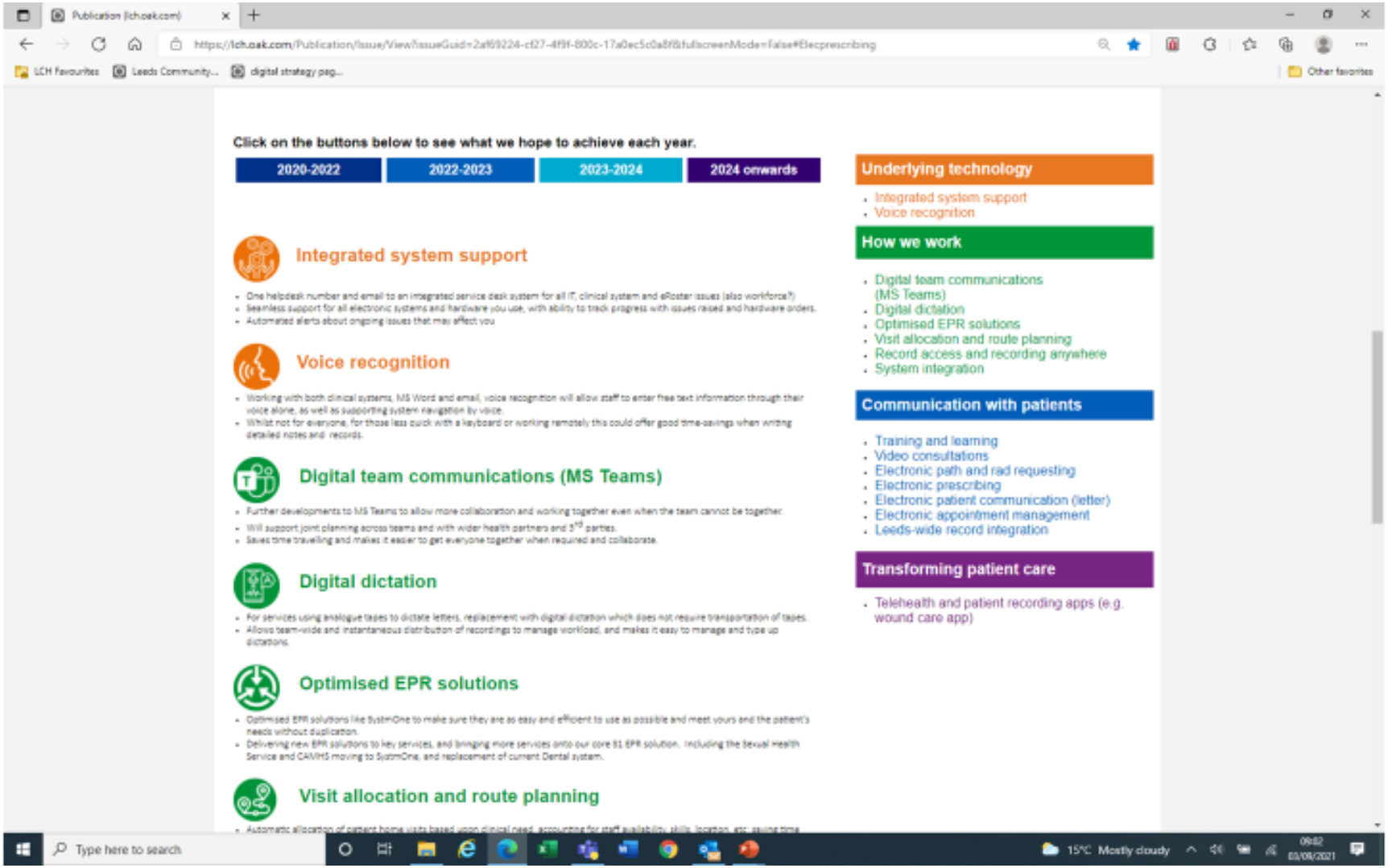
6. Recommendation

The Board is asked to note the progress made against the Digital Strategy Implementation plan and seek any further information required.

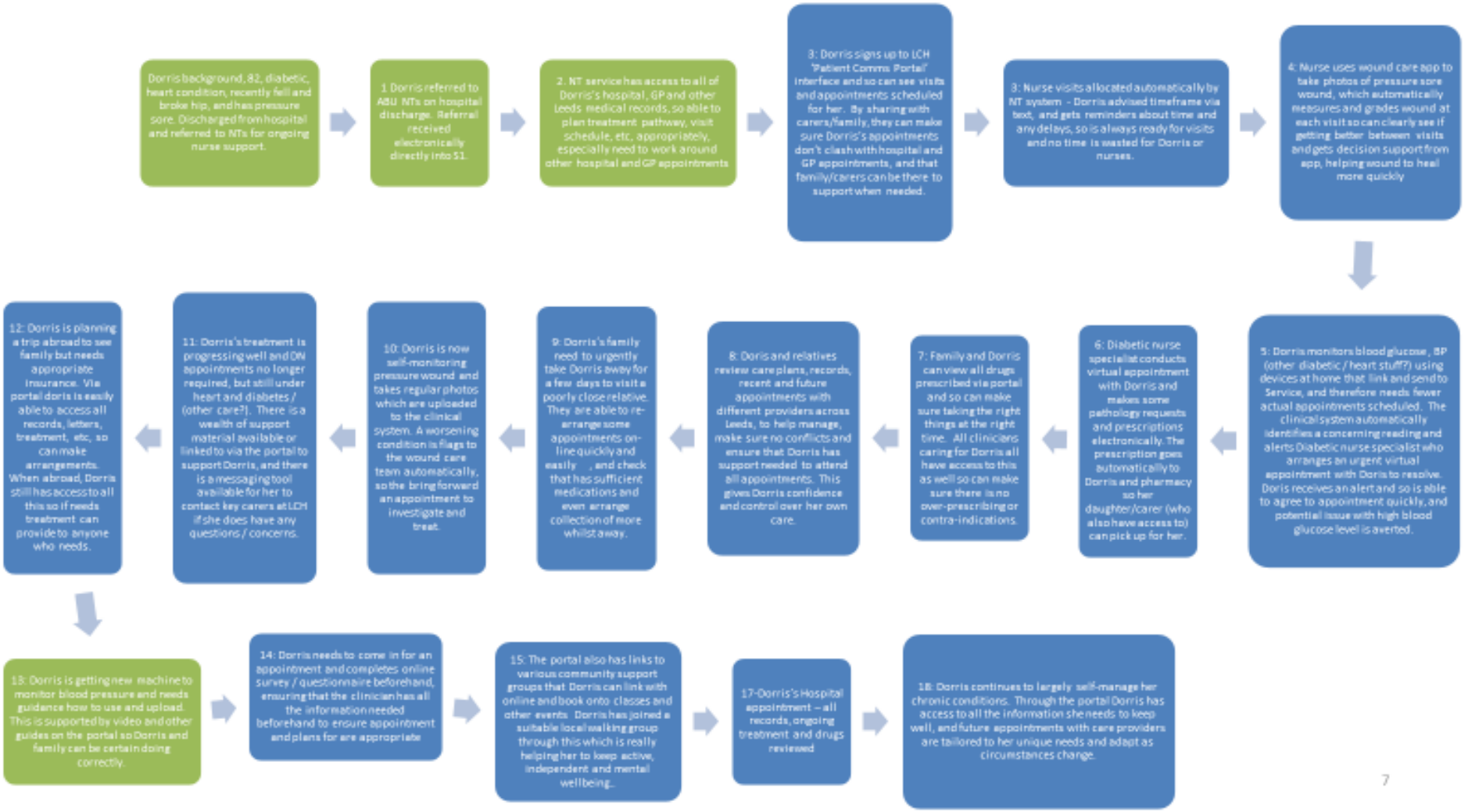
Appendix One – Draft Digital Roadmap



Each “step” on the roadmap would provide additional information to the reader as illustrated below:



Appendix Two – Example of a Patient Story which demonstrates how digital services will support patient care using a patient information portal



Patient story: Doris Background

Doris, 82, diabetic, heart condition, recently fell and broke hip, and has pressure sore. Discharged from hospital and referred to NTs for ongoing nurse support.

Digital technologies linked to…			

8

Patient story: 1 – Initial referral to LCH

Doris referred to Adult Business Unit Neighbourhood Teams on hospital discharge. Referral received electronically directly into S1.

Digital technologies linked to…			
13: Leeds-wide record integration			

9

Patient story: 2 – Access to Doris's records

2. NT service has access to all of Doris's hospital , GP and other Leeds medical records, so able to plan treatment pathway, visit schedule, etc, appropriately, especially need to work around other hospital and GP appointments

Digital technologies linked to…			
1: Patient record access and recording anywhere	13: Leeds-wide record integration		

10

3 – Doris sign's up to the Comm's Portal

3: Doris signs up to LCH 'Patient Comms Portal' interface and so can see visits and appointments scheduled for her. By sharing with carers/family, they can make sure Doris's appointments don't clash with hospital and GP appointments, and that family/carers can be there to support when needed.

Digital technologies linked to...			
14: Patient Communication Portal			

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Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 1 October 2021

Agenda item number: 2021-22 (81)

Title: Infection Prevention and Control Assurance Framework

Category of paper: for assurance
History: Quality Committee 27 September 2021

Responsible director: Executive Director of Nursing and Allied Health Professions
Report author: Head of Infection Prevention and Control and Deputy DIPC

Executive summary (Purpose and main points)

This report is to appraise the Trust Board and Quality Committee of the measures in place around identified key lines of enquiry in relation to Infection Prevention and Control (IPC) and Covid-19, in line with national guidance from NHS England and NHS Improvement and Public Health England (PHE). The second part to the report provides assurance as part of the risk assessment as prioritised within the Hierarchy of Controls.

Main issues for consideration

- The updates around gaps in assurance that have been previously identified.
- BAF updated to reflect current guidance.

IPC Current Overview

- Cooperation agreement continues to be in place with a review meeting held between LCH and Leeds City Council September 2021.
- IPC 2020/2021 Annual Report to go to Quality Committee / Board September 2021.
- Considerations around organisational preparedness for winter outbreaks in particular respiratory prevalence of influenza and RSV.
- Updated risk assessments around use of mask wearing – 20th September 2021.
- Introduction of Asymptomatic screening programme with Lateral Flow Testing – 20th September 2021.
- Hierarchy of Control Risk Assessment completed.
- Ongoing implementation of the NHS E/I National Cleaning Standards and identification of risks
- Continuation of HCAI activity with specific emphasis on Gram Negative Blood Stream reduction strategy.
- Strong IPC Leadership, team building, succession planning and implementation of new IPC structure to reflect increase in funding through Cooperation Agreement with LCC.
- CQC Preparedness in line with relevant criterion and Health and Social Care Act requirements.
- Enhanced visibility, seven-day service, IPC Surgery for staff support and clinical activity throughout business units.

Recommendations

To note the contents of this report.

Infection Prevention and Control Board Assurance (BAF) Covid-19

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	• Risk assessments are undertaken in relation to NHS England hierarchy of controls for Covid – 19 (see appendix 1) messaging in place as outlined in this document for the control measures and risk assessment available on Oak.	•	•
• the documented risk assessment includes: ○ a review of the effectiveness of the ventilation in the area; ○ operational capacity; ○ prevalence of infection/variants of concern in the local area.	• Risk assessments completed for each building in relation to ventilation and ensuring that each clinical space and shared office space has natural ventilation and where possible for doors that are not fire doors to be kept open. • Operational capacity – Steph • Local prevalence and surveillance rates infection are discussed collaboratively with partners. Monitoring of outbreaks is completed and engagement with PHE is undertaken. Variants of concern are discussed and IPC support with cases	• Assurance around mechanical ventilation maintenance from premises not owned by LCH	•

	of VOC and VOI where patients are not contactable.		
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;	• Face masks (type IIR), FFP3 and hoods are available to all staff member working within 2 metres of a patient or colleague. • Midday brief to share information around fit checking masks, cleaning and storage. • Fit testing undertaken as per HSE guidelines and documents on ESR for re check, filter and valve change.	•	•
• resources are in place to enable compliance and monitoring of IPC practice including: staff adherence to hand hygiene;	• Hand hygiene leaflets, posters, screen savers are available to encourage staff around adherence to hand hygiene. • National Hand Hygiene in May celebrated and educated staff around importance. • Hand hygiene packs provided to all staff members • Hand hygiene and PPE self-assessment • Statutory and mandatory training coverage around hand hygiene importance and reasoning behind breaking the chain of infection.	• Overuse and inappropriate glove use, audit to be undertaken and LCH to be part of NHS England MOOC with RCN to improve compliance and unnecessary use leading to occupational health concerns and dermatological issues.	•
Patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care	• Risk assessment undertaken by estates and facilities. • Staff messaging around social distancing. • Information on Oak	•	•

and are wearing appropriate PPE.			
Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical; ▪ b) non-clinical setting; monitoring of staff compliance with wearing appropriate PPE, within the clinical setting;	• All staff are reminded through communication channels such as Midday Brief, line management, posters that a type IIr face mask must be worn in a clinical environment. • Risk assessment undertaken inline with hierarchy of controls to reduce mask wearing in office space when seated at desk and maintaining social distancing (17th September 2021). • Awaiting delivery of IPC panels to go front of house in high footfall premises to encourage visitors around social distancing, hand hygiene and provide a provision of masks.	• To enhance assurance mechanism undertake a mask audit of compliance in non-clinical environments.	•
• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered;	• IPC Champions are in place throughout services	• Develop role further to become a PPE Champion.	•
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;	• Twice weekly LFT in place for all clinical staff since December 2020. • Staff portal for a submission of results • LFT kits available through stores. • Frequent communication through Midday brief and line management. • LFT 'Is it me'?	•	•

	• Asymptomatic Screening Programme Assurance Report • Comms for Mask wearing and LFD Testing extension to all staff • Supporting information and flow charts for extension to all staff comms. • Updated Participation Framework to include Extension to all staff and changes to the dataset around Assurance • Adapted form for both interim usage of remaining stock of 25 packs and new model of distribution for packs of 7. Linked to completion of NEW Participation Status Dataset. • Specific information for early adopter services of the New Model of test pack distribution. Linked to completion of the NEW Participation Status Dataset. • Guidance for all line managers on the responsibility and completion of the NEW Staff Participation Status dataset.		
• training in IPC standard infection control and transmission-base precautions is provided to all staff;	• Online provision of IPC training in line with health education england – average 92% staff compliance • In the even of outbreaks local education provided • Virtual IPC Surgery in place for staff to drop in	•	•

• IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training;	• IPC attaned Trust induction to go through roles and responsibilities around IPC,	•	•
• all staff (clinical and non-clinical) are trained in: o putting on and removing PPE; o what PPE they should wear for each setting and context; all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance;	• All staff undertake stat mand training that covers donning and doffing. • Videos available on Oak for staff to watch	• Enhance assurance mechanisms and undertake audits on donning and doffing from each business unit • Consideration whether it should be part of appraisal or other staff competency checks	•
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace;	• Posters, floor stickers, screen savers available to remind staff and patients. • Regular communications in Midday brief. • Line management and team meeting discussions	• Ascertain proof of team meeting discussions	•

• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way;	• Updates sent to Covid-19 email address. • IPC Lead and Head of attend NE Regional Updates for DIPCS and Lead Nurses • Interface with IPS. • All new guidance is monitored and changes implemented. • Changes communicated through staff midday brief and clinical leads cascade at service level.	•	•
• changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted;	• DIPC takes changes to the Quality Committee / SMT / Board	•	•
• risks are reflected in risk registers and the board assurance framework where appropriate;	• Risk register has documented items throughout the pandemic and is monitored / updated.	•	•
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens;	• Policies are in place outlining practice in relation to other pathogens such as influenza and gastrointestinal.	• Outstanding and needs to be implemented. Head of IPC to meet with Cara Mcquire in Risk Team to discuss further	

• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	• The BAF is reviewed and the Board are appraised on a 6 monthly basis. The BAF is a standing agenda item of the IPCG and concerns are escalated to	•	•
• the Trust Board has oversight of ongoing outbreaks and action plans;	• Outbreaks are reported by the IPCG and escalated to QAIG where there are concerns.	•	•
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	• Quality challenge visits are undertaken and this provides a opportunity for SMT to check and challenge as well as sense check staff in clinical / non clinical environments • Evidenced in quality challenge visits	• Discuss further with Clinical Governance and ask if a question can be added around this into quality challenge visit documentation	•
Systems and processes are in place to ensure: • Infection risk is assessed at the front door and this is documented in patient notes	• Screening questions asked at triage and on arrival at patients own home, and appropriate PPE worn as outlined in current national guidance. This is reviewed in line with national guidance changes and updates are communicated within the midday brief. • Documented in patient notes • Vulnerable staff have a risk assessment in place to identify any additional support required when visiting suspected or confirmed cases of Covid-19 • Flowchart in Community Care Beds (CCBs) to direct appropriate	• Audit of EPR to ensure clear documentation to ensure accuracy of detail in the patient notes – an audit of 10 patients per neighbourhood team has been undertaken to identify that patients have been triaged. • **Results showed that Covid symptoms documented** : Of the 80 records 28 had evidence of Covid-19 symptoms or Covid-19 diagnosis documented within the care record = 35%	• Risk assessment in place and Covid-19 risk identified on the risk register • Working strategy principles for face to face contacts during Covid-19 period developed for the organisation including ensuring safety of patients and staff when seeing Covid-19 positive patients, patients who are shielding and non-Covid-19 patients. • Identified hot, warm and cold sites throughout LCH and in partnership with primary care.

	placement and cohorting, where required, inclusive of hospital discharge pathway • As services are re-set an IPC checklist has been developed for all services to complete to ensure practice is in line with national guidance, and appropriate audits of compliance are included • Adult business unit has completed an audit of 10 per team identifying the level of completion • Front of house flowchart to triage patients coming into LCH buildings • A random sample of notes from CBU has been recorded • If a breach of PPE is identified this is recorded as a Datix incident. **Supporting evidence / documents:** Minutes of Trust Board Minutes of Quality Assurance Committee	**PPE**: 55 of 80 care records have evidence of PPE being worn recorded = 69% Team Leads in the ABU have been reminded that this is a mandated requirement and will be raising directly with their teams. Also a new Neighbourhood Team memo is being released that reconfirms the requirement. **All** business units (ABU, CBU, SBU) to have a monthly report ran on the pre-sets within EPR now that it has been fully embedded (24/09/20). We are exploring how this might work for non Sys1 patient recording systems such as dental, sexual health. • Track and tracing plans to be developed as per national guidance – work is being undertaken to determine an enhanced localised track and tracing system with Leeds City Council. Internal support is provided by IPC should a positive case be identified to understand if there have been any contacts or breaches. Examples of this work have been undertaken in the neighbourhood teams as well as WYOI.	• Use of pre-set coding on EPR in patient notes to enhance recording and efficacy. This will allow for a more efficient way auditing the triaging of patient for Covid-19 and use of PPE.

• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Working strategy principles for face to face contacts during Covid-19 period e.g. PPE usage, triaging prior to visit. Fundamentally this part of the resetting. Checklists in place for each service to complete to identify gaps, as well as resetting training for staff members • LCH will continue to treat patients who have or are suspected of having Covid-19, with a preference for telephony/ video conferencing treatment, particularly at the triage stage • Flowchart in CCBs to direct cohorting, in line with national recommendations • Daily communication via IPC team to facilities (care homes or LCH sites) where there are confirmed cases and care is being provided. This provides expert advice and guidance on management of patients. • Cleaning schedules adapted as outlined in national guidance • New and updated guidance shared with business unit clinical leads through Clinical Bronze Meeting, Director of Infection, Prevention and Control (DIPC) and Deputy DIPC, and communicated via Midday Brief • Agreed flow chart with LCC for discharge to Community Care Beds	Liaise with BI to identify performance data demonstrating an increase in virtual/telephone consultations. Due to current capacity IPC have been unable to complete the full programme of environmental audits.	• Risk assessment in place for staff providing care to patients with confirmed/suspected Covid-19. • PPE provision and updated guidance made available to staff through midday brief. • Frequent communication and support provided through the Infection Prevention and Control (IPC) Team • The IPC team will oversee all arrangements to ensure that infection control arrangements offer a safe environment for staff and patients. • Purchase of electronic audit platform to improve the audit cycle and enhance assurance mechanisms. • Reset checklist for services to complete to identify concerns within the environment • Space management group

• Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• New and updated guidance shared with business unit clinical leads through Clinical Bronze Meeting, DIPC and Deputy DIPC, and communicated via Midday Brief • Citywide Bronze and silver meetings for CCB's / Care Homes in place to ensure there is a citywide agreement in place. • Action and decision log in place for the Clinical Bronze Meetings • Covid-19 email address accessed by SMT and alerts shared appropriately • IPC team work in a reactive capacity and are there as a point of contact to support service if required around discharge. Frequent communication and support provided from IPC Team • Identified hot, warm and cold sites throughout LCH • Flowchart and statement from LCC/LTHT/LCH supporting discharge of Covid positive, negative and contacts to CCBs and care homes. • Reopening guidance shared with providers to enhance the reopening if facilities to aid system flow.	We currently do not have an identified mechanism to record consistency of this.	Completion of Datix for any discharge not following the specified guidance. Each case would then be subject to a review.
• Patients and staff are protected with PPE, as per the PHE national guidance	• Public Health England (PHE) message reiterated throughout midday briefs, previous messages archived on intranet	• Challenging environments with third party involvement such as Adel Beck and WYOI: IPC and wider system involvement have provided support when there has	• Staff returning to practice through resetting to receive virtual training to discuss Covid-19, PPE

	• Ensured consistency by following PHE advice rather than individual professional bodies • Posters in place • VLOGs by the Director of Nursing and AHP's and Senior Nurse for IPC • Online IPC training • Table 4 PHE guidance is being followed • Decision log from Bronze Command detailing discussions around use of PPE • LCH PPE silver command group notes and decision log • Leeds command and control PPE group chaired by Cath Roff, Leeds City Council (LCC) • Grid identification for each service outlining relevant PPE required updated monthly or when guidance is released	been the identification of positive cases. Local IMT meetings have been held with PHE and partners. • Audit process is being developed for PPE. Plans are in place around delivering a virtual huddle within ABU, CBU and SBU for October to provide clarity around requirements for the teams and updates.	and national guidance to be followed. • Risk assessments in place which are reviewed.
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Midday brief is utilised to ensure messages are communicated to staff., • National call attendance and evidence of updates feeding in to internal command and control • Covid-19 inbox management and evidence of circulation of key messages • Contact with Y&H IPC Lead and Infection Prevention Society (IPS)		

	• Director of Nursing and AHP's and Medical Director attend regular regional updates which include IPC updates		
• Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Areas relating to Covid-19 feature on the Risk register • Covid-19 update on all committee / Board agendas • CEO update to Chair and NED's on a weekly basis • IPC Head of Service contact and communication with SMT and the chair of the Board • Changes in guidance shared on Elsie and communicated through Midday Brief and cascaded through Clinical Leads via Bronze Clinical Meeting **Supporting evidence / documents:** - Trust Corporate Risk Register, evidenced in action log and minutes		
• Risks are reflected in risk registers and the Board Assurance Framework where appropriate	• As above • Covid-19 Risk assessment detailing multiple potential hazards including PPE		

• Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Partnership agreement in place with LCC detailing proactive measures around preventative work in reduction of Health Care Associated Infections (HCAI's) • Post Infection Review (PIR) process for MRSA/C. Diff in place working with partners throughout the system to identify learning. These have continued throughout the pandemic. • GNBSI E-coli pro-active work to identify ways in reducing infection rates • PPM+ citywide communication process for HCAI's: Clostridium difficile, MRSA • Monitoring Data Capture System (DCS) for all recordable HCAI's • Policies and guidelines in place • LCH training – face to face and online statutory and mandatory training. • Clinical risk assessments on SystmOne record for individual patients e.g. Catheters • Educational study days on HCAI and Sepsis awareness • Market stalls and preventive health promotion work with public health	• PIR paperwork and timeline completed however meetings not held to discuss learning with partners – meetings have now been held to understand learning related to MRSA blood stream infections. All PIR's currently up to date. • Proactive health promotion work has not been completed during the pandemic, including engagement and social prescribing. This would normally be undertaken to educate and inform both staff and patients helping to reduce HCAI's including Gram Negative Blood Stream Infections and AMR awareness – resetting work has not started around the gram negative reduction programme in terms of social prescribing and preventative measures. We are still awaiting trajectories from NHS E/I for this current fiscal year. IPC have continued to keep the PHE Data Capture system up to date and RCA's have been completed on time. • IPC policies and guidance have been extended by 6 months – work has been started to ensure all policies are continuing to be up to date.	• Engagement with services from IPC team • 7 day IPC service • IPC Head of Service representation on Clinical Bronze Meeting • System working with LCC/CCG/LTHT sharing best practice • Electronic auditing platform usage

		• Due to social distancing measures all IPC training has moved from face to face to online – by moving to an online virtual training system we have seen an increase in compliance. 92% of staff are up to date with their Level 1 training, which is on average 20% higher than when delivered face to face. • Audits and premises visits have been postponed and we hope will start in September with the use of an electronic auditing tool – a new electronic auditing tool 'MEG' has been purchased and LCH premises audits have been recommenced. The use of the electronic auditing tool will improve efficiency and out coming of the actions, aiming to close the loop more effectively and gain greater assurance. • The E.coli HCAI Conference which was planned for May 2020 has been postponed until 2021 – this remains on hold and a date will be identified early 2021. IPC may need to consider alternative ways of delivering a conference such and explore digital options such as an online conference.	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Care Home training offered to all 151 facilities including Community Care Beds in July / August as well as prior to the pandemic. • Cohorting of patients and staff employed in CCBs • Hannah House – single rooms availability and source isolation for suspected or confirmed cases • Little Woodhouse Hall cohorting process in place • Risk assessment on hot / cold areas and involvement from LCH estates/emergency planning • WYOI / Adel Beck – single pods/rooms, source isolation • Reset Covid-19 training being provided as part of reset and recovery. • IPC e-learning averaging 92% frontline line uptake. Content of IPC training ensures staff have appropriate training • November: Initial roll out of asymptomatic lateral flow testing for front line members of staff. Evidenced by daily sit rep of positive / negative rate.		

	• Included as part of reset and recovery programme • April: commencement of Clinical Educator for Care homes, social care and where identified outbreak require enhanced engagement and education.		
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Hannah House – all cleaners have mandatory IPC training and a schedule in line with government guidance. Cleaning audited completed. • Staff have access to Clinell disinfectant wipes, are also aware of the need to follow manufacture guidance and recommended contact times. • Cleaning teams have been trained on use of Chlor-clean, dilution methods and contact time. Evidenced in attendance records and environmental cleaning audits • CCBs, LWH, WYOI, Adel Beck not LCH responsibility for cleaning – assurance measures gained from cleaning providers: schedules, audits, COSHH regulations. • April/ May: National Cleaning Standards released by NHS E/I		

• Decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Cleaning schedule in place to reflect PHE guidance in relation to Covid-19. Additional touch-point cleaning (at least twice daily) has been implemented which includes electronic equipment, desk space and touch point areas. • A Chlorine releasing agent (1,000PPM would be used on hard surfaces): Chlorclean is, in the main, used by Estates and Facilities staff, and they have been trained in its use, which includes following manufacture guidance an contact time • Cleaning audits in place and assurances gained from external companies that provide cleaning services to facilities such as Reginald Centre, LWH and St Georges – including schedules and audits. • Minimal carpeted areas for example audiology booths, therapy rooms – there would be a triaging system in place for patients coming into that area and to consider a monthly steam clean through external contractors.		
• Increased frequency of cleaning in areas that have higher environmental contamination rates as	• Cleaning services would be contacted in the event of a deep clean. For community settings a routine clean would be required, including touch point areas by the clinician and		

set out in the PHE and other national guidance	cleaning of the floors etc. by a cleaner at the end of the working day. • Outbreak flow chart in place for teams who experience a staff or patient outbreak and those that need to be informed for example cleaning services and estates, FES etc.		
• reusable non-invasive care equipment is decontaminated: o between each use o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing or repair equipment;	• Training is provided through stat mand on decontamination on equipment and surfaces. • Clinell 'I'm Clean' labels used on items of equipment. • Cleaning policy in place – under review	Implementation of the Standards of Healthcare Cleanliness 2021 to be implemented by November 2022. Risk assessment in place	
• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Hannah House undertakes own laundry – processes in place and policy • CCB has process in place for laundry.		
• Single use items are used where possible and according to Single Use Policy	• PPE risk assessment inclusive of expired and re-usable PPE, listed on the risk register • Decision log from PHE guidance on expired PPE		

	• Silver PPE group sited on single use items. • Communication added to midday brief about correct use of single use items.		
• Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• Daily midday brief – guidance re cleaning of visors / eye protection, alternative wipes to Clinell when shortage occurred • Evidence of 'S' cleaning technique and information available on Elsie and as part of resetting checklist (evidence based method of cleaning) • Online IPC training discusses decontamination of reusable items		
• Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Cleaning schedule in place to reflect enhanced cleaning required in line with national guidance • Cleaning staff trained on use of chlorine releasing agents • Embedded into IPC resetting checklist for services to consider frequency, patient appointment times etc. • Auditing enhanced cleaning mechanisms with the use of MEG electronic system • Checklist in place • September: Dashboard in place for IPC this is discussed at the IPCG and escalated to QAIG where concerns are highlighted.	Task and Finish group established to understand the requirements of the national cleaning standards with a subgroup in place to risk assess and to understand the resource demand for implementation across the estate. Item listed on the risk register.	

	• New national cleaning standards released April 2021 – to be fully embedded by November 2022.		
• Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	• As above • Part of resetting checklist and consideration to allocated toilet facilities	• Consideration for a checklist to be in place in toilets settings, providing patient assurance on cleanliness.	• Cleaning audits and service resetting checklist to identify signage.
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Chlor-Clean is used on all floors, toilet areas which meets the requirements of a chlorine based detergent (1,000 PPM). Cleaning staff have been trained in the use of this product and the COSHH regulations that are in place including storage and disposal. • Adel Beck and WYOI cleaned by contracted cleaners – environmental audits in place. • Interserve contract for Hannah House • Adel Beck and WYOI – Amy • Purchase of electronic audit platform MEG to increase assurance mechanisms around cleaning and the environment. Direct action plans can be sent to estates or teams depending on the outcomes	• Due to the pandemic IPC have been unable to complete IPC environmental audit schedule. September – these have been reinstated including relevant reaudits to ensure outstanding actions have been addressed.	• Frequent IPC visits to locations and follow up visits made to monitor cleaning schedules and solutions used are in line with national guidance. • Checklist completed by services identification of problems • Safe space management group in place • Health and safety and Water Safety meetings being held.

• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	• 'S' cleaning guide to using disinfectant wipes and contact times available on Elsie and product website • (contact time 60 seconds) • IPC online training • Cleaning staff trained on safe use and contact time of Chlor-clean • Information on cleaning part of resetting checklist - resetting virtual training delivered by IPC discusses transmission of Covid-19 and cleaning measures in place.		
• 'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	• Posters available on intranet site • Resetting measures and checklist available and completed by services identifying gaps • IPC online training and resetting virtual offer of Covid 19 training for staff member providing information and training on cleaning of surfaces. • Standard infection control precautions		
• Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Posters available on intranet site • Midday brief information and audit trail of advice provided • IPC Training encouraging all mobiles, laptops, hot desks, phones to be cleaned with a Clinell disinfectant wipe (contact time 60 seconds) and S cleaning method		

	• Wipes available in all office and meeting room areas.		
• Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Cleaning schedule in place and waste disposal routes determined. • Safe space management group to discuss concerns raised will action log and audit trail • Information posters displayed and updated when new guidance is available highlighting disposal route • Staff FAQ explaining disposal route dispending on setting. • Virtual resetting training highlighting safe disposal route of PPE		
• Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• Ongoing work with estates and discussions with microbiology in relation to A/C and oscillation fans • Oscillation fans to not be used in clinical/non clinical environments, information shared in Midday Brief and cascades through business unit clinical leads • Assurance around maintenance checks of air conditioning. • Encourage good window ventilation in rooms both clinical / non clinical, information shared in Midday Brief and cascades through business unit clinical leads. • Increased window ventilation recommended to staff members if		

	working in shared office space. Communicated in FAQ's, IPC checklist, posters.		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • Arrangements around antimicrobial stewardship are maintained	• Citywide responsibility for AMR • Prescribing formulary on Leeds Health Pathways • Clostridium difficile Root Cause Analysis (RCA) and PIR process to identify lapses in prescribing throughout the healthcare economy, system working with CCG and LCC • Local information can be extracted in real time from the electronic patient record – depending on how this is configured will affect how the search can be conducted.	• AMR multi agency meeting on hold – recommenced September 2020. • September – AMR ICS group re-established. • PR agency commissioned via LCC not actively providing marketing around AMR. • There have been no recent engagement or awareness days held – these have been postponed until 2021, digital alternatives are being explored by Leeds City Council • There is a delay in prescribing data (ePACT) becoming available – for prescriptions written in June 2020, the data will not be available until mid-August 2020. This is a national position, and will not change.	Compared to primary care, there is minimal prescribing of antibiotics within LCH. The exception is Sexual Health – however, a main part of their remit is treatment of sexually transmitted infections, so you would expect them to use antimicrobials. There is no expectation form the city that this should reduce. All usage is in line with national guidance as advised by BASHH (British Association of Sexual Health & HIV).

• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Citywide AMR Board with LCH representation • C. Diff PIR process to identify prescribing issues – continued throughout Covid • Completion of Public Health England Data Capture System is continuing to be monitored • Engagement with CCG/LCC relating to AMR • Cooperation partnership agreement review completed for quarter 4 – annual review has taken place with partners from Leeds City Council, LCH and NHS Leeds. An updated and extended cooperation agreement has been written to reflect the increase in funding for IPC. Initially this will see an increased involvement with track and trace, and elements around preventative work in universities, school and nurseries.	• NHS England / Improvement have not announced national targets for gram negative blood stream infections, however we are working from a reduction on last years figures	• Continued with completion of PHE Data Capture System and root cause analysis for healthcare associated infections.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	• **Mitigating Actions**
Systems and processes are in place to ensure:	• Patients isolated • Individualised process for individuals in Little Wood House Hall and Hannah House in line with national guidance	• To consider implementing electronic patient record system contains an infection alert and a red flag shows for	• Guidance shared with units on visiting and reviewed regularly.

• Implementation of national guidance on visiting patients in a care setting	continue to review in line with national changes • New guidance shared 5th June on visiting healthcare inpatient settings during Covid-19 pandemic and plans to implement being put in place.	positive COVID-19 patients and shielding patients.	• Worked with community care beds and commissioners about a flow chart for discharge into CCB's and how this may impact visiting if positive. • Information shared on EDAN from LTHT if patient positive.
• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Areas cohorted if patients are tested as positive. CCB's with hot bays / areas have correct signage – reviewed when visited by IPC as part of outbreak visit. Checklist discussed over the phone in initial outbreak contact.		
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Covid-19 part of LCH intranet, inclusive of links / guidance / blogs / vlogs		
• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• SPUR / Bed Board process outlines on discharge that there is a confirmed case • Communication on discharge EPR and coding has been implemented. • System wide flow chart agreed for patients discharged into community care beds. Patient information identified on EDAN.		

• Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Every Action Counts logo added onto posters and screen savers. • Posters available on Oak	Action to discuss at next IPCG (December 2021)	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection and to segregate them from non COVID-19 cases	• Patient contacted prior to appointment to discuss infection status in line with government guidance Covid-19 criteria • Face to face triage upon arrival on own status and those they have been in contact with / own household – flowchart in place. This is then documented in EPR. • Poster signage on key IPC measures and social distancing guidance	• Part of resetting programme: consider text messaging reminders –services are sending reminder text messages to patients asking them to rearrange should they have Covid symptoms, been in contact with a person who is positive in the last 14 days or travelled abroad and should currently be in isolation as per current government guidelines.	

• Patients with suspected COVID-19 are tested promptly patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested instigation of contract tracing as soon as possible	• Flow chart for CCBs, WYOI, Adel Beck, LWHH, Hannah House • For patients receiving home visits if they are unable to access testing a pathway is available for internal testing • Guidance on isolation and cohorting of patients available • Contact from IPC team providing support and information • 7 day IPC service • Defining local track and tracing system. IPC support teams should an outbreak be identified or a breach in PPE / social distancing has occurred.		•
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Triaging plans in place, hot and cold identified areas • Risk assessment in place and identified on the risk register • PPE available for suspected or confirmed cases of Covid • Enhanced cleaning schedules in place and audit process • IPC support, 7 day service • Re-set & recovery work, identified on IPC checklist – this is service lead and will identify further risk assessments that may require to be undertaken. • Each clinical area is risk assessing their ability to deliver two metre social distancing.		

•Patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	• Screens in place in waiting areas and receptions • Floor stickers reminding patients and staff about social distancing. • Health and safety assessment undertaken to determine safe number of people of one room.		
• staff are aware of agreed template for triage questions to ask;	Triaging template available to clinical and FOH staff, determining questions to be asked. Clinical teams may contact via telephone day before to understand. Hierarchy of controls in place.	Review principles and undertake audit of activity to enhance assurance mechanisms.	
• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible;	Patients are triaged prior to appointment in relation to Covid -19 symptoms. This is evidenced on EPR / SysOne / LCR. Audit undertaken to determine that it is documents throughout each service. Staff visiting patients homes triage before seeing patient and where possible if positive visit at end of list depending if a time specific visit required for medication.		
• face coverings are used by all outpatients and visitors;	• Signage to remind patients and visitors that masks are still required in a healthcare setting are in place.	To complete an audit to review assurances in relation to this.	
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Up to date PHE guidance followed. At present LCH is following table 4. Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact. • Aerosol generated procedures as outlined in the guidance. • Covid-19 guidance and any updates are shared on the Midday Brief, Elsie Covid page and cascaded through clinical bronze meeting. • Work with partners within the system to have a shared vision around use of PPE for staff particularly cross working – for example community care beds and Leeds City Council.		
• All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Vlogs available on Elsie • Donning and doffing guidance on intranet with videos available on how to • PHE Compendium of information followed and agreed material used for training • Online stat/mandatory IPC training reiterate standard infection control precautions and usage of PPE • Staff returning from redeployment to undertake training in format of webinar. This will cover what Covid is, potential		

	chain of infection, cleaning, PPE usage etc. This is to be embedded into the resetting of services. This training can also be provided for staff who may display enhanced anxiety about wearing PPE and returning to a work based setting. The training can be delivered to services that have continued to deliver throughout the pandemic.		
• A record of staff training is maintained	• IPC training – recorded on ESR and BI • A record of staff that have undertaken FIT testing.		
• Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Visors are the only piece of PPE that LCH has had to reuse due to demand and supply issues. This has ceased now as adequate supplies available. • Reuse of PPE listed on the risk register and relevant risk assessment. • Silver PPE Group aware of re-usage • Sessional use of PPE is monitored and guidance on how to use PPE in accordance has been shared	• Visors: assurance that staff are following agreed usage guidance and cleaning 3 times and then disposing – all visors are now single use and the communications have been shared to reflect this. • Non accredited/kite marked PPE items used – this has been identified on the risk register and are items such as the 'clear mask' that has been received through government push stock.	• A supply has been determined through the PPE Logistics Group and visors are to be used as single use • All non-kite marked stocks have now been returned to stores and communication shared that only visors supplied through ordering routes can be used rather than donations. • Communications shared with staff that all visors are now single use
• Any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Evidence of weekly report from Clinical Governance Team (CGT), discussed at bronze command		

• Adherence to PHE national guidance on the use of PPE is regularly audited	• Currently it is not audited but peer review • SOP in place for IPC staff taking swabs and working in pairs to peer review	• Clinical leads to establish a way an audit of use of PPE – an audit tool has been rolled out for Hand hygiene and PPE at the beginning of September to Business Units (CBU, ABU and SBU)	• Donning and doffing videos shared with staff members and available on intranet. Emphasis on its ok to ask colleagues about their PPE. Peer to peer support.
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Prior to Covid-19teams completed Essential Steps which captured in hand hygiene audits • Monthly hand hygiene audits were completed at inpatient facilities • Essential Steps to be restarted which will capture hand hygiene observations • Hand hygiene kits available to all clinical staff • A good supply of alcohol gel and soap available through PPE logistics • Discuss with Clinical Leads as part of Clinical Bronze Meeting	• Outstanding hand hygiene and PPE audits from Business Units, as highlighted previously this is an ongoing piece of work.	• Purchased electronic auditing platform for a phased roll out to all services to upload audit figures and show outcomes.
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Laundering of uniform guidance has been shared in the Midday Brief as outlined in current national guidance • Options around types of uniforms has been considered, particularly for services where they normally wear civilian clothing • Minimal options for changing at work, risk assessed> guidance around travelling from work location directly to home setting, staff member to change, shower/bath and launder uniform with		

	no other items on a temperature hot enough that can be tolerated, tumble dried and ironed. • Decontamination of cars considered however by staff following Standard Infection Control precautions this has been deemed not necessary. • Information on use of staff coats		
• All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member	• Regular information has been sent out to all staff, with links to the necessary guidance, via the Midday Brief. • Trust wide midday bulletins regarding the steps required to be taken if a staff member, or a member of their household displays any the recognised Covid-19. • All national guidance around the criteria for suspected Covid-19cases has been shared. • Posters displayed throughout LCH • Information displayed on Elsie and new intranet site. • OH support and advice via telephone service. • Vulnerable risk assessments have been provided to line mangers to complete with staff and shared with WFI.		
Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• All hand hygiene dispensers throughout the organisation show evidence based hand hygiene technique in both staff and patient areas		

	• A mixture of posters and floor stickers are in place		
Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• There are very few hand dryers throughout LCH premises or LIFT buildings, paper towel dispensers restocked daily by cleaning staff • IPC on line training • Standard Precautions Policy • Hand hygiene kits • Covid – 19 posters • Sign posting to national guidance • Elsie and Covid page • Resetting training for staff members	• Estates to complete a risk assessment to understand the exact number of hand dryers throughout the organisation – this is still to be completed by estates. Communications has been shared to use paper towels for hand dryers. Facilities such as Shine where we use for training have been asked to turn hand dryers off and advise use of paper towels.	
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• Flow chart in CCBs • Regular communication with LTHT Geriatricians that cover CCBs • CCBs with positive cases receive daily contact with IPC to discuss figures and identify concerns in relation to IPC provision and PPE		

	• In June a weekly IPC Q&A webinar to be available for care home staff inclusive of CCBs **Supporting evidence / documents:** Evidence of interface with IPC and advice provided. Engagement with PHE if further advise required.		
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Cleaning schedules reflect national Covid guidance, cleaning staff provided by LCC. • IPC visits made to CCBs, Hannah House, Little Woodhouse Hall, Adel Beck and WYOI to provide support and advice	• Concerns raised around Leeds City Council cleaning staff refusing to clean positive patients' rooms – this is being addressed by the CCG as raises concerns around confidentiality. In this instance cleaning is being completed by care staff in the community care hubs.	Cleaning schedules in place and regular interface with LCC.
• Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Relevant policies in place relating to multi resistant organisms • Patients are managed according to Trust IPC guidance. • Organisms identified on PPM+ and information added to the patient's notes and recommendation of a risk assessment to be completed in line with guidance.		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Testing is undertaken by competent and trained individuals	• Staff testing available and this has been advertised through the midday brief. • Local measures have been put in place to support key worker testing, as there were delays identified in the national programme. • A drive thru alternative has been made available to staff. **Supporting evidence / documents:** Evidence of training Standard Operating procedure Shared Evidence of attendance on virtual training of swabbing and transportation of swabs to the lab Regular engagement and minutes of citywide testing group Regular interface with LTHT lab manager to identify potential problems e.g. specimen leakage, incorrect labelling		
• Patient and staff COVID-19 testing is undertaken promptly	• Local testing available to staff members in a timely manner,		

and in line with PHE and other national guidance	information on bookings accessed via Midday Brief and Elsie. **Supporting evidence / documents:** • Flow charts available • Staff engagement with IPC and swabs taken through local lab capacity reported back through IPC		
• Screening for other potential infections takes place	• As per policy other screening such as MRSA swabs taken as per local/national guidance and information and support provided through the IPC Team **Supporting evidence / documents:** Reportable organisms through Leeds Health Records Learning identified from post infection reviews Training records		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:	• There are processes in place to support staff in adhering to IPC policies, including staff induction, IPC mandatory training and appraisal		

• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• Evidence and minutes from staff team meetings • Policies on Elsie, Leeds Health Pathways and IPC page • IPC Induction and mandatory training • Online training • Posters and resources • Midday brief • Seasonal staff flu programme • Appraisals and staff understanding that IPC is a responsibility and duty of care by all as outlined in the Health and Social Care Act 2008 • Audit completion • Champion training events • Conferences • Virtual Q&A session and online Covid-19 specific training for staff that will be involved in having their services reset **Supporting evidence / documents:** Vulnerable staff member risk assessment Competency Frameworks Evidence of staff appraisal's ESR Training records Quality Challenge / Quality Walks		

	Evidence identified in Post Infection Reviews Relevant coding on Sys1 e.g. adherence to PPE, staff follow aseptic technique		
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Changes to PHE guidance re PPE are overseen and co-ordinated by the Trust PPE Group with representation from IPC • Midday brief • Information available on Elsie • Leaders Network • Regular VLOGs **Supporting evidence / documents:** Minutes / action log from PPE group and Joint Bronze / Silver		
• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Evidence of guidance in midday brief • Evidence in meeting notes with CCBs re supporting appropriate waste management processes		
• PPE stock is appropriately stored and accessible to staff who require it	• PPE logistics group established an electronic ordering form • Weekly stock checks • Engagement with leads from business units • Partnership working as part of Silver PPE group with LYPFT		

	• Escalation to procurement of push stock deliveries • Evidence minutes and action log from PPE logistics and Silver Command Group • A portal is available to order supplies through and these are dispatched from central stores **Supporting evidence / documents:** Identified on the risk register, PPE portal ordering system and delivery to each base.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Risk assessment shared with line mangers to complete with vulnerable staff members in the 'at risk group' • Staff psychological and wellbeing support provided through occupational health and employee assistance programme • Regular virtual drop in sessions for staff around various aspects of physical and psychological wellbeing including working at home, shielding etc. • Dedicated OH clinicians provide telephone advice to staff and		

	managers. This includes advice on providing support for physical and psychological wellbeing, and includes signposting to internal and external resources. **Supporting evidence / documents:** Vulnerable staff member risk assessment		
• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• All staff identified as requiring FFP3 masks due to delivering Aerosol Generating Procedures (AGP's) have been fit tested in line with national guidance • Evidenced through sign in sheet • Information and guidance shared on Midday Brief regarding 'fit checking' when using an FFP3 • Identified on the risk register **Supporting evidence / documents:** IPC hold staff training records as well as identification of filter changes	• Consideration of options going forward as LCH receives different brands of FFP3 and further testing may be required. • Silver PPE group to consider using reusable FFP3 as part of resilience plans • Recording of filters to be added onto ESR	• Staff fit tested on reusable FFP3's as stock variation increases on disposable.
• Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing	• Staff absence is recorded through ESR • Evidence of review in silver command • HR guidance on intranet		

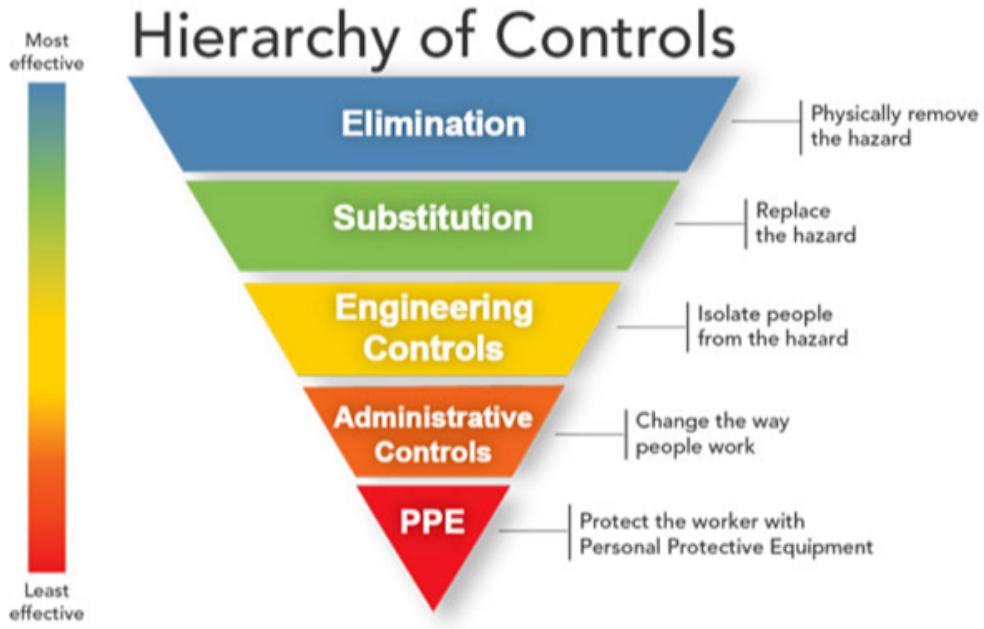
	• Staff support for psychological wellbeing through employee assistance programme and regular virtual drop in sessions		
• Staff that test positive have adequate information and support to aid their recovery and return to work	• Staff to follow national guidance and support available to staff member through IPC, occupational health, HR and employee assistance programme • Most up to date guidance available on gov.uk , shared through midday brief and available on Elsie. • Risk assessment and return to work assessment to be completed by line manager		
Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Where possible staff allocation maintained and consistency of staff caseload is maintained. • Standard infection control precautions policy and distancing measures to reduce forward transmission • Guidance and principles developed for all staff and services to ensure consideration of when visits are done etc. • Evidence in staff e-rostering • Where possible a reduction in staff cross over on sites such as Adel Beck and WYOI, to reduce the possibility of transmission		

	• Implement asymptomatic staff swabbing and daily sitrep of reporting of results		
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• National guidance available on Elsie • Posters displayed in all staff areas highlighting social distancing measures • PPE guidance if working less than 2 metres, ongoing assessments being completed by Estates and Health and Safety in relation to room assessments and safe distancing • Encouragement of staff to work from home where this is possible. • Staggered break times for staff. • Checklists completed by areas a		
• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Estates building risk assessments completed identifying number of people that can use kitchen staff areas for breaks • Social distancing measures in place • Risk assessment to identify number of people in room at once • Discourage food sharing and fuddles in teams, open packets of food. • Monitored by line managers, leading by example ethos and encourage staff that its ‘ok to ask’.		

Appendix 1: Risk assessment of the Infection prevention and control measures as prioritised within the Hierarchy of Controls- (Primary Care and Outpatients Settings)

Purpose: to support organisations and employers to undertake a local risk assessment in the context of managing infectious agents based on the measures as prioritised in the hierarchy of controls.
This includes: a set of risk mitigation measures prioritised in the order: elimination, substitution, engineering, administrative controls, and PPE (including Respiratory Protective Equipment RPE).
Risk assessments must be carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazardous associated with respiratory infectious agents. This can be the employer, or a person specifically appointed to complete the risk assessment, during development and on completion this need to be communicated to employees.

Trust/Organisation Name	Date of initial Assessment:	Assessors name:	Date of review:
Leeds Community Healthcare NHS Trust	07/09/2021	Liz Grogan	January 2022



What are the hazards?	Who might be harmed and how?	What are you already doing to control the risks?	What further action do you need to take to control the risks?	Who needs to carry out the action?	When is the action needed by?	Done

Contracting or spreading SARs-CoV-2 and other seasonal respiratory infections	Patients
	Staff
	Contractors
	Visitors
		Monitor
		• Community prevalence of infections
		• New variants of concern
		• Number of outbreaks
		• Consider other Metrix systems.
		
		Monitor
		• Organisational Operational Capacity e.g.
		  ○ Staff absence
		  ○ Number of face to face contacts				

Contracting or **spreading** **SARs-CoV-2 and other seasonal respiratory infections**	Patients Staff Contractors	**ELIMINATION** **(Physically remove the hazard)** **Redesign the activity such that the risk is removed or eliminated.** **Key mitigations:** Systems are in place to ensure that: • Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes or consider virtual alternatives to support diagnosis and treatment. • Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 and whose treatment cannot be deferred should receive care from services who are able to operate in a way which minimises the risk of spread of the virus to other patients. **Patients.**				

		Triaging and testing is in place for SARs-CoV-2 and other respiratory agents relevant to the setting e.g. RSV/Influenza. This must be undertaken to enable early recognition and to clinically assess patients prior to face to face attendance/procedures to identify whether: • Patient is fully vaccinated • Patient has no respiratory symptoms link to clinical case definition for SARs-CoV-2 • Patient has not been advised to self-isolate by NHS Test and Trace. • Consider where appropriate a negative lateral flow test carried out on day of attendance. **STAFF** Systems are in place to ensure: • **Fully vaccinated** staff and students who are identified as a contact of a positive COVID-19 case will no longer be expected to isolate and will be				

		expected to return to work.
		• Twice weekly Lateral Flow Device testing should be carried out for all staff
		• Staff working in all clinical areas
		  ○ Are fully vaccinated against respiratory infections (including COVID-19) as advised by public health/occupational health
		  ○ Are asymptomatic				

Contracting or spreading SARs-CoV-2 and other seasonal respiratory infections	Patients Staff Contractors	**SUBSTITUTION** **(Replace the hazard)** **Replace the hazard with one that reduces the risk.** **Key mitigations:** This is not possible for healthcare to achieve as treatment needs to be carried out, so emphasis needs to be on the mitigating risks on other controls. However, some services may still consider the use of: Implementing virtual consultations (telephone or video) and offering these where appropriate to patients with a suspected or confirmed respiratory infection.				
Contracting or spreading coronavirus	Patients Staff Contractors	**ENGINEERING** **(Control, mitigate or isolate people from the hazard)**				

		Design measures that help control or mitigate risks, such as barriers, and screens. **Priority should be given to measures that provide collective protection rather than those that just protect individuals or a small group of people.** **Key mitigations:** Systems are in place to ensure: • Ensure adequate ventilation systems are in place i.e. Mechanical/or natural national recommendations for minimum air changes are met as defined for the care area. • Follow advice outlined in • HTM 03-01 Specialised ventilation for healthcare buildings • Identify areas (clinical and non-clinical) which are poorly ventilated or where existing ventilation systems are inadequate.				

		• Dilute air with natural ventilation by opening windows and doors where appropriate • If considering screens/partitions in reception/ waiting areas to ensure air flow is not affected and cleaning schedules are in place, consult with appropriate facilities teams • Where a clinical space has very low air changes and it is not practical to increase dilution effectively then consider alternative technologies with appropriate facilities team				
Contracting or **spreading SARs-CoV-2 and other seasonal respiratory infections**	Patients Staff Contractors	**ADMINISTRATIVE controls (Change the way people work)** **Administrative controls are implemented at an organisational level (e.g. The design, appropriate processes, systems and engineering controls and provision and use of suitable work equipment and materials) to help prevent the introduction of infection and to control and limit the transmission of infection in healthcare.** **Key mitigations**:				

		Systems in place to ensure that: • Triaging and testing within all health and other care facilities is undertaken to enable early recognition of SARs-CoV-2 and other infectious agents (e.g. Influenza and /RSV). • Maintaining separation in space and/or time between patients with or without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid cross-over of infectious and non-infectious patients. • There is provision of appropriate infection control education for staff, patients, and visitors. • The provision of additional hand hygiene stations (alcohol - based hand rub) and signage – to ensure good hygiene practices in staff, patients and visitors. • Ensure regular cleaning regimes are followed and compliance is monitored including shared equipment. • Staff and patients should comply with current public health measures including face coverings and physical				

		distancing measures and limiting the number of visitors as appropriate.				
Contracting or spreading SARs-CoV-2 and other seasonal respiratory infections	Patients Staff Contractors	**PPE/RPE** **(Protect the worker with personal protective clothing)** **PPE (Personal Protective Equipment)** **Employers are under a legal obligation – under the control of COSHH regulations, to adequately control the risk of exposure to hazardous substances where exposure cannot be prevented.** **PPE must** be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in **line with SICP's and TBP's (add Link)** **PPE should be considered in addition to all previous mitigation measures higher up in the hierarchy of controls.**				

		Key mitigations: Systems in place to ensure that: • There is adequate supply and availability of PPE including respiratory protective equipment (RPE), fluid resistant surgical masks, disposable gloves, aprons and gowns and eye/face protection to protect staff, patients and visitors. • All staff required to wear an FFP3 mask have been fit tested (this is a legal requirement). • Face masks/coverings should be worn by staff and patients in all healthcare facilities as per government guidelines • all staff (clinical and non-clinical) are trained in putting on, removing and disposing of PPE. • Visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance			
If transmission remains following this risk assessment, it may be necessary to consider the extended use of RPE (Respiratory Protective						

Equipment) (FFP3) for patient care in specific situations	

Reference: Coronavirus » Infection Prevention and Control supporting documentation (england.nhs.uk) page.

Compendium of guidance and resources: COVID-19. This contains the key COVID-19 documents relevant for England including the documents linked within this tool. This resource is update quarterly with settings specific guidance is highlighted within relevant sections of this document.

A full suite of COVID-19 infection prevention and control guidance for healthcare settings can be accessed here: COVID-19: infection prevention and control (IPC) - GOV.UK (www.gov.uk).