Bundle Public Board Meeting 31 March 2022

Agenda

Final Agenda Public_Board_Meeting_31 March_2022V3.docx

122 09:00 - Welcome, introductions and apologies:

123 Declarations of interest

124 Questions from members of the public

Minutes adoption for approval

125 Minutes of previous meeting and matters arising:

125.a 09:10 - Minutes of the meetings held on 4 February 2022

Item 125a Draft Public Board minutes 4 February 2022.docx

125.b Actions' log

Item 125b Public Board Actions log 31 March 2022.doc

126 09:15 - Patient's story video: Homeless Health Inclusion Team

127 09:35 - Guardian of safe working hours - quarterly report

Item 127 GoSWH Quarterly report March 2022_SM+SN.docx

128 09:45 - Chief Executive's report: including including verbal update on current system pressures

Item 128 CEO report Board March 2022.docx

129 09:55 - Committee Chairs' Assurance Reports:

129.a Nominations and Remuneration Committee: 25 February 2022

Item 129a N&R assurance report Feb 2022.docx

129.b Charitable Funds Committee : 25 February 2022

Item 129b CF assurance report Feb 2022.docx

129.c Quality Committee: 21 February and 21 March 2022

Item 129ci QC Chairs assurance report Feb 2022.docx

Item 129cii QC assurance report Mar 2022.docx

129.d Business Committee: 23 February and 23 March 2022

Item 129di BC Chairs Assurance report Feb 2022.docx

Item 129dii BC Chairs assurance report March 2022.docx

129.e Audit Committee: 11 March 2022

Item 129e AC Assurance Report 11 March 2022.docx

130 10:30 - Annual plan 2022-23

130.a Organisational plan (priorities) 2022/23

Item 130a Board Operational Plan (Priorities) 2022-23 V1.0 24 03.docx

130.b Revenue and capital budgets 2022/23

Item 130bi Finances cover paper.docx

Item 66P Financial Plan 2022 23 v6 for Private Board.docx

130.c Draft Key Performance Indicators for Performance Brief 2022/23

Item 130ci KPI cover.docx

Item 130cii Board KPI report March 22.docx

130.d Board Assurance Framework (BAF) - draft strategic risks 2022/23

Item 130d BAF 2022-23 Risk Review.docx

131 11:00 - Corporate governance

131.a Going concern statement - to approve

Item 131a Going Concern Consideration.docx

131.b Declarations of interest and compliance with fit and proper person requirements made by directors for 2021/22

Item 131b Directors declarations of interest (draft).docx

131.c Risk appetite statement

Item 131c Risk appetite statement review March 2022.docx

132 11:10 - Green plan

Item 132i Green Plan Cover paper.docx

Item 132ii Green Plan.docx

133 11:20 - Performance brief: February 2022

Item 133i PB Cover paper.docx

Item 133ii Performance Brief (Feb 2022) BOARD FINAL v2.docx

134 11:25 - Risk register and Board Assurance Framework report

Item 134 Significant risks and risk assurance report March 2022.docx

135 11:30 - Staff survey 2021

Item 135 Staff Survey Results 2021.docx

136 11:50 - Patient Safety Strategy Implementation update

Item 136 Patient Safety Strategy Update March 2022 Board.docx

137 12:05 - Any other business and questions on Blue Box items

138 Close of the public section of the Board

139 Blue Box Item: Digital strategy update - reviewed by Business Committee February 2022

Item 139 Digital Strategy Cover Paper and Content BC_Feb22.docx

140 Blue Box Item: Engagement strategy update - reviewed by Quality Committee March 2022

Item 140 Engagement Strategy Update Report.docx

141 Blue Box Item: Third Sector Strategy update – reviewed by Business Committee March 2022

Item 141i 3rd Sector Strategy UpdateCover Paper - March 2022.docx

Item 141ii 3rd Sector Strategy March 2022.pptx

142 Blue Box Item: Infection prevention control assurance framework - reviewed by Quality Committee March 2022

Item 142 IPC_BAF_0322 v1.0.docx

143 Blue Box Item: Board workplan

Item 143 Public Board workplan 2021-22 v8 08 02 2022.pdf

144 Blue Box Item: Approved minutes for noting

144.a Audit Committee: 10 December 2021

Item 144a AC Minutes 10 December 2021.docx

144.b Quality Committee: 24 January 2022 and 21 February 2022

Item 144bi QC minutes 24 January 2022_.docx

Item 144bii QC minutes 21 February 2022.docx

144.c Business Committee: 25 January 2022 and 23 February 2022

Item 144ci BC Minutes 26 January 2022.docx

Item 144cii BC Minutes Feb 2022.docx

NHS
Leeds Community Healthcare
NHS Trust

Agenda Trust Board Meeting Held In Public

Virtual meeting via MSTs

Date 31 March 2022
Time 9:00 – 12.10pm
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			Paper
2021-22 122	9.00	**Welcome, introductions and apologies:** *(Trust Chair)* Apologies: Ruth Burnett	**N**
2021-22 123		**Declarations of interest** *(Trust Chair)*	**N**
2021-22 124		**Questions from members of the public**	**N**
2021-22 125	9.10	**Minutes of previous meeting and matters arising** *(Trust Chair)* *For approval*	
125.a		Minutes of the meetings held on: 4 February 2022	**Y**
125.b		Actions' log: 4 February 2022	**Y**
2021-22 126	9.15	**Patient story (video) – Homeless Health Inclusion Team** *(Steph Lawrence)*	**N**
QUALITY AND DELIVERY			
2021-22 127	9.35	**Guardian of safe working hours - quarterly report** *(Dr Nagashree Nallapeta presenting)*	**Y**
URGENT DISCUSSION			
2021-22 128	9.45	**Chief Executive's report – including verbal update on current system pressures** *(Thea Stein*	**Y**
ASSURANCE			
2021-22 129	09:55	**Committee Chairs' Assurance Reports:**	
129a		Nominations and Remuneration Committee: 25 February 2022 *(Trust Chair)*	Y
129b		Charitable Funds Committee – 25 February 2022 *(Alison Lowe OBE)*	Y
129c		Quality Committee: 21 February 2022 and 21 March2022 *(Helen Thomson)*	Y
129d		Business Committee: 23 February 2022 and 23 March 2022 *(Richard Gladman)*	Y
129e		Audit Committee: 11 March 2022 *(Khalil Rehman)*	Y
BREAK			

APPROVAL/SIGN OFF			
2021-22 130	10.30	**Annual plan 2022-23:** a. Operational plan (priorities) 2022/23 b. Revenue and capital budgets 2022/23 c. Draft Key Performance Indicators for Performance Brief 2022/23 d. Board Assurance Framework (BAF) - draft strategic risks 2022/23	**Y** **Y** **Y** **Y**
2021-22 131	11.00	**Corporate governance:** a. Going concern statement – to approve b. Declarations of interest and compliance with fit and proper person requirements made by directors for 2021/22 c. Risk Appetite Statement	**Y** **Y** **Y**
2021-22 132	11.10	**Green plan** *(Sam Prince - presented by Peter Ainsworth and Harriet Jones)*	**Y**
QUALITY AND DELIVERY			
2021-22 133	11.20	**Performance brief:** February 2022 *(Bryan Machin)*	**Y**
2021-22 134	11.25	**Risk register and Board Assurance Framework report** *(Thea Stein)*	**Y**
2021-22 135	11.30	**Staff survey 2021** *(Jenny Allen/Laura Smith)*	**Y**
2021-22 136	11.50	**Patient Safety Strategy Implementation update** *(Steph Lawrence)*	**Y**
CLOSE			
2021-22 137	12.05	**Any other business and questions on Blue Box items** (Trust Chair)	**N**
2021-22 138	12:10	**Close of the public section of the Board** *(Trust Chair)*	**N**

Additional items (Blue Box)		
2021-22 139	**Digital strategy update** – reviewed by Business Committee February 2022	**Y**
2021-22 140	**Engagement strategy update** - reviewed by Quality Committee March 2022	**Y**
2021-22 141	**Third Sector Strategy update** – reviewed by Business Committee March 2022	**Y**
2021-22 142	**Infection prevention control assurance framework** – reviewed by Quality Committee March 2022	**Y**
2021-22 143	**Board workplan**	**Y**
2021-22 144	**Committee minutes – for noting** a) Audit Committee 12 December 2021 b) Quality Committee 24 January 2022 and 21 February 2022 c) Business Committee 26 January 2022 and 23 February 2022	**Y**

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (125a)

Title: Draft Trust Board meeting minutes 4 February 2022

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
	Professor Ian Lewis (IL)	Non-Executive Director
	Richard Gladman (RG)	Non-Executive Director
	Helen Thomson (HT)	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)
	Dr Ruth Burnett	Executive Medical Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Alison Lowe (AL) OBE	Non-Executive Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
	Diane Allison	Company Secretary
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	John Walsh	Freedom To Speak Up Guardian (for Item 115)
	Bridget Lockwood	Business Support Manager, Chief Executive and Chair's Office
Minutes:	Liz Thornton	Board Administrator
Observers:	None	
Members of the public:	None	

Item 2021-22 (102)
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 Board members and attendees to the meeting.

Apologies
Apologies were received and accepted from Alison Lowe (AL) OBE, Non-Executive Director, Jenny Allen, Director of Workforce, Organisational Development and System Development (JA) and Diane Allison, Company Secretary.

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:

The challenges the Trust faced were unrelenting. Staff were dealing with an enormous amount of pressure and continued to perform brilliantly. The Trust had prepared well for the extreme pressure over the Christmas holiday period. An effective set of measures had been put in place to meet the challenges around deployment issues, staff sickness and staff isolating due to covid. These included a set of temporary working arrangements, an associated staff incentive program and a staff welfare package. The Board had established and activated a program of assurance in respect of patient safety arrangements, through its committee structure and through targeted senior level direct involvement and inspection. The absolute priority had been the safe and proper treatment of patients together with the support and collaboration the Trust could offer to partner trusts and organisations across the City. The Trust had done an outstanding job, maintained vital services to its utmost ability and changed gear very effectively. He placed on record his thanks to all members of the Trust who had contribution to that success.

The Trust Chair observed that the agenda for this meeting focussed on staff and patient care issues and the need to be absolutely sure and assured that things are not being missed or ignored. Patient and staff care was above all other consideration, at this particular time.

The Trust Chair concluded by referring to the recently published NHS priorities for 2022/23. He said that healthcare in the community was clearly enunciated as one of the key priorities and the Trust should be the architects of as much of the new structure and associated practice as possible over the coming months and years for the good of the communities it served, and in support of the effectiveness of the system.

Item 2021-22 (103)

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

Item 2021-22 (104)

Discussion points:
Questions from members of the public
There were no questions from members of the public.

Item 2021-22 (105)

Discussion points:
Minutes of the last meeting, matters arising and action log
a) Minutes of the previous meeting held on 3 December 2021
The minutes were reviewed for accuracy and agreed to be a correct record.
b) Actions' log 3 December 2021
There were no actions on the log.

Item 2021-22 (106)

Discussion points:

Staff Story – Hilary's Story

The Executive Director of Nursing and AHPs introduced the story which had been pre-recorded and delivered as a video.

Hilary is 81 and following a road accident in 2018, she received care from both the Trust's Neighbourhood Teams and the Musculoskeletal and Rehabilitation Service (MSK). In her story she told the Board about her experience of accessing the MSK service; her reluctance to take up the offer of surgery; how to date steroid injections have kept her free from knee surgery and how exercises and walking a mile every day had kept her mobile. She said that she received a regular phone call from the physiotherapist who was overseeing her care to check on her progress, the effectiveness of the injections and whether she wanted to take up the continuing offer of surgery. She said that throughout her treatment everyone from the front of house staff to the clinical professionals had treated her with dignity and compassion. Overall, her experience of the Trust's services was a very positive one.

The Trust Chair invited questions from members of the Board.

Non-Executive Director (HT) was pleased to see that clinicians had maintained contact with Hilary by telephone in between face to face appointments. She asked how clinicians could help patients overcome their anxiety about surgery.

The Executive Director of Nursing and AHPs said that Hilary had a fear of surgery and how successful the subsequent rehabilitation process might be. She said that the MSK team were exploring options with her and working hard to explain how the Trust could support her care after surgery and during her rehabilitation journey.

The Trust Chair asked if maintaining contact with patients in between face to face appointments was a consistent approach across all the Trust's services.

The Chief Executive said that it was pleasing to see evidence of a personalised care approach and the Trust hoped to be able to extend this type of offer in future as part of continuing care package.

The Executive Director of Nursing and AHPs said that she would expect clinicians to focus and tailor their approach and support to meet the needs of the individual patient to achieve the right clinical outcomes. The extent of contact was variable across services in the Trust and could pose a challenge if services were under severe pressure.

The Trust Chair said that Hilary's story reflected very positively on the Trust's services and he extended his thanks to Hilary on behalf of the Board for taking time to record her video story.

2021-22 Item (107)

Discussion points:

a) Chief Executive's report – including update on current system pressures

The Chief Executive presented her report particularly highlighting:

- Annual Thank You awards
- The Trust's award of the Level Two Domestic Violence and Abuse Quality Mark (Children and Adults)
- 2022/23 operational planning guidance
- An update from the Youth Board

The Executive Director of Operations and the Executive Director of Nursing and Allied Health Professionals (AHPs) provided verbal updates on infection rates and current system pressures.

Omicron and current infection rates

- The Leeds infection rate had reduced to 1101 per 100k and was now described as the 'cruising rate' and unlikely to reduce for some time.

- Leeds over 60's rate was 459 per 100k.
- 101 patients in hospital had tested positive for Covid – a 50/50 split between patients admitted with Covid or tested positive whilst in hospital for other treatment. This was expected to reduce to 85 during week commencing 7 February 2022 which would allow some wards to revert back to general purpose use.

The level of operational pressure in the Trust had been deescalated but remained high at Opel level 3. Silver command meetings were scheduled for once a week.

Wetherby HM Young Offender Institution (HMYOI)
Pressure in HMYOI was very high due to a combination of increased clinical demand and staff capacity.

The Executive Director of Nursing and AHPs reported that three young people with very complex needs were of particular concern and had recently been placed under constant watch in the Unit. Two of the young people were female which had added pressure on staffing. She emphasised that responsibility for the constant watch intervention fell to the HM Prison Service staff and not staff working for the Trust.

In the last 24 Hours two of the young people had been transferred to hospital; one was awaiting surgery and one was awaiting the outcome of tests. Both could return to HMYOI at any time. One young person remained at HMYOI.

The Executive Director of Nursing and AHPs advised that the potential to offer incentives for staff to work additional shifts was under consideration and the option for additional staff to be recruited was being explored with NHS England as the commissioner of the service.

Associate Non-Executive Director (RB) asked what mix of staff delivered health care services in the Unit.

The Executive Director of Nursing and AHPs said that a mixed team of nurses (including paediatric, mental health and learning disability and adult nurses), healthcare assistants and pharmacy technicians provided healthcare, working 24 hours a day 7 days a week.

Associate Non-Executive Director (RB) noted that the Board had received previous reports about the Unit carrying a significant number of staff vacancies and the risk associated with this. She asked what progress had been made to recruit to the vacant posts.

The Non-Executive Director of Nursing and AHPs advised that current vacancies were being covered by agency staff where possible. A successful recruitment exercise had taken place and she hoped that substantive staff would be in place by the end of February 2022 once all the required checks had been completed.

The Executive Director of Operations said that under normal operational pressures sufficient staff were deployed to meet the needs of the young people. She added that HMYOI was not currently at full capacity but the presentation of these three young people with complex healthcare needs, two of which were female had added significant additional pressure and balancing staff capacity was a challenge.

The Trust Chair asked about the relationship with staff from HM Prison Service.

The Executive Director of Operations confirmed that the Trust had a good relationship with Prison Service staff at all levels and they were very supportive of the work provided by healthcare staff.

Non-Executive Director (IL) thanked both executive directors for providing a comprehensive update which he said provided assurance to the Board that the situation at HMYOI was being well monitored and managed. He asked what other contingency plans were in place if new equally complex cases presented in the near future.

The Executive Director of Nursing and AHPs said that the situation was being monitored carefully and additional resources could be drawn from specialist agencies, if necessary, at short notice. She was confident that any further increase in pressure could be managed and both she and the Executive Director of Operations would be on-call over the coming weekend to support the service if necessary.

Vaccine as a condition of deployment
The Chief Executive updated the Board about the Government mandate to require all healthcare workers to be double vaccinated against Covid-19 by 1 April 2022. The Secretary of State for Health announced on 31 January 2022 that the legislation requiring vaccination as a condition of deployment (VCOD) for healthcare workers is to be reconsidered. A two week consultation has been announced on ending VCOD, with a view to revoking the legislation, due to come into effect on 1 April 2022.

She said that for the Trust's staff working or deployed in CQC registered care homes, VCOD came into force on 11 November 2021 and whilst the understanding was that the planned review may also include the rules applying to both care homes and healthcare settings, this had not been formally confirmed. It was still therefore a legal requirement for staff entering care homes as part of their duties to be fully vaccinated unless exempt.

As a community healthcare provider, the Trust remained committed to encouraging vaccination to protect colleagues, families, and the most vulnerable people in society, however the deadlines which had been set for receiving the first dose of the vaccination by 3 February 2022 would not be taken forward.

The Chief Executive said that the Trust continued to approach this topic with the empathy, compassion, and integrity that staff would expect. Dealing with the emotional impact of the Government's change of direction would be challenging for both individual members of staff and managers who had had difficult conversations about vaccination status, and with staff who were anxious about working with colleagues who were unvaccinated.

The Trust acknowledged and valued personal choice and support offers remained in place to help staff decide whether to have the vaccine if they remained unsure. A letter would be sent to all staff to update them on the current position, remind them about the support in place for them. The Chief Executive and the Director of Workforce and Organisational Development (JA) would be holding a Live Event on 10 February to allow staff to ask questions anonymously if they wished.

Non-Executive Director (RB) asked how the Trust was preparing for the Public Inquiry into the Covid-19 pandemic.

The Chief Executive advised that the Company Secretary had already undertaken a piece of work to facilitate preparation for the Trust's possible involvement in the Inquiry, which was expected to start in the Spring of 2022. Along with the Executive Director of Finance and the Company Secretary, she had attended a series of webinars designed to help NHS organisations plan for the forthcoming Inquiry.

No further questions were raised.

Outcome: The Board:

- received and noted the Chief Executive's report and the update on system pressures.

Item 2021-22 (108)

Discussion points:
Assurance reports from sub-committees
a) Audit Committee 15 October 2021
Non-Executive Director (KR), Chair of the Committee presented the report and highlighted the key issues namely:

- **Internal Audit:** the Committee noted progress with the 2021/22 internal audit plan. The Internal Auditors confirmed that good progress was being made against the plan and they were confident that they would be able to provide an audit opinion at the end of the year.
- **Risk Appetite Statement:** the Committee reviewed the statement and had a mixed view on the 'minimum' risk appetite applied to risks that could compromise the delivery of high quality safe services. The Committee had asked the Senior Management Team (SMT) to give this further consideration prior to it being received at Board in March 2022.
- **Proposed changes to Standing Financial Instructions:** the Committee had endorsed a recommendation that the Board approve an amendment which would improve decisions related to the recruitment process to avoid long gaps between staff leaving and new staff joining the Trust.
- **Information Governance Update:** the Committee received an update on the progress being made on the Data Security and Protection Toolkit.

b) Nominations and Remuneration Committee 17 December 2021

The Trust Chair, Chair of the Committee presented the report and highlighted the key issues namely;

- **The Real Living Wage:** the Committee approved the payment of the Real Living Wage where appropriate to members of staff currently on Agenda for Change band 2. For the members of band 2 affected by this the award would be backdated to November 2021 when the last uplift to the Real Living Wage was published nationally.
- **Very Senior Managers (VSM) pay benchmarking:** the Committee received a paper relating to VSM benchmarking against both national and local individual organisation information. The Committee made several recommendations in respect of VSM pay following consideration of the information.

b) Quality Committee 24 January 2022

Non-Executive Director (HT), Chair of the Committee presented the report and highlighted the key issues discussed, namely:

- **Neighbourhood Team Model Transformation Project:** the Committee noted that some elements of the project had been paused due to operational pressures but some areas such as podiatry and referrals from Primary Care had made good progress.
- **Covid 19:** the Committee received an update on current system pressures and infection rates.
- **Safe Staffing Report:** the Committee received a comprehensive bi-annual report. The Committee requested that future reports should connect with risks that were not at a level to be reported in the risk register report.
- **Patient experience and engagement:** the Committee received a report that provided data on the Trust's statutory requirement in relation to complaints. Members supported the work planned to ensure that the voice of patients and the community was heard and evidenced more clearly in future reports.
- **Assurance on strategic risks:** members had reviewed the levels of assurance against the strategic risks assigned to the Committee and agreed that the level assurance for each one was reasonable. This was pleasing given the pressures and challenges the Trust was currently facing.

c) Business Committee 26 January 2022

Non-Executive Director (RG), Chair of the Committee presented the report and highlighted the key issues namely:

- **Third Sector Strategy:** the Committee noted that a full report on progress and updated action plan would be available for the meeting in March 2022.
- **Business Intelligence Strategy:** the Committee had considered the draft presented in detail and recommended its approval by the Board on 4 February 2022.
- **Health and Safety Compliance Report:** the Committee received a report which contained information on the current level of compliance with health and safety legislation and policies as well as an update on the developments and effectiveness of the Trust's health and safety management system. The Committee noted that progress had been impacted by the pandemic and staff pressures.

- **Assurance on strategic risks:** members had reviewed the levels of assurance against the strategic risks assigned to the Committee and decided that the level of assurance for most was reasonable. Risk 3.5 related to embedding a suitable health and safety management system and had been assessed as limited.

Non-Executive Director (IL) said that he would welcome sight of the updated Third Sector Strategy and queried whether it would be shared with the Quality Committee as well as the Business Committee and more regularly with the Board.

The Executive Director of Operations said that currently the Third Sector Strategy was presented to the Business Committee and subsequently to the Board twice each year, but she would review the frequency of reports and where it was presented in future.

Action: Presentation of the Third Sector Strategy to committees and Board to be reviewed.
Responsible Officer: Executive Director of Operations

Outcome: The Board

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

Item 2021-22 (109)

Discussion points:

Business Intelligence Strategy

The Executive Director of Finance and Resources presented the strategy for approval. He said that the aspiration for the strategy was to put high quality data and intelligence at the heart of the Trust's decision making process to deliver the best possible care to every community it served.

He said that the strategy had been the subject of wide consultation and previous drafts had been reviewed by the Business Committee, Quality Committees and the Senior Management Team. The strategy presented for approval reflected the comments made.

Non-Executive Director (IL) suggested the strategy should make more reference to the importance of clinical leadership and engagement and in particular the role of the Chief Clinical Information Officer.

The Executive Medical Director said that Dr Rob Arnold currently held the position of Chief Clinical Information Officer alongside his role as Deputy Medical Director in the Trust. The Trust was considering whether the role of Chief Clinical Information Officer should be a standalone post.

The Executive Director of Finance and Resources agreed to review the strategy with a view to strengthening the references to clinical leadership and the role of the Chief Clinical Information Officer.

Non-Executive Director (RG), Chair of the Business Committee said that the Committee had recommended the Board approve the Strategy. He said that next steps would be to develop a change plan to underpin its implementation and work alongside service colleagues to develop a system which would support an improved data structure for each service.

The Board noted that additional resources would be required to support implementation of the strategy. The level of investment would be subject to prioritisation discussions in advance of 2022/23 budget approval.

Outcome: The Board

- approved the Business Intelligence Strategy subject to references to clinical leadership being strengthened and the additional resources required to support implementation been identified and agreed.

Item 2021-22 (110)

Discussion points:

Proposed change to Standing Financial Instructions

The Executive Director of Finance and Resource presented the paper that proposed a change to the Standing Financial Instructions. The change was recommended to the Board for approval by the Audit Committee on 10 December 2021.

He explained that the Trust needed to respond flexibly to the resourcing challenge of ensuring as many staff are employed as total funding permits. It has been identified that the Standing Financial Instructions needed to change as outlined in the paper to allow more flexibility on recruitment and to clarify the meaning.

Outcome: The Board

- accepted the Audit Committee's recommendation and approved the changes to the Standing Financial Instructions as set out in the paper.

Item 2021-22 (111)

Discussion points:

Chief Executive and Chair's action- e-Community allocation software

The Executive Director of Finance and Resources presented a paper that asked the Board to ratify a decision approved by the Chair and Chief Executive in January 2022 in consultation with two non-executive directors, both members of the Business Committee.

The decision related to the purchase of a digital allocation solution (Allocates's eCommunity software solution) that will help digitally automate the scheduling of visits within the Neighbourhood Teams.

Outcome: The Board

- ratified the decision to purchase the e-Community Allocation software.

Item 2021-22 (112)

Discussion points:

Performance Brief and Domains Report: December 2021

The Executive Director of Finance and Resources presented the report that provided information on quality, performance, compliance and financial matters for the nine months to December 2021. In light of the silver command response to the Omicron wave, the report provided only the Key Performance Indicators (KPIs) tables.

It was planned to bring a full report to the committees and Board in March/April 2022 when performance against the KPIs for the eleven months to February 2022 would be considered.

Finance

The Executive Director of Finance and Resources provided a brief verbal update on the latest position and year-end update. A detailed presentation had been made to the Business Committee on 26 January 2022. The update included information about the planned utilisation of financial resources across the Trust and across Leeds over the remainder of the financial year.

He advised the Board of some changes to the information presented at the last Trust Board meeting about the plans to manage resources and the potential for more changes as resources were managed across the Integrated Care System and all its partner organisations. There was potential for a small surplus to remain in the Trust at the year-end. The Trust remained on course to meet all its statutory financial duties for the 2021-22 financial year.

There were no questions raised about the performance pack.

Outcome: The Board:

- received the report and the information presented on quality, performance, compliance and financial matters for the nine months to December 2021. Noting that, in light of the Silver Command response to the Omicron wave, the report provided only the Key Performance Indicators (KPIs) tables.

Item 2021-22 (113)

Discussion points:

Significant risks and Board Assurance Framework (BAF) report

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 Board noted changes to the risk register as follows:

- There was one extreme risk scoring 16 currently on the risk register
  - Risk 1002 Coronavirus (Covid 19) increased spread of infection
- There were six risks scoring 12 (very high). One of these had recently been added to the risk register:
  - Resuscitation training skill compliance
- One risk had been de-escalated from a score of 12
  - Inability to deliver services at Wetherby Young Offenders Institute due to reduced staffing levels.

Outcome: The Board

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

Item 2021-22 (114)

Discussion points:

Patient experience: complaints and concern report

The Executive Director of Nursing and AHPs presented the report which provided a six-monthly update on patient experience within the Trust. The information also incorporated the data around the Trust's statutory requirements in relation to complaints.

The Trust Chair asked what plans the Trust had to ensure the views and voices of patients and the wider community was strengthened in future reports.

The Executive Director of Nursing and AHPs said that the Quality Committee had discussed how the Trust could ensure there was a greater focus on hearing all voices about its services and developing alternative ways of collecting patient experience feedback alongside the Friends and Family Test. The Committee had supported the plan for a workshop in Spring 2022 with external partners, including Healthwatch and service users to hear people's voices more widely in addition to the work undertaken by service level patient engagement champions.

The Board noted that the current Patient Involvement Strategy was due for review in 2022 and the Chair requested an update on this be provided as soon as it was available.

Non-Executive Director (HT) suggested that the review should include more reference to engaging and making connections with the Primary Care services.

Non-Executive Director (IL) suggested that the review should also consider how learning from complaints could be effectively shared and embedded across all the Trust's services.

The Executive Director of Nursing and AHPs said that both these suggestions would be considered as part of the review, and she would welcome the involvement of Board members as part of the process.

Outcome: The Board:

- received and noted the report.

Item 2021-22 (115)

Discussion points:

The Freedom to Speak Up Guardian (FTSUG) presented the report which provided an overview for the period 6 August 2021 to 4 February 2022 and this included a record of the work of speaking up at the Trust and across the wider system.

The FTSUG reported that the role was working well and that he received strong support from the Chief Executive, Chair and directors including the Non-Executive Director Champion for FTSU.

The FTSUG said that the feedback from staff in the Trust using the FTSU route was very positive about the support it offered, how it enables their voice to be heard and how the Trust's leadership quickly starts to respond to issues. The majority of cases raised were resolved to the satisfaction of staff and manager. Some were very difficult to fully resolve due to different perspectives, the complexity of the concerns and concerns which were multi-layered.

The FTSUG worked regionally through the Freedom To Speak Up Regional Network for Yorkshire and the Humber and with the National Guardian Office in developing speaking up in the wider health and care system. The work supporting Freedom To Speak Up Guardians at Leeds City Council continued and was moving towards recruitment and work supporting Leeds General Practice continued with Leeds CCG and the Leeds GP Confederation.

The Trust Chair observed that the report demonstrated the powerful impact of the work undertaken by the FTSUG within the Trust and he commended the support being offered to external partners which was leading to wider national recognition. He also welcomed the peer review of the freedom to speak up work in the Trust by Locala in 2022-23.

Non-Executive Director (HT) asked how new colleagues in the Trust were made aware of the role of the FTSUG.

The Chief Executive said that she spoke about speaking up at each induction session and a film about the role of the FTSUG was also shared.

The Board placed on record its thanks to the FTSUG for his exceptional commitment to this important work and for presenting such a comprehensive report.

Outcome: The Board:

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

Item 2021-22 (116)

Discussion points:

Any other business including questions on Blue Box items

Non-Executive Director (RG) asked for an update on the opening of the Children and Young Peoples Mental Health Service inpatient unit at Red Kite View and sought assurance that the interplay between this service (provided by Leeds and York Partnership NHS Foundation Trust (LYPFT)) and the community based child and adolescent mental health services (CAMHS) provided by the Trust had not been adversely affected by the transfer.

The Chief Executive said that the transfer had gone very smoothly and the CAMHS pathways were all working well. It was agreed that a formal update would be provided to the Quality Committee.

There were no questions raised on any items in the Blue Box.

Item 2021-22 (117)

Discussion points:

Close of the meeting

The Trust Chair closed the meeting at 11.30am

Date and time of next meeting
Thursday 31 March 2022 9.00am-12.00 noon
Both virtual meeting and live streamed

Additional items (Blue Box)	
2021-22 (118)	Mortality Report Quarter 3 2021-22 – reviewed by Quality Committee January 2022
2021-22 (119)	Serious Incidents Report - reviewed by Quality Committee January 2022
2021-22 (120)	Safe Staffing Report - reviewed by Quality and Business Committee January 2022

2021-22 (121)	Committee minutes for noting: a) Audit Committee – 15 October 2021 b) Quality Committee –22 November 2021 c) Business Committee –24 November 2021

AGENDA ITEM 2021-22 (125b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 31 March 2022

Agenda Number	Action Agreed	Lead	Timescale	Status
4 FEBRUARY 2022				
2021-22 (108)	**Business Committee assurance report:** Presentation of the Third Sector Strategy to committees and Board – frequency to be reviewed.	Executive Director of Operations	To be agreed Post meeting	Update on 31 March 2022

Actions on log completed since last Board meeting on 4 February 2022	
Actions not due for completion before 31 March 2022; progressing to timescale	
Actions not due for completion before 31 March 2022; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding at 31 March 2022; not having met agreed timescales and/or requirements	

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (127)

Title: the Guardian of Safe Working Hours - Quarter 3 Report 21.22

Category of paper: For assurance

History: N/A

Responsible director: Executive Medical Director

Report author: Guardian of Safe Working Hours

Executive summary (Purpose and main points)

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

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

Main issues for consideration

- The progress made with Red kite view CAMHS ST Inpatient unit non-resident on-call cover and CAMHS ST Community on-call rota
- On going discussion to address CAMHS ST historic rota compliance issues.
- Improved engagement with Junior Doctors in the Junior Doctor Forum (JDF)

Recommendations

Board is recommended to:

- Receive this assurance regarding plan in place for addressing issues related to CAMHS current rota and historic rota compliance issues.
- Support GSWH with the on-going work related to CAMHS ST historical rota compliance issue
- Support GSWH for joint working with LYPFT and LTHT team to improve training opportunities in LCH

Quarterly Report of the Guardian of Safe Working Hours

1.0 Purpose of this report

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

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

2.0 Background

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

3.0 Quarterly report of guardian of safe working hours

There are currently 23 Junior Doctors employed throughout the Trust (in different specialities, both fulltime and less than full time training) as detailed in the table below. This includes Junior doctors employed directly by LCH and on honorary contracts.

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

3.1 **Rota gaps and CAMHS ST rota**

The CAMHS ST rota consists of a 1:5 rota, and gaps on this rota are covered by locums, typically doctors who have worked on the rota in the past or doctors currently working for LCH who are willing to do extra shifts. Gaps occur due to long term vacancies, staff who are not working full time or when staff take leave. A system has been put in place to check and ensure the Locum shifts picked up by Junior doctors (who are currently on the rota) do not breach the Junior doctors' terms and conditions of hour worked. This is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota.

GSWH was unable to prepare a quarterly overview of the CAMHS ST gaps and cover arrangements over the periods of Dec 2021 to Feb 2022 due to challenges in obtaining the data. CAMHS ST locum cover arrangement was done by CAMHS trainees (with oversight from CAMHS consultant and clinical lead) and this system recently moved to CAMHS admin team. Due to this changeover, it was difficult for CAMHS team to provide with breakdown of CAMHS ST gaps and internal/external cover arrangements for the last three months. Going forward this has now been rectified and the GSWH will be able to review the hours worked by internal locums in LCH.

In the last year it has become apparent that there has been no monitoring of the hours worked by doctors in training for a few years. An exercise was carried out to monitor the out of hours worked in Autumn 2021. This has resulted in changes in the rota pattern of the doctors, with regular time off put in place due to the workload. This new rota was constructed with the help of LYPFT to ensure compliance with the rules around junior doctor working.

Following the monitoring exercise issues have been raised about the payment of junior doctors in LCH for a few years, there are plans in place to explore this and the implication for the staff and the service. We are ensuring that reliable systems are in place going forward to ensure that the rota reflects the hours worked and is compliant with regulations around this.

A doodle poll is in the pipeline to identify a suitable date for the initial meeting to support and address these issues in depth with relevant staff members (CAMHS manager, CAMHS medical lead, HR team, DME, DMD, GSWH and BMA).

3.2 **Exception reports**

One exception report was filed during this Quarter. This was filed on 05/01/22 by CAMHS ST Junior doctor. The exception report was due to workload intensity due to a busy on-call and lack of cover from specialist practitioner and lack of support from Core trainee who was on-call. The ST junior doctor was not able to get adequate rest during non-resident on-call, they should get five hour of uninterrupted sleep per night as part of a non-resident on-call. The issue was brought to the attention of clinical supervisor and GSWH and the Junior doctor took the time off as expected. GSWH highlighted this issue to the LYPFT trust who employ the Specialist practitioner, the issue was

related to core trainee competencies and training in CAMHS and this was highlighted to LYPFT, clinical lead in CAMHS and DME for further support for the ST on-call with limited cover/support from CT/specialist practitioner.

3.3 **Fines**

No fines levied by the GSWH.

3.4 **Feedback from trainees**

Junior Doctors Forum (JDF) was held on 26/01/2022. The date was selected as an outcome from a doodle poll based on the date and time with maximum number of trainee's availability. Attendance and engagement from Junior doctors continues to improve in JDFs.

The GSWH from LCH invited their counterpart from LYPFT and medical education lead from LYPFT to join the JDF in LCH, in view of the shared rota for CAMHS trainees. It was a useful platform to discuss the CAMHS trainee on-call and rota issues. There was written and verbal feedback from Junior doctors regarding the usefulness of the JDF to voice their issues that span between both Trusts. The LCH Head of Medical Education updated trainees around the plans for use of the remainder of Fatigues and Facilities funding for additional laptops – this was money awarded centrally in 2020 to support doctors in training experience. The JDF, GSWH and BMA all agreed with the proposal, noting it has been a challenge to find other acceptable ideas to use the remaining funds.

Head of Medical education updated to have the new software Doctors toolbox going live from 1st April. This will be useful to streamline the induction process for new doctors in LCH and for exception reporting.

The LNC trainee representative role is currently vacant (from Feb 2022) due to the current post holder being on maternity leave. GSWH is working with the BMA to draft the Junior doctor forum constitution and encourage Junior doctors to come forward to take up the post of LNC trainee representative. This was discussed in January JDF and will be further addressed in April JDF.

3.5 **Update from the BMA**

BMA Updated regarding the Junior doctors Wellbeing and Leadership Charter at JDF. LCH are very keen to support both the Leadership Charter which aims to expose doctors in training to leadership opportunities in the NHS and the wellbeing charter with the caveat that not all of the points raised can be implemented in a smaller, community trust.

4.0 Impact

4.1 Quality

This report has been informed by discussions with Junior doctors, supervisors, CAMHS Medical Lead, Head of medical education, JNC, GSWH and medical education team from LYPFT and information from HR and guidance received from NHS employers and Health Education England.

4.2 Community Paediatric Training

Exception reports related to missed educational opportunities in community paediatrics remains to be low. GSWH continues to support training opportunities for paediatric Junior doctors and has used the paediatric departmental induction meeting as a platform to engage with junior doctors to understand the impact of on-calls on training. GSWH's attendance in departmental induction has been appreciated by College tutor and induction lead.

As community paediatric trainees work on call in LTHT any issues related to the hours they work on-call or rota issues are managed within LTHT.

GSWH has offered to attend the Junior doctors forum in Leeds Teaching Hospitals NHS Trust (LTHT) to advocate for Junior doctors in community training and has worked with LCH paediatric college tutor, LTHT rota co-ordinators to work around the impact of on-calls on paediatric training.

4.3 Red Kite View CAMHS inpatient unit

Red Kite view is the new CAMHS in-patient unit and this is managed by LYPFT trust. Previously, the CAMHS in-patient unit was under LCH NHS Trust, based at Littlewood house hall and was covered by the CAMHS ST who covered non resident on-call for both Littlewood house hall and community CAMHS. There was uncertainty with junior doctors non resident on call cover as Red Kite view unit is larger and busier due to new intensive care unit and this would impact on the non resident cover and the workload. Discussions took place between both Trusts (with input from the medical director, the GSWH, DME and CAMHS Medical Lead during changeover to ensure a safe system was put in place for Junior doctors covering this resident on-call.

There is significant progress made around this issue and Red Kite view CAMHS inpatient unit on-call is now staffed by CAMHS ST junior doctors on a separate on-call rota and they will only cover the unit during the on-call time. This is organised and managed by LYPFT trust.

5.0 Recommendations

Board is recommended to:

- Receive this assurance regarding plan in place for addressing issues related to CAMHS current rota and historic rota compliance issues.

- Support GSWH with the on-going work related to CAMHS ST historical rota compliance issue

- Support GSWH for joint working with LYPFT and LTHT team to improve training and impact of on calls on training opportunities in LCH

Trust Board meeting held in Public: 31 March 2022

Agenda item number: 2021-22 (128)

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:

- Fuel cost challenges
- Covid-19 vaccination mandate
- Leeds Health and Care Partnership update

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 Update on current system pressures

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

3 Fuel costs

Rising fuel costs have led to multiple concerns being raised by LCH staff who are often undertaking considerable business mileage in the course of their duties. These concerns are replicated in many Trusts across the country, particularly in community services requiring daily business travel.

LCH to date has used NHS national mileage rates for staff business mileage expenses. These have not altered since 2014.

LCH has engaged nationally with the NHSE/I People Directorate and with NHS Employers, to ensure LCH's mileage circumstances and staff perspectives are able to contribute to ongoing national considerations on this topic.

In the meantime LCH, like a number of other Trusts, is proposing local action to increase mileage rates, pending the confirmation and implementation of a national solution. This kind of local action, agreed in partnership with staff representatives, is permissible under NHS Employers guidance.

The local increase will be applied from 1 April 2022, and the possibility of backdating to 1 February 2022 is being considered.

LCH is also proposing to consult on a revision to the methodology for calculation of business journeys beginning or ending at an employee's home; in response to the changed (reduced) patterns of employee attendance at contractual bases at the beginning and end of the working day.

4 Covid-19 vaccination mandate

On 15 March 2022 all legislation requiring vaccination as a condition of employment for healthcare workers was revoked. This removed the requirements already in place in care homes, as well as those due to come into force on 1 April 2022. Information on the outcome of the Vaccine Mandate Parliamentary review was shared with all employed staff on 2 March 2022, with a range of mechanisms utilised to ensure the message was cascaded widely. Staff were encouraged to

discuss this with their line managers and raise any further queries via a central, dedicated email address. To date, no queries have been received.

The redeployment workstream has stopped. There were no individuals in in any formal process. Implementation of the November 2021 Care Home Regulations resulted in temporary adjustment of duties for around 20 staff across the Trust. Individuals have been supported by Heads of Service and the HR Business Partners to enable a return to usual duties. Recruitment processes (including advert templates and pre-employment checks) have been updated in light of the revocation of VCOD implementation. New recruits are advised that the Trust continues to support vaccination as the most important defence against the virus to protect vulnerable patients and staff.

5 CEO and senior team visits

Members of the Senior team continue their regular visits and meetings to frontline services including those under particular pressure such as neighbourhood teams and health visiting teams. There are no key themes or issues to highlight to the Board.

6 Leeds Health and Care Partnership

Recruitment for the two Independent Members of the Leeds Health and Care Partnership (the Leeds Committee of the West Yorkshire Integrated Care Board (WY ICB)) has now taken place, with two appointments made. Interviews for the Independent Chair have also taken place, but no appointment was made, and the post will be readvertised.

A Place Based Partnership operating model is being finalised alongside communication and engagement tools which will be used to help describe the main commissioning changes to staff and people before they come into effect this summer. The Leeds Health and Care Partnership and associated Population Boards and Care Delivery Boards are already starting to meet in shadow form and are making the move towards more place based/ population focussed commissioning. In addition, NHS England and the Local Government Association are supporting Leeds' participation in a Place Development Programme which will support us in transforming our partnership arrangements to becoming even stronger as we move into the new arrangements from July 2022.

7 Board workshop 4 March 2022

A Board workshop was held on 4 March 2022 with topics including Health Equity and the Trust's priorities for the coming year.

The Health Equity workshop asked the Board and wider management group to consider how our policies support us to address inequities in access throughout a patient's journey from referral to treatment.

At the workshop, the Board and wider management group also established what the Trust's proposed priorities for 2022/23 should be. This included a review of NHS

England's 2022/23 Planning Guidance, an understanding of the regional and local context, the Trust's vision and strategic objectives, and a thematic review of the three Business Unit's plans. The draft annual plan, including the 2022/23 priorities is included in the Board papers for approval.

8 NHS Rainbow Badge Initiative Phase 2

Since 2019, the Trust has been a proud member of the Rainbow Badge Initiative, designed to promote the equality and inclusion of the LGBTQIA+ community. After successful application, we have been selected to be one of only 40 NHS Trusts to pilot the NHS Rainbow Badge Phase II which has moved from a pledge-based system to an assessment model (Bronze, Silver, Gold).

As part of the assessment process, we submitted the following policies for review:

- Adoption Policy
- Special or Compassionate Leave Policy
- Maternity Policy
- Paternity Policy
- Shared Parental Leave Policy
- Trans inclusion policy
- Uniform/dress code policy
- Discrimination, bullying and harassment policy

Following this, we will launch the NHS Rainbow Badge services survey for completion by service managers. NHSEI will assess our submitted evidence together with the results from all three surveys and will then request any evidence they require for the assessment process to determine our Bronze, Silver or Gold grading and the next steps for performance improvement.

9 Developing Links With Children`s and Young People`s Third Sector Groups

Links with a number of 3rd sector Children`s and Young People`s groups have been made and there is now an agreed procedure for approaching and involving them around consultations to develop services provided by the Children`s Business Unit (CBU). An involvement toolkit that is being developed that will give an overview of involvement within CBU, including how we involve 3rd sector groups and the practical steps of how this takes place.

10 Leeds Academic Health Partnership Review

The Leeds Academic Health Partnership (LAHP) is a collaborative partnership between Leeds' universities, local NHS organisations, Leeds City Council, Leeds City College, the regional health and care partnership, the regional economic enterprise partnership, industry and third sector organisations. It was established to drive innovation which transforms the health and wellbeing of the people of Leeds.

The LAHP has recently reviewed its priorities to ensure it continues to align with and best support its core partners' evolving strategies. There were several reasons for the review:

Reducing health inequalities, building an inclusive economy, tackling climate change and addressing the many pressures exacerbated by the pandemic have all come into sharper than ever focus over the last 18 months. At the same time, across the city, region and nation, there is preparation for changes to organisational structures in health and regional governance. Following the UK's EU exit, there is an emerging, new policy context in health, innovation and research.

Following the review, the LACP strongly reaffirmed its collective commitment to and value of the partnership in the City.

The LACP has agreed to work in partnership on these three strategic priorities:

- health innovation and economic development
- partnership in research
- partnership in workforce

Through collaboration across and beyond the City, the LACP's ambition is to improve the health, wellbeing and prosperity of all communities and especially reduce inequalities, by taking a whole system approach and utilising its unique academic and economic strengths.

11 Donations for Ukraine and support for asylum seekers

Many members of staff have been keen to help with the humanitarian crisis as people are fleeing Ukraine. Arrangements have been for donations of urgent supplies to be delivered to Poland. Members of staff have been working alongside the Polish Centre in Leeds to help with donations received.

We have been working with Leeds and York Partnership NHS Foundation Trust (LYPFT) to set up a number of drop off sites across Leeds for donations of toiletries, clothing, bed sheets and unused medical supplies. We hope to include out of date supplies such as bandages from our sites and patients, although medicines are not being accepted (the Department of Health and Social Care is co-ordinating this). Staff have also been asked to consider supporting the charity Positive Action for Refugees and Asylum Seekers (PAFRAS) in Leeds who offer support and advice for all refugees and asylum seekers.

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022
Agenda item number: 2021-22 (129a)

Title: Nominations and Remuneration Committee – 25 February 2022
Chair Assurance Report

Category of paper: for assurance
History: n/a

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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting held on 25 February 2022 and it indicates the level of assurance based on the evidence received by the Committee.

Please note that the last regular quarterly meeting of the committee was held in December 2021.

Items discussed:

Gender Pay Gap Report:
The Director of Workforce highlighted some main points from the report which was drawn from available data in March 2021, and which the Trust was obliged to publish at the end of March 2022.

The report and assurance statement were approved for publication.

Clinical Excellence Awards:
The committee considered a paper relating to the allocation of Clinical Excellence Awards for 21/22 and according to national guidance.

The committee approved the proposed allocation and eligibility criteria set out in the paper.

Committee Review of Annual Report, Reviews of Performance and Terms of Reference:
The committee considered the above items, ratifying the Terms of Reference for the coming financial year and approving the Annual Report.

The committee also discussed its effectiveness and considered several points of feedback raised in the questionnaires submitted.

Recommendations

The Board is recommended to note this information.

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (129b)

Title: Charitable Funds Committee Chair's Assurance Report 25 February 2022

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

Charitable Funds Committee Chair's Report

1 Executive summary

The Charitable Funds Committee is a subcommittee of the Trust Board. The Trust Board members collectively act as the agent for the corporate trustee (Leeds Community Healthcare NHS Trust) for the Leeds Community Healthcare Charity.

The Committee oversees the strategic direction of the LCH Charity and provides information and assurance to the Trust Board following each quarterly meeting. This report identifies the key issues for the Board from the Committee meeting held on 25 February 2022.

Items discussed:

1.1 Charitable Funds Administrator

The Charity's administrator left the Trust at the end of December 2021. The post was advertised but unfortunately there were no applicants. The operational group and ongoing work is currently paused as there is no capacity to absorb this within the directorate.

The Committee received a paper from the Executive Director of Nursing and AHP's outlining the current situation and a proposal that to ensure the charity continues to try and raise funds it would be a fundraiser that is required, rather than an administrator.

The paper outlined the case for this and gave the costing of just over £25,000 per annum.

The committee debated this and were reminded by the Executive Director of Finance of the financial risks of this post. However, the Committee agree that without this post the charity would not be able to move forward.

At the meeting, the Committee agreed on balance to recommend to the Board that the post is advertised for a fixed term period of 1 year with a clear review at 6 months with an exit plan agreed at that stage if fundraising is not going to meet the required levels. One of the stipulations of the post would be to as a minimum raise enough money to cover the cost of the post.

Following the meeting and further discussion between the Executive Director of Finance and the Executive Director of Nursing and AHPs, there has been a decision taken to pause this post and a further conversation will be held at the next Committee meeting in June 2022.

Prior to the June 2022 meeting further information regarding the reserves policy for charitable funds and the responsibility of Trustees will be provided and can then be debated further at that meeting. Trust Board will receive a further update following the next Committee meeting.

1.2 Finance Report

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

1.3 Committee's Draft Annual Report and Terms of Reference

The Committee agreed its draft annual report and terms of reference. These will be submitted to the Audit Committee in April 2022 for scrutiny.

2 Recommendations

The Board is recommended to note the information provided in this report.

Trust Board meeting held in public:

Agenda item number: 2021-22 (129ci)

Title: Quality Committee Chair's Assurance Report 21 February 2022

Category of paper: For Assurance

History: N/A

Responsible director: Quality Committee Chair

Report author: Assistant Director of Nursing & Clinical Governance

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Executive summary:
This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 21 February 2022, and it indicates the level of assurance based on the evidence received by the Committee. This meeting was held by MS teams.

Recommendations:
The Board is recommended to note this information.

Items discussed:

QAIG verbal update
A deep dive took place last week exploring and comparing patient safety incident data over the past 24 months. This identified trends in incident reporting and work was agreed to further review teams where trends of low or high incident reporting was noted. The QAIG paper will be circulated to Committee members for further information.

Covid-19 update
The Committee heard that Covid-19 rates across Leeds are decreasing, with reducing numbers of people requiring hospital admission and therefore some limited recovery of elective surgery procedures. Outbreaks in Care Homes were noted to have reduced significantly and positive feedback from Healthwatch regarding IPC input to Care Homes throughout the pandemic was acknowledged.
It was recognised that a system wide impact remained, with Covid-19 related absences across health and social care workforce, an increased demand through the hospital and in Primary Care and the Trust remained at OPEL level 3.
A system visit took place last week from the national team concluding that a comprehensive community offer was available. National recommendations are expected to come from this national work in due course.
A discussion took place regarding the national changes in mass testing and isolation. This is being monitored however it is not expected significant changes will take place across the NHS IPC requirements. Likewise, national guidance is still awaited in relation to the vaccination of children.

Closed culture
The Committee heard whilst there have been very few Quality walks this last quarter, leaderships visits have continued, and senior clinical staff have been more visible in services. As a result, there are currently 3 services within the Trust that are being monitored more closely for closed cultures and specific visits or attendance at team meetings is being arranged to monitor this further. A conversation is taking place this week to co-ordinate the re-commencement of the Quality walks.
In the meantime, specific questions have been incorporated into the Quality Walk template to explore potential triggers for closed cultures which received positive acknowledgement from Committee. It was suggested that the Trust should consider how this culture is considered and monitored along a spectrum. The Committee also heard about the work progressing with the Foundation of Nursing Studies, and specifically their support in 'Creating Caring Cultures'. It was agreed feedback to Committee will continue through the Quality Walk updates.

Cancelled and rescheduled visits
A verbal update was provided by the Executive Director of Nursing and Allied Health Professionals regarding the daily data reviewed and local escalation process where clinical visits are unable to be undertaken. It was reported that there is no significant variation across Neighbourhoods with the number of cancelled visits being minimal. A further position was agreed to return to Committee in May 2020.

Neighbourhood Transformation project update
The SRO provided a progress update on the Performance and Outcomes workstream established as part of the Neighbourhoods transformation programme. Progress against the

overall aim of developing a simple and accessible performance / operational management dashboard, based on existing data, was provided. Committee requested further consideration of themes / categories to ensure an effective and user friendly system for all staff.

Update on CAMHS pathway following CAMHS Tier 4 transfer
A verbal update was provided by the Executive Director of Operations regarding the current challenges with recruitment at Red Kite View. The lack of progress with recruitment to these posts has resulted in the unit being able to open all beds including the PICU beds. This has resulted in some young people having to move out of area. It was noted however the Section 136 suite was working well.

An update was provided in relation to the Trust's recruitment challenges to the posts within the transitions business case, specifically the Psychiatrist and Psychologist posts. Quality Committee will continue to be apprised of this situation.

Mortality report: themes in deaths under 65s
Following a request from January Quality Committee, the Executive Director of Nursing & AHPs confirmed a review of the increasing number of deaths in the under 65's did not identify any themes or trends and that the cause of death has predominantly been related to long term conditions. Further analysis may be possible following the publication of the national excess death data.

Service spotlight: CIVAS
The Committee heard from the service lead regarding a cluster of separate incidents of upper arm Deep Vein Thrombosis (DVT) in patients with a Central Venous Access Device receiving care within the service. Committee heard the data around the incidence of upper arm DVTs and the exploration that has taken place in relation to different practices across the Integrated Care System footprint. Committee heard how the team became curious after one incident and commenced partnership working after the second incident. This resulted in quality improvement work and the service developing a Standard Operating Procedure (SOP), in partnership with LTHT, to ensure patients are seen as soon as possible when a DVT is suspected, and this has been demonstrated through early diagnosis and treatment of subsequent cases. Committee heard how there is still work to do, given the incidence and level of clinical risk, and potential research opportunities to understand the significance of this cluster of incidents. It was agreed Committee would receive a further update given the quality and safety implications.

Schedule of KPIs
The proposed KPI schedule for 2022/23 was presented to Committee acknowledging the ongoing work in the performance and outcomes dashboard to have a framework of indicators from KPIs to service level data. Committee members challenged the balance of measures within each domain and the requirement for Committee to hear about successes as well as challenges. Committee requested to see the breadth of data within the context of specific escalations from QAIG. Following a lengthy conversation agreement was made to undertake a further review of the indicators with Business Units giving consideration of system measures / indicators and how to incorporate a health equity lens before returning to Committee for approval.

Quality Account 1st draft
The first draft of the 2021/22 Quality Account was received by Quality Committee with a clear emphasis on the intended inclusion of stories and videos. Committee members felt this was progressing in the right direction and welcome the further iteration back to Committee in April.

Risk Register
The paper was presented by the Company Secretary who noted 2 escalated risks, 2 de-escalated risks and 2 closed risks since last Committee. The Executive Director of Nursing

& AHPs confirmed the increased risk related to constant supervision of young people at WYOI has now reduced and will be reflected within the next report.
Positively, the previous telephony system risk in Sexual Health was reported to have progressed with movement to an LTHT operator system which informs callers they are in a call queue. Three additional reception staff have also been recruited to in order to understand the subsequent demand as it is expected callers will hold to be answered and resource will be aligned once the regular demand is better understood.
Concerns were acknowledged in relation to the newly identified cyber-threat risk and Committee were keen to be kept informed.

Safeguarding strategy update
The update paper was presented by the Executive Director of Nursing & AHPs. Committee were pleased to see the progress, despite the pressures that had remained over the past 6 month period.

Strategic internal audit plan
The paper was presented by Sharron Blackburn from Audit Yorkshire, the Trust's new internal auditors and designated audit manager. The proposed framework for audits through 2022-2026 was shared in the paper. Discussion took place to clarify the flexibility of the plan to enable any additional internal audit requirements to be addressed in a timely manner. Committee were happy to support the proposed plan as it stands with the caveat of the need for flexibility as quality issues arise.

Learning and development strategy update
The paper was presented by Executive Director of Nursing & AHPs and received positively by Committee members.

Integrated Care Steering group progress
Further to the update received by Committee in January, a verbal update was provided by the Executive Director of Nursing & AHPs to confirm integration work has continued through various projects, ahead of the group reconvening in March 2022. This included work in relation to Care Home populations; Frailty; Advanced clinical practitioner and ARRs roles across PCNs and the expansion of integrated wound care clinics.

The Quality Committee provides the following levels of assurance to the Board on these strategic risks	Risk score (current)	Agenda items reviewed	Overall level of assurance provided	Additional comments (and any areas for consideration for internal strategic audit)
RISK 1.1 The risk that the Trust does not have **effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards**	**12 V High**	• Risk register report • Safeguarding strategy update • Mortality report: themes in deaths in under 65s • CIVAS: DVT incident trend and improvement actions • QAIG meeting feedback	Reasonable assurance	Limited assurance was agreed in relation to CIVAS spotlight. Whilst this showed positive partnership working in response to an incident trend, further work is required in relation to the clinical risk – potential future audit or research opportunity Draft KPI schedule received, and lengthy discussion took place. Acknowledged comments have been taken to re-shape and reform the schedule
Risk 1.2 The risk that there are insufficient Are there **sufficient clinical governance arrangements in place for new care models?**	**9 High**	• Integrated Care Steering Group: update on progress • Update on CAMHS pathways following CAMHS T4 transfer	Reasonable assurance	Limited assurance was agreed in relation to the CAMHS pathway given the quality impact on recruitment challenges
RISK 1.3 The risk that the Trust does not maintain **and continue to improve service quality**?	**8 High**	• Covid-19 update: current pressures • Cancelled and rescheduled visits • Neighbourhood transformation project update • CIVAS: DVT incident trend and improvement actions • Learning and Development Strategy update • Risk register report	Reasonable assurance	See above re CIVAS limited assurance

		• QAIG meeting feedback		
RISK 1.4 The risk that the Trust does not **engage with patients and the public effectively?**	**12 V High**	No specific items relevant to this risk are on the agenda		
RISK 1.5 The risk that the Trust's **altered (Covid) capacity** will **affect the quality** of service delivery and patient outcomes	**12 V High**	• Covid-19 update: current pressures • Risk register report	Reasonable assurance	

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (129cii)

Title: Quality Committee Chair's Assurance Report 21 March 2022

Category of paper: For Assurance

History: N/A

Responsible director: Quality Committee Chair

Report author: Assistant Director of Nursing & Clinical Governance

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Executive summary:
This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 21 March 2022, and it indicates the level of assurance based on the evidence received by the Committee. This meeting was held by MS teams.

Recommendations:
The Board is recommended to note this information.

Items discussed:

Covid-19 update
The Committee heard that Covid-19 rates across Leeds are increasing again, with increasing numbers of people requiring hospital admission and increasing pressure across the system. The Trust are seeing an increase in Covid related staff sickness.
Today sees the start of the Spring booster campaign encouraging people over 75 and severely immunocompromised to receive a fourth dose. As Elland Road closes this week, the vaccination centre home is moving to Woodsley Health Centre with pop-ups and outreach from there.

Service spotlight: WYOI including feedback from the CQC inspection
The presentation was delivered by the Clinical Head of Service in relation to the 24-hour healthcare provided by the Trust to both WYOI and Adel Beck, with a sub-contracted arrangement with SWYFT for Mental Health care. It was noted there has been an increasing complexity of the young people being admitted over recent years.
Committee heard about the positive initial feedback from the January 2022 CQC inspection. This included acknowledgement of the infrastructure to building strong partnership working. Difficulties with staffing were acknowledged in the presentation and within the CQC visit where effective mitigation was recognised.
Incident themes were discussed with abuse to staff and self-harm, followed by medication related incidents as the two greatest incident categories. Medication incident trends were well understood by the presenter and safety improvements were discussed. Significant increase in self-harm incidents were noted in May and June 2021 and these related to a small number of young people with complex mental health needs awaiting a specialist bed within the Mental Health system. This also occurred at a time when the admission of female young people was introduced in to WYOI.
Conversations concluded that further exploration of Mental Health care for individuals prior to offences would be helpful information to influence care pathways as well as sharing young people's experiences of the youth and justice system to influence national systems and processes. The service will consider these.

Performance Brief (this paper is on the Board agenda)
Presented by the Executive Director of Nursing and Allied Health Professionals (AHP) the report provides quantitative data supported by narratives. Information in relation to early learning and improvements from a Category 4 Pressure Ulcer at Seacroft Neighbourhood Team were noted.
Medical devices incidents, related to bio-connectors were noted and the Committee were assured that the Trust Medical Devices Safety Officer is developing more robust systems for inventories, incident reviews and incident reporting.
It was acknowledged that, in addition to FFT data, the Trust were to consider ways to feedback other means of patient experience and feedback. People with a long wait to be seen in Community Gynaecology, detailed within the report were confirmed to have been seen.

Clinical Governance report
The bi-monthly report was presented by the Executive Director of Nursing and AHPs. Committee were pleased to hear of the improvements in safety processes and to see the development of the nurse apprenticeship roles within the Trust.

Discussion with regard the Community Dental Service (CDS) allowed Committee to hear the Trust have recruited to a full-time dentist who is due to take up position in early summer. It was agreed a paper for CDS presented to the Adults, Health and Active Living Scrutiny Board working group providing details on how the Covid pandemic impacted the service and the current position in relation to waiting times will be shared with Committee ahead of more detailed paper on the Dental Transformation Programme later in the year.

Neighbourhood Triangulation report
A Comprehensive quarterly report was presented by the Executive Director of Operations. Committee heard that the Trust are working with a noted capacity gap despite an increase in self-management facilitators and non-registered staff and a step change in demand. It was noted that a step change increase in referrals from Primary Care and hospitals occurred in April 2020, which has been sustained. It is expected this will continue and will be addressed in an integrated manner. It was confirmed the Neighbourhood transformation project will provide a re-calibration of staffing requirements and will also take account of skill mix and how the Trust works differently. This will not necessarily resolve a capacity gap due to national shortages in available professionals.
The report provided evidence that appraisal rates have increased since introducing the abridged appraisals.
Increased sickness rates were in part related to work related stress and long Covid.
Assurance was provided in relation to managerial processes for supporting colleagues on long term sick leave.

Operational Plan (Priorities) 2022/23 (this paper is on the Board agenda)
The paper was presented by the Business Planning Manager and Head of Clinical Governance who provided an update following the Trust Board workshop on the Trust four Strategic Goals with the underpinning proposed Trust Priorities. Committee were pleased to see the linkage to strategic priorities and the Board Assurance Framework risks. The focus on all communities was well received and believed to capture the Board workshop conversations well.

Risk Register
The thematic paper was presented by the Company Secretary who noted 1 escalated risk related to IT support desk capacity, 1 de-escalated risks in relation to health records and 1 closed risk since last Committee related to patient safety incidents. Committee received the paper and had no further questions.

IPC Assurance Framework (please see Board paper in the Blue Box).
The 6 monthly update on the IPC assurance framework was presented by the Executive Director of Nursing & AHPs. This identified the limited assurance around centrally held fit testing records and noted the ongoing work to ensure a more robust process.
Ongoing work in relation to the Implementation of the National Cleaning Standards, due November 2022, were also recognised. Committee received the update.

Asymptomatic staff testing
The paper was presented by the Deputy Medical Director who reported that testing was well embedded in the organisation with the number of people opting out being minimal. Since the move to a national reporting system, Committee heard how the Trust have been unable to access local data.
Concerns are being managed in relation to accessing LFTs at the end of the month. The Trust have confirmed staff will not be expected to pay for tests, however it was noted guidance on national arrangements for accessing kits for health and social care staff was still awaited. ***Committee will recommend to the Board that it ceases reporting on asymptomatic testing due to the inability of accessing local reliable data.***

Patient Group Directions
The paper presented by the Deputy Medical Director was ratified by Committee

Clinical Audit Plan
The paper presented the audit programme plan for 2022/23 was introduced by the Executive Director of Nursing & AHPs. The impact of Covid-19 was noted, with a request for outstanding plans to be submitted within the next 6 weeks, to ensure inclusion in the forthcoming year's audit activity. Committee accepted the proposed programme.

Patient Led Assessment of Care Environment (PLACE) summary
The report, presented by the Executive Director of Nursing & AHPs informed Committee that due to the Covid-19 pandemic there have been no PLACE inspections undertaken since 2019. Due to changes within the Trust over this time a voluntary assessment took place at Hannah House, which is the only in-patient service in the Trust at this point. Committee noted the report and recommendations.

Engagement strategy update (please see Board paper in the Blue Box).
The paper, presented by the Executive Director of Nursing & AHPs provides an update on the work to date as part of the year 2-year operational plan of the strategy. Maintenance of progress was noted. The Committee was supportive of the planned working group in April 2022 with partners, to strengthen a renewed strategy, due this year. It was suggested the strategy would benefit from more thought about how people can influence their own journey and national direction of services.

Quality Committee Annual report
The paper presented by the Assistant Director of Nursing and Clinical Governance fulfils the annual review of the Trust governance process by reviewing the Committee's annual activity and reviewing the terms of reference. It was agreed that the quality of papers would be considered in Committee reflections. Committee approved the paper for Audit Committee as a good reflection of the work undertaken by the Committee. Committee also endorsed the amendments to the terms of reference prior to Board approval.

Board Assurance Framework activity report
Presented by the Company Secretary this report provided a summary of the five strategic risks the Committee is charged with providing assurance to the Board on and demonstrates the extent to which each risk has been considered by Committee. The report provided an improved situation regarding the number of levels of assurance provided for Risk 1.2 New Care Models clinical governance. It was agreed that there was value in the process to review BAF risks and the report was accepted by Committee.

Safeguarding Committee minutes
Committee were informed of the recognition of the work in Leeds in relation to the standard of Child Protection Medicals against The Royal College of Paediatrics (2021) guidance.

The Quality Committee provides the following levels of assurance to the Board on these strategic risks	Risk score (current)	Agenda items reviewed	Overall level of assurance provided	Additional comments
RISK 1.1 The risk that the Trust does not have **effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards**	**12 V High**	• Performance Brief (effective) • QAIG Key issues / assurance report • Clinical Governance Report • Risk register report • Quality, staffing and finance: triangulation (NTs) • IPC Assurance framework • Our secure estate - WYOI • Clinical Audit • Closed culture feedback	Reasonable assurance	
Risk 1.2 The risk that there are insufficient **clinical governance arrangements in place for new care models**	**9 High**	*There were no items on the agenda that related to this risk*		
RISK 1.3 The risk that the Trust does not maintain **and continue to improve service quality**	**8 High**	• Reset and Recovery update • Covid update • Performance Brief (safe) • QAIG Key issues / assurance report • Clinical Governance report • Safeguarding Children's and Adult's Group: minutes • Risk register report • IPC Assurance framework • Our secure estate - WYOI	Reasonable assurance	Good level of assurance from WYOI presentation. Awaiting formal report for WYOI CQC report for further assurance.
RISK 1.4 The risk that the Trust does not **engage with patients and the public effectively**	**12 V High**	• Performance Brief (caring) • QAIG Key issues / assurance report • Engagement strategy update report • PLACE report	Limited assurance	Work in progress to improve assurance in relation to patient engagement / experience
RISK 1.5 The risk that the Trust's **altered (Covid) capacity** will **affect the quality** of service delivery and patient outcomes	**12 V High**	• Covid-19 update • Reset and Recovery update • Performance Brief • Clinical Governance report • Risk register report • NHS asymptomatic staff testing • Quality, staffing and finance: triangulation (NTs)	Reasonable assurance	Whilst acknowledged staffing resource is not where need to be and has potential safety implication, Committee received assurance this is being monitored and any risk mitigated.

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (129di)

Title: Business Committee Chair's assurance report 23 February 2022

Category of paper: For assurance
History: Not applicable

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

Executive summary (Purpose and main points)
This report identifies the key issues for the Board from the Business Committee held on 23 February 2022 and provides assurance on how well its strategic risks are being managed. The level of assurance is based on the information in the papers and other information received and the Committee's discussion.

Items discussed:

Covid and system pressures, including back log situation
The Committee was advised of the current situation, including infection rates and hospital occupancy rates. Pressures on the health system, including our own services, continues.

The Committee received a paper on key themes from a recent stocktake of waiting times. The paper also highlighted several services where additional focus was required to tackle the backlog. Reports can now be generated that split the patients waiting for care into populations by ethnicity and deprivation, and these reports will be used alongside backlog modelling to ensure that at risk groups are not further disadvantaged by recovery approaches. Discussions continue with each service to agree a recovery plan and realistic timescales for improvement. The current waiting lists are being validated both from a Service and Business Intelligence perspective with a view to a comprehensive report being presented to Business Committee in March 2022.

Digital strategy
The Committee agreed that the strategy was moving the digital agenda in the right direction. It was suggested that there should be a greater emphasis in the digital roadmap on transforming patient care and a recognition of digital exclusion. It was recommended that there should be discussion with the Leeds Place Based Partnership and wider Integrated Care System on how more support could be provided. Concerns were raised about the interoperability of systems across organisations.

KPIs (draft)
The Committee was provided with the proposed list of indicators to be included in the 2022/23 Performance Brief and was advised that the list included KPIs in the NHS England System Oversight Framework. The Committee discussed how the Board could be assured that performance information was being reviewed at different levels throughout the organisation so that there was a good understating of what was on and wasn't on track, as not everything needed to be reviewed at Board and committee level. It was suggested that evidence should be collated of where service level indicators were discussed with a view to either removing some of the indicators from the performance brief or reporting them less frequently.

Strategic Internal Audit Plan 2022/23
The Committee welcomed the representative from the Trust's new internal auditors, Audit Yorkshire, who presented the strategic internal audit plan for 2022/23. The Committee was advised that there had been engagement with the Senior Management Team in the production of the draft plan. The Committee was assured that whilst it was a three-year plan, the plan could flex as required if additional or alternative internal audits were needed.

The Committee agreed that it was a logical and comprehensive plan. The plan is to be presented at Audit Committee in March 2022 for approval.

There was discussion about aligning workforce resourcing information to provide a holistic view of workforce capacity. The Director of Workforce advised the committee that several types of absence would affect service capacity. Workforce modelling was being currently being reviewed to account for all these scenarios to predict and monitor their impact.

Internal Audit report – Emergency Response Planning
The Emergency Response Planning audit obtained a reasonable assurance opinion. There were three routine recommendations and some good practice identified.

Workforce Strategy – inclusion
The Committee received a presentation on the Workforce Strategy's inclusion theme, and an update on the specific objectives within this theme. This included information, actions, and progress on inclusivity for race, disability and sexual orientation. The Committee discussed how the Trust could learn from good practice elsewhere, including the support that was available from third sector partners. The Committee recognised the hard work involved in pushing forward the inclusion agenda, the achievements so far, and the desire to make a difference.

Recommendation:

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

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

The Business Committee provides the following levels of assurance to the Board on these strategic risks	Risk score (current)	Agenda items reviewed	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 2.1 The risk that the Trust does not deliver on its **major change programmes**	**9 High**	• Estates management report • Digital strategy update	Reasonable	
RISK 2.3 The risk that the Trust is not **improving productivity, efficiency and value for money**	**9 High**	• Digital Strategy update report	Reasonable	
RISK 2.6 The risk that the Trust is not investing in and creating the **capacity and capability** to respond to the increasing dependency on **digital solutions**	**12 V High**	• Digital Strategy update	Reasonable	
RISK 3.1 **The risk that** the Trust does not have **suitable and sufficient staff capacity and capability** and is it maintaining a low level of **sickness absence**	**12 V High**	• Covid update / system pressures (verbal) including backlogs/hot spots • Workforce focused topic: Diversity and Inclusion • Risk register report	Reasonable	The Committee agreed that the Trust is doing all it can to manage this risk. The Committee was further assured by the information received about the review of workforce modelling to include various types of absence
RISK 3.3 The risk that the Trust does not **engage with and involve staff**	**9 High**	Workforce focused topic: Diversity and Inclusion	Reasonable	

RISK 3.6 The risk that the Trust is not maintaining **business continuity** in the event of significant disruption	**12 V High**	• Covid update / system pressures (verbal) including backlogs/hot spots • Risk register report • Internal audit report - EPRR	Reasonable	

The following BAF risks assigned to the Business Committee for scrutiny can probably not be evaluated at this meeting as there does not appear to be any specific items on the February 2022 agenda that relate to these risks:

RISK 2.2 The risk that the Trust does not deliver its **contractual requirements**
RISK 2.5 The risk that the Trust does not deliver on its agreed **income and expenditure** position
RISK 3.4 The risk that the Trust is not investing in developing **managerial and leadership capability**
RISK 3.5 The risk that the Trust does not develop and embed a suitable **health and safety management system**
RISK 4.2 The risk that the Trust does not have robust agreements and clear **governance arrangements for complex partnership** arrangements

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (129dii))

Title: Business Committee Chair's assurance report 23 March 2022

Category of paper: For assurance
History: Not applicable

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

Executive summary (Purpose and main points)
This report identifies the key issues for the Board from the Business Committee held on 23 March 2022 and provides assurance on how well its strategic risks are being managed. The level of assurance is based on the information in the papers and other information received and the Committee's discussion.

Items discussed:

Covid and system pressures update
The Committee received an update on the local situation including current infection rates, the system challenges, and the latest information on the vaccination programme. A similar update will be provided to the Board at its next meeting.

Capital and Revenue Budgets (this paper is on the Board agenda)
The Committee reviewed the revenue expenditure budget and the capital budget. The Executive Director of Finance and Resources described the context in which the budget had been set, and the risks associated with it. The Committee recognised the uncertainty of the current financial planning context. The Committee agreed to recommend that the Board should approve the budgets.

Annual Plan (priorities) 2022/23 (this paper is on the Board agenda)
The Committee reviewed the proposed priorities and agreed that they were appropriate, although it did suggest some alterations to the way they were worded. The Committee will recommend that the Board approved the annual plan.

Service focus: Risk and Safety Team
Representatives from the Risk and Safety Team joined the Committee meeting to present information about the team's responsibilities and activities, the challenges presented in particular by the pandemic in relation to health and safety regulatory requirements and how the Trust had complied with these, the improvements made since the Health and Safety Executive inspection, the current risk and issues, and an indication of the maturity of the Trust's Health and Safety culture. The team also listed the areas they would be focussing on for the year ahead. It was agreed by the Committee that the Trust senior leadership needed to do more to embed a strong safety culture amongst all staff.

Performance Brief (this paper is on the Board agenda)
The Committee was advised that there were reduced sickness absence levels in February, however Covid absence continues. Staff turnover has been increasing, although the rate slowed during February. The Committee discussed the reasons why staff may be leaving the Trust, the value of independent exit interviewers, and ways of retaining staff when they may have 'itchy feet'.

Waiting List Position
The Committee received an update on the work being done to validate waiting lists, recovery plans, and the consideration being given to health inequity when prioritising the waiting lists. The report focussed on the services where challenges remained. The Committee was advised work continued to explore different ways of working to manage demand, and the need to balance this with staff's health and wellbeing. The Committee agreed that the report provided a good overview of the difficult situation, recognising that

demand was increasing in some services which put further pressure on waiting list management.

Third Sector Strategy update (please see Board paper in the Blue Box).
The Committee reviewed the 'Plans on a page' that described the current activities where the Trust had partnered with Third Sector organisations. The three main pieces of work where there was Third Sector partnership working were: improving accessibility in health centres for the visually impaired, involving children from the Gypsy and Traveller communities in the Youth Board, and the Enhance programme which aims to support discharge and reduce admissions.

Board Assurance Framework (BAF) summary of Committee's activity
The Committee received a report that demonstrated the extent to which each strategic risk has been considered by the Business Committee since it had adopted the revised assurance process in July 2020. The Committee noted that some strategic risks have not had many assurance levels assigned to them during this period. These were BAF risk 3.4 Management/leadership capability, and BAF Risk 4.2 Partnership governance arrangements. The Committee agreed to review its workplan and incorporate more items that can provide assurance on these two strategic risks. The Committee was also supportive of having a new strategic risk included in the BAF that described the current and future challenges associated with managing backlogs/waiting lists.

Business Committee's annual report and review of terms of reference
The Committee reviewed and approved its annual effectiveness report and agreed some minor changes in its terms of reference, for which it will seek approval at the Board meeting in May 2022.

Recommendation:

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

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

The Business Committee provides the following levels of assurance to the Board on these strategic risks	Risk score (current)	Agenda items reviewed	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 2.1 The risk that the Trust does not deliver on its **major change programmes**	**9 High**	• Priority Projects list	Reasonable	
RISK 2.2 The risk that the Trust does not deliver its **contractual requirements**	**6 Moderate**	• Performance brief (waiting times, KPIs against financial penalties) • Neighbourhood team triangulation report • Operational and non-clinical risks register	Reasonable	
RISK 2.3 The risk that the Trust is not **improving productivity, efficiency and value for money**	**9 High**	• Priority Projects list • Performance Brief	Reasonable	
RISK 2.5 The risk that the Trust does not deliver on its agreed **income and expenditure** position	**6 Moderate**	• Performance Brief (Finance) • Budget 2022/23	Reasonable	
RISK 3.1 **The risk that** the Trust does not have **suitable and sufficient staff capacity and capability** and is it maintaining a low level of **sickness absence**	**12 V High**	• Performance Brief (turnover and stability) • Covid update / system pressures • Neighbourhood Teams triangulation report • Third Sector Strategy report	Reasonable	The Committee was assured that the Trust is managing the aspects of this risk that are within its control
RISK 3.5 The risk that the Trust does not develop and embed a suitable **health and safety management system**	**12 V High**	• Health and Safety Group annual effectiveness report • Performance Brief (staff RIDDOR incidents)	Limited	The Committee recognised that whilst there was significant work being done by the

		• Performance Brief (statutory mandatory H&S training compliance) • Health and Safety Group minutes • Service focus: Risk & Safety Team		Risk and Safety Team, a cultural change was needed across the organisation in order to make sustained improvements.
RISK 3.6 The risk that the Trust is not maintaining **business continuity** in the event of significant disruption	**12 V High**	• Performance Brief (Reset and Recovery) • System pressures update • Risk register report	Reasonable	
RISK 4.2 The risk that the Trust does not have robust agreements and clear **governance arrangements for complex partnership** arrangements	**9 High**	• Risk register report • Third sector strategy report	Reasonable	

The following BAF risks assigned to the Business Committee for scrutiny were not evaluated at this meeting as there were no specific items on the March 2022 agenda that related to these risks:

RISK 2.6 The risk that the Trust is not investing in and creating the **capacity and capability** to respond to dependency on **digital solutions**
RISK 3.3 The risk that the Trust does not **engage with and involve staff**
RISK 3.4 The risk that the Trust is not investing in developing **managerial and leadership capability**

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (129e)

Title: Audit Committee Chair's Assurance Report 11 March 2022

Category of paper: for assurance
History: Not applicable

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

Meeting summary

Internal audit (TIAA)

The Committee noted progress with the 2021/22 internal audit plan. The Committee discussed the executive summary and strategic findings for the four audits completed since the last Committee meeting. These were General Data Protection Regulation (substantial assurance), Key Financial Systems (reasonable assurance), Quality Challenge (reasonable assurance), Emergency Planning Response (reasonable assurance).

The Committee was advised that the service-related audits that had not been possible to complete (Wetherby Young Offenders' Institute and Police Custody Suites) would be picked up in the 2022/23 audit plan.

The Committee noted sufficient progress had been made against the 2021/22 internal audit programme for the internal auditor to provide an interim opinion. The internal auditor said that his overall interim opinion was there was reasonable assurance that there was generally a sound system of internal control.

External audit strategy memorandum (Mazars)

The Committee received the external auditor's strategy for the year ending 31 March 2022 which had been prepared following initial planning discussions with management. The document summarised Mazars audit scope, approach and timeline. It highlighted significant audit risks and areas of key judgements and provided the details of the audit team. From the work that had already begun, the external auditors confirmed that there were no matters that it wished to bring to the Committee's attention.

Annual report and accounts 2021/22

The Committee were advised of the Trust's progress with the Trust's annual report, accounts and associated activities. All activities were proceeding to schedule.

Going Concern statement

The Director of Finance and Resources presented the going concern paper for consideration by the Committee. The Committee considered the matters in the paper and with an awareness of all relevant information it concluded that there were no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern. The Committee will recommend to the Board that when approving the annual accounts, it does so in agreement that the Trust is a going concern.

Information Governance Update

The Committee noted the progress being made on the Data Security and Protection Toolkit. The baseline submission had been submitted by the deadline of 28 February 2022. The Trust is working towards achieving compliance with all the mandatory assertions by the final submission date 30 June 2022. The Committee was advised of additional submissions to the baseline required by NHS Digital in response to the increased cyber security risk resulting from the war on Ukraine. The Trust had submitted its additional responses and would continue to assess actions and mitigations to the risk.

Internal Audit draft strategic plan 2022/23
The Committee reviewed and approved the internal audit strategic plan 2022/23 which had been drafted by Audit Yorkshire. The plan included increased days over that tendered for to enable the service-based audits deferred from 2021/22 to be undertaken.

Assurance
The Audit Committee has been assigned BAF risk 2.4: 'If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber-attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage'. The Committee recognised that the risk was currently heightened, and that additional demands were being made to ensure it was being adequately controlled. Having reviewed all the information presented, the Committee agreed that it provided reasonable assurance that the risk was being managed adequately.

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (130a)

Title: 2022/23 Operational Plan (Priorities)

Category of paper: For approval
History: Board workshop, 4th March 2022. SMT, Quality Committee and Business Committee, March 2022.

Responsible director: Chief Executive
Report author: Executive Director of Finance and Resources, Business & Planning Manager and Head of Clinical Governance

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Executive summary

The purpose of this report is to present to SMT the draft 2022/23 operational plan which outlines the strategic framework for 2022/23. This includes the Trust vision, ambition, strategic goals and proposed priorities for 2022/23.

Our Trust vision is that '**we provide the best possible care in every community'** and is underpinned by our four Strategic Goals. This year we have developed our Key Priorities to directly align to and provide evidence in the achievement of a Strategic Goal. However, whilst the Priorities are aligned to a specific goal, they have been developed with a cross cutting intention to support achievement of the other goals.

Our four Strategic Goals with the underpinning proposed Trust Priorities are:

- Strategic Goal - To deliver outstanding care,
    - **We will be responsive to the needs of our populations as we continue to rebuild our services back better.**

- Strategic Goal - Use our resources wisely and efficiently.
    - **We will continue to rebuild our services with a focus on our waiting list backlogs through continuous improvement.**

- Strategic Goal - Ensure our workforce community is able to deliver the best possible care in all of the communities that we work with
    - **We will support our workforce to recover and flourish, with enhanced focus on resourcing and health & wellbeing.**

- Strategic Goal - To work in partnership to deliver integrated care, care closer to home and reduce health inequalities
    - **We will work pro-actively across all the communities we serve to improve health outcomes.**

The document in Appendix 1 aims to provide a cohesive overview of how each of our proposed priorities supports both the achievement of a strategic ambitions and evidence how we mitigate risk.

Time has been allocated at SMT on 6th April 2022 to discuss how we will aim to achieve the priorities; SMT will identify the specific actions underpinning each priority.

Recommendation

Board is asked to provide feedback on the contents of the paper and approve the proposed Trust Priorities for 2022/2023.

1 Introduction

The annual planning and commissioning process for the financial year 2022/23 recommenced in December 2021. However, due to the continuing pressures of the COVID-19 pandemic the planning was completed later than in previous years and the LCH Board workshop to identify the 2022/23 Trust priorities was delayed until 4th March 2022.

The aim of the workshop was to develop the Trust's key priorities, informed by the National, Regional and Leeds Place based context, and to ensure they were coherent with the organisations Business Unit and Corporate Team's Business plans for the coming year which outline the ambitions of our services in this coming year.

A proposition was made in the workshop, for formal consideration by Board, to align this and future years Trust Priorities directly to the Strategic Goals to demonstrate how LCH is working to achieve its strategic ambitions.

In addition, as the Board Assurance Framework is aligned to the Strategic Goals, the BAF will now also align with the Trust Priorities and progression against the Priorities will evidence mitigation of the organisation's risks.

The detail underpinning the proposed Trust Priorities is detailed in Section 6 and is derived from the feedback from the Board workshop. Time has been allocated at SMT on 6th April 2022 to discuss how we will aim to achieve the priorities; SMT will identify the specific actions underpinning each priority.

2 Context

On 24 December 2021, NHS England and NHS Improvement (NHSEI) released its operational planning guidance for 2022/23, including its nine priorities for the NHS which informed the board workshop alongside regional and local intelligence.

The priorities are similar to those outlined for the second half of 2021/22 but do include important differences. One of the most significant points to note is the delayed implementation of integrated care systems (ICS) from 1 April 2022 to 1 July 2022. Current statutory arrangements will remain in place until July and LCH will continue to work with its Leeds Place partners and the West Yorkshire & Harrogate ICS during this continued preparatory period.

The national priorities for 2022/23 are:

A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.

E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

Across all these areas, we must maintain a focus on preventing ill-health and tackling health inequalities and be responsive to the needs of our local population.

3 Trust Priorities

Our Trust vision is that '**we provide the best possible care in every community'** and is underpinned by our four Strategic Goals. This year we have developed our annual Trust Priorities to align and evidence progression towards our Strategic Goals, and in addition to provide evidence of risk mitigation for the Board Assurance Framework.

Our four Strategic Goals with the underpinning proposed Trust Priorities, identified at the board workshop, are detailed below.

Strategic Goal - To deliver outstanding care

Trust Priority: We will be responsive to the needs of our populations as we continue to rebuild our services back better.

The conversation focussed upon the need to: support services to understand their health equity performance data to develop strategies to reduce health inequity, and promote continuous improvement through the provision of support for key enabling projects.

Strategic Goal - Use our resources wisely and efficiently

Trust Priority: We will continue to rebuild our services with a focus on our waiting list backlogs through continuous improvement

The discussion at board focussed on consideration of ensuring the right offer to our patients at the right time and right place. Key areas for SMT to consider when setting the supporting actions include: working with partners to deliver integrated pathways and challenge areas of duplication or gaps in service provision, adopting a standardised approach to waiting list management, safeguard our patients whilst they are on our waiting lists, and supporting delivery of person-centred care with specific consideration for our end of life patients.

Strategic Goal - Ensure our workforce community is able to deliver the best possible care in all of the communities that we work with

Trust Priority: We will support our workforce to recover and flourish, with enhanced focus on resourcing and health & wellbeing.

Key areas for consideration here include how we continue to: look after and protect our staff and their health and wellbeing, attract new staff who are representative of the communities we serve, explore new innovative staffing models through a partnership approach, and ensure LCH is an achievable employment opportunity for all.

Strategic Goal - To work in partnership to deliver integrated care, care closer to home and reduce health inequalities

Trust Priority: We will work pro-actively across all the communities we serve to improve health outcomes.

This links in with the above need to support services to understand their health equity data and use it to: target communities that are underrepresented in access to healthcare. Consideration also needs to be given around how we ensure service changes and developments are: co-produced and therefore capture local needs and perspectives, and that to recognise that for effective partnerships it is essential that we: ensure adherence to LCH's partnership governance standards. We will be a proactive partner in all Place based partnerships where we deliver services.

Each Key Priority directly aligns to and provides evidence in the achievement of a Strategic Goal. However, whilst the Priorities are aligned to a specific goal, they have been developed with a cross cutting intention to support achievement of the other goals.

The Key Priorities will also align to the Board Assurance Framework to provide evidence of how the organisation's strategic ambitions over the year will also mitigate the organisation's risks. It should be noted that the risk will not drive the Key Priority but the Priorities alignment will provide ongoing evidence that through joined up working LCH is continually monitoring and mitigating the risks to improve outcomes.

In addition, the organisation's existing strategies will also be included. As new strategies are developed and existing strategies renewed, the associated specific priorities will be fully aligned with the most relevant Strategic Goal/Trust Priority/Trust Risk.

Appendix 1 provides an example of how each of the above will be linked to provide both a visual and working document. The document, with the associated reporting to Board, provides evidence of strategic direction and achievement of the organisations ambitions whilst evidencing how the organisation is mitigating risk to achieve high quality care for all.

4 Next steps

Time has been allocated at SMT on 6th April 2022 to discuss how we will aim to achieve the priorities; SMT will identify the specific actions underpinning each priority.

Once agreed, the Priorities and underpinning actions will be communicated to the Business Units and Corporate Services and work will commence to achieve the Priorities through the business plans.

In terms of assurance, business units will provide a quarterly progress update against their business plans alongside a quarterly update outlining progress against the four priorities.

A programme of engagement and co-production in the development of the 2023/2024 Trust Priorities is proposed. The aim would be to involve staff and patients in the development of our priorities, within the constraints of the National, Regional and Leeds Place requirements. Through involvement we aim to hear their voice and demonstrate that LCH is a listening, inclusive organisation and part of the community it serves.

5 Recommendations

Board is asked to provide feedback on the contents of the paper and approve the proposed Trust Priorities for 2022/2023.

6 Appendices

Appendix 1 - 2022-23 Key Priorities Aligned with Strategic Goals, Strategies and the BAF

Strategic Goals	Deliver outstanding care	Use our resources wisely and efficiently	Ensure our workforce is able to deliver the best possible care in all of the communities that we work with	Work in partnership to deliver integrated care, care closer to home and reduce health inequalities
Supporting Strategy	Quality Strategy Quality Improvement Strategy Research and Development Strategy Health Equity Strategy Patient Engagement Strategy Third Sector Strategy	Digital Strategy Business Development Strategy Procurement Strategy Estates Strategy Third Sector Strategy	Workforce Strategy Health Equity Strategy Estates Strategy Digital Strategy Third Sector Strategy	Third Sector Strategy Health Equity Strategy Patient Engagement Strategy Business Development Strategy
Trust Priority	We will be responsive to the needs of our populations as we continue to rebuild our services back better.	We will continue to rebuild our services with a focus on safeguarding our waiting list backlogs and continuous improvement	We will build and deliver a resourcing plan to ease the burden on staff.	We will work pro-actively across the Leeds Place to improve health outcomes.

Strategic Risks	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective **(Exec Director of Nursing / Quality Committee)**	**Risk 2.1** If there is insufficient resource across the Trust to deliver major change programmes and their associated projects, then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised. **(Exec Director of Operations / Business Committee)**	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development and a low level of sickness absence) then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.**(Director of Workforce / Business Committee)**	**RISK 4.1** If the Trust does not play an active part in the collaboration across the health and care system (ICS and ICP), then the system may not achieve better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. **(CEO / Board)**
	Risk 1.2 If there are insufficient clinical governance arrangements put in place as new care models develop and evolve, the impact will be on patient safety and quality of care provided.**(Exec Medical Director / Quality Committee)**	**RISK 2.2** If the Trust does not deliver contractual requirements, then it may be an indicator of patient care not being delivered at the required level or quality required by commissioners and adverse consequences for the immediate and longer term financial position of the Trust. **(Exec Director of Operations / Business Committee)**	**RISK 3.2** If the Trust does not create and embed a culture of equality and inclusion, then it will fail in its duty to attract and retain a diverse workforce that is representative of the communities it serves, and will not reap the benefits of diverse thinking and representation. **(Director of Workforce / Trust Board)**	**Risk 4.2** If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships. **(Exec Director of Finance and Resources / Business Committee)**
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm **(Exec Director of Nursing / Quality Committee)**	**RISK 2.3** If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of accurate performance information, then it may fail to retain a competitive market position **(Exec Director of**	**RISK 3.3** If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services **(CEO / Business Committee)**	

		Finance and Resources / Business Committee)		
	RISK 1.4 If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve. **(Exec Director of Nursing / Quality Committee)**	**RISK 2.4** If the Trust does not maintain the security of its IT infrastructure then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, financial loss and reputational damage. **(Exec Director of Finance and Resources / Audit Committee)**	**RISK 3.4** If the Trust does not invest in developing managerial and leadership capability then this may impact on effective service delivery, staff retention and staff wellbeing **(Director of Workforce / Business Committee)**	
	Risk 1.5 If, as a result of the Trust's altered capacity due to the Covid-19 pandemic, the Trust cannot deliver services in a timely and equitable manner, then the impact will be further increases to waiting lists and the potential for harm to patients or complaints to the Trust. **(Exec Medical Director / Quality Committee)**	**RISK 2.5** If the Trust does not deliver key financial targets agreed with NHS England through the ICS financial framework then it will cause reputational damage and raise questions of organisational governance **(Exec Director of Finance and Resources / Business Committee)**	**Risk 3.5** If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related death, injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention. **(Exec Director of Finance and Resources / Business Committee)**	

	Risk 1.6 If the Trust does not optimise its services to reduce the impact of health inequalities, and allow appropriate data capture to understand and address this, there will be a negative impact on patient outcomes, the Trust's resources and reputation. **(Exec Medical Director / Trust Board)**	**Risk 2.6** If the Trust does not invest and create the capacity and capability to respond to the increasing dependency on digital solutions then systems may be unreliable, under developed, not used effectively, lack integrity or not procured. The impact will be on the delivery of patient care and on staff resources and wellbeing. **(Exec Director of Finance and Resources / Business Committee?)**	**Risk 3.6** If the Trust is unable to maintain business continuity in the event of significant disruption, there is a risk that essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss **(Executive Director of Operations / Business Committee)**	

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (130bi)

Title: Revenue and Capital Budgets 2022/23

Category of paper: for assurance
History: Business Committee, 23 March 2022

Responsible director: Executive Director of Finance and Resources
Report author: Deputy Director of Finance / Executive Director of Finance and Resources

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Executive summary (Purpose and main points)

This paper presents the revenue and capital budgets for the Trust for 2022/23. The budgets are presented in times of continuing uncertainty concerning Covid, the impact of the war on Ukraine and the economic consequences of both. The budgets represent a plan at the time of writing but there remains uncertainty about some revenue income streams, funding for commissioned developments, cost inflation and final agreement by the ICB of capital resource allocations to Trusts.

However, both the revenue and capital budgets should allow the Trust to continue to make good progress on its priorities for 2022/23 whilst striving to always provide the best possible care to the communities we serve

Recommendations

The Board is asked to approve the proposed revenue and capital budgets for 2022/23.

Revenue and Capital Budgets 2022/23

1. Introduction

1.1. This paper presents the revenue and capital budgets for the Trust for 2022/23. The budgets are presented in times of continuing uncertainty concerning Covid, the impact of the war on Ukraine and the economic consequences of both. The budgets represent a plan at the time of writing but there remains uncertainty about some revenue income streams, funding for commissioned developments, cost inflation and final agreement by the ICB of capital resource allocations to Trusts.

1.2. However, both the revenue and capital budgets should allow the Trust to continue to make good progress on its priorities for 2022/23 whilst striving to always provide the best possible care to the communities we serve.

2. Revenue Context

2.1. National Revenue Allocations 2022/23

2.1.1. NHSE/I has allocated revenue allocations to Integrated Care Boards (ICBs) based on the system funding envelopes calculated for H2 2021/22. This continued the basis of calculating funding at ICS level, albeit adjusted as time has gone on, introduced at the start of the Covid-19 pandemic.

2.1.2. Core ICB allocations have grown by 3.6% in 2022/23, against an adjusted 2021/22 baseline. This is intended to fund inflation and activity growth, but there is a 1.1% efficiency requirement (and deficit reductions in some systems). Specific allocations to meet Covid costs have also reduced as NHSE/I expects savings to be made as the NHS recovers from Covid-19 and direct costs associated with the pandemic, particularly infection control, are reduced. The reduction in Covid funding is the start of a tapered withdrawal over several years.

2.1.3. Additional funding has been made available for elective recovery.

2.1.4. The allocations also recognise some of the commitments in the planning guidance, including the maintenance of the mental health investment standard, and service development funding for mental health, primary care, cancer, and diagnostics. Service development funding has risen by 28% overall in 2022/23.

2.1.5. Core allocations to ICBs have been based on the fair shares target allocation. A number of changes have been made to the funding distribution model following recommendations by the Advisory Committee on Resource Allocation. These include a more accurate formula and data in the model for general and acute hospital services; improvements in the health inequalities and unmet need adjustment; an adjustment for the unavoidable costs due to remoteness; and a new adjustment to recognise the unavoidable costs of some private finance initiative contracts.

2.1.6. A convergence adjustment has been made to move ICBs closer to their fair share over time in a measured way. For 2022/23, the average convergence factor has been set at -0.7% with variation at ICB level between -0.94% and +0.25%.'

2.1.7. NHSE/I expects ICBs and partner Trusts to collectively deliver a break-even financial position across their system. Although delayed, it is expected the Health and Care Bill will hold ICBs and trusts responsible for their use of revenue (and capital) resources.

2.2. West Yorkshire ICB

2.2.1. West Yorkshire ICB received core revenue allocations comprising:

Core Allocation (2021/22 H2 x 2)
Plus 1.7% tariff cost growth, comprising:
2.3% for pay and price inflation (pay at 2%)
0.6% for increase in employers' NI
(1.1%) efficiency
Plus 2.3% for activity growth
Less 0.6% convergence
Plus health inequalities and maternity funding

2.2.2. The specific Covid allocation has reduced by 57%.

2.2.3. Additional Service Development Funding, including additional funds for Virtual Wards and Ageing Well has either not yet been allocated to ICBs or the basis for allocation by the ICB to places / Trusts has not yet been determined.

2.2.4. All current West Yorkshire CCG Chief Financial Officers (CFOs) and Trust Finance Directors worked together with the ICB Finance Director to agree that the national approach of rolling forward the 2021/22 H2 allocations would be applied to CCGs/places and Trusts, with the net growth allocation allocated to the ICB replicated at individual organisation level. One difference being the application of the -0.6% convergence adjustment which was attributed to places based on their distance from target; Leeds gained / lost less at the expense of the other places.

2.2.5. At the time of writing the ICB has been unable to submit a balanced draft financial plan; with a £122m deficit still to be addressed before final plan submission in April. The implication of this for LCH is that, given the collective need to achieve financial balance across the ICB, all constituent organisations including LCH will be asked to improve their planned position. For LCH that would mean delivering a surplus to mitigate deficits elsewhere. LCH would expect that each of the five places in West Yorkshire would manage organisational deficits within their place first before recourse to other places.

2.3. Leeds Place

2.3.1. The CFO of NHS Leeds CCG and the three Trust Finance Directors worked together to agree that, as far as possible, the general increase

and decrease percentages applied to the Leeds place allocation would be replicated in individual organisations' funding. Where specific adjustments were identifiable to individual organisations those adjustments have been made.

2.3.2. At the time of writing the Leeds place has been unable to submit a balanced draft financial plan. The implication of this is the risk that, given that each place will be expected deliver financial balance within a balanced ICB, LCH may need to improve on a balanced position to offset any organisation(s) with deficit positions.

3. Leeds Community Healthcare Revenue Budget 2022/23

3.1. The Trust's financial plan reflects the changes to the approach to NHS commissioning income with the establishment of the ICB, NHS Commissioning income is based on the value the Trust received in the second half of 2021/22 adjusted for national uplifts, growth assumptions, efficiency requirements and the transfer of top up and growth income that had been handled nationally during 2020/21 and 2021/22.

3.2. The Trust continues to receive £3.6m non-recurrent covid income to support Covid specific operational costs; as explained above this is 57% less than the income in 2021/22.

3.3. The Trust is expected to sign contracts with NHS Commissioners by 31 March 2022. Contract discussions take place at a Leeds System and ICB level. The values in this report reflect the collaborative work undertaken.

3.4. The Trust has a realistic but challenging expenditure plan which includes efficiency savings of £3.0m (1.5%) to achieve the required break-even position.

3.5. After taking into consideration recurrent and non-recurrent income and expenditure for 2022/23 the Trust has a recurrent underlying deficit of £1.1m.

3.6. In summary, the revenue plan is shown in the following table:

Income & Expenditure Summary	Annual Plan £m
Income	
Contract Income	(189.6)
Other Income	(8.3)
Total Income	***(197.9)***
Expenditure	
Pay	139.6
Non pay & Reserves	48.0
Total Expenditure	***187.6***
EBITDA	**(10.3)**
Depreciation	9.2
Public Dividend Capital	0.6
Interest Paid	0.6
Interest Received	(0.1)
Retained Net Surplus	**(0.0)**

3.7. The key drivers for the revenue financial plan are illustrated in the bridge diagram at Appendix A. The under-pinning detail is contained in the remainder of the report.

Income Detail

3.8. Total income planned for the Trust for 2022/23 is shown in the table below. This report has been prepared based on the income discussed with the ICS for the submission of the draft planning returns at both the ICS and Trust level; this represents the most likely contract income position.

Income Summary	Annual Plan £m	£m
Contract Income		
NHS Leeds CCG		
Block contract	127.5	
Sytem top up and growth via NHS Leeds	12.7	**140.2**
SDF System Funding		
Ageing Well	2.8	
Long Covid	1.6	
CAMHS Trailblazer	1.3	**5.7**
ICS via NHS Wakefield CCG		
Covid top up income		**3.6**
NHS England		
Block contract		**9.2**
Police Custody		**8.2**
Leeds City Council		
Public Health	7.3	
Recovery Hub	0.2	
Community Care Beds Service	1.6	
0-19 Public Health Intergrated Nursing	10.8	
Leeds Equipment Service	1.3	**21.2**
MH Provider Collaborative via Leeds & York FT		**0.2**
Other Patient Care		**1.3**
Other Income		**8.3**
Total Income		**197.9**

3.9. At the time of writing the Trust has agreed contract income for 2022/23 with **NHS Leeds CCG** of £140.2m. This includes £2.1m for inflation (1.7% to cover pay award, NI changes and non-pay inflation less a 1.1% efficiency requirement) and growth of £2.4m. System top up and growth funding that has been received via the ICS in the past two years has now been allocated to NHS Leeds and these are now included in the contract value. The growth and system income has been used to meet the additional costs of the developments that have been agreed with NHS Leeds.

3.10. This aggregate contract sum included some previously separate contract income values. Work will be required to identify the separate contract values. It is also unclear at present how CQUIN will operate across the LCH contracts although nationally it is expected that 1.25% income is dependent on achieving CQUIN targets.

3.11. There is no provision in the contract sum for adjustment, up or down, in the event that activity varies from agreed levels. However, the expectation is that partners in the Leeds place would work together to mitigate any such unanticipated activity and consequent cost variances.

3.12. The CYPMH trailblazer, Ageing Well and Long Covid developments totalling commissioned by NHS Leeds and totalling £5.7m will be funded from the Special Development Funds held centrally by the ICS. It is expected these will flow via NHS Wakefield.

3.13. Further national money to support Ageing Well initiatives and virtual wards will be allocated to the ICB / Leeds place in year.

3.14. **NHS England**'s commissioned service lines have all had the 1.7% inflator applied in the planning assumptions. The direct commissioning income from NHS England includes the Liaison & Diversion development of £0.1m agreed last year. Additional funding of £0.5m has also been included for the Wetherby Secure Stairs MH development. This had not been included in the national calculation of the blocks for the last two years and had been managed as part of overall resources locally. £2.2m for Young Offender Healthcare is sub-contracted to South West Yorkshire Partnership NHS FT.

3.15. The planned income from the **Regional Police Custody** contract is £8.2m. Penalties may apply in respect of non-delivery of KPIs for this contract. The Trust has agreed a three-year contract extension which will take this service to the end of the current contract. The contract extension does not include additional income to cover the impact of the 6.3% increase in NHS employers' pension contributions as this is funded centrally at the moment. Should this cost fall to the Trust in future the contract variation contains a clause which would see the Police Commissioners increase the value of the contract for 2023/24 and 2024/25 to meet this additional cost. Therefore, the financial risk of the additional pension increase does not sit with the Trust.

3.16. **Local Authority** contracts have yet to be formally agreed. Assumed income is as in the table above. The sexual health and the 0-19 PHINS contracts include penalties for non-delivery of KPIs. Both these contracts terminate at the end of 2022/23. The historical issue of Agenda for Change pay increases not being funded through local authorities has been theoretically made good through the

new funding regime and planning guidance suggests that further funding will be made available to LAs when the 2022/23 pay award is known.

3.17. **Other patient care income** includes numerous contracts with schools for speech and language therapy services, £0.8m and from MacMillan Cancer Care of £0.3m plus a number of other small contracts.

3.18. **Other income**. This is income for non-patient care activities and includes £2.8m for training and education, £1.7m for PCN staff, £0.3m research and developments, £0.8m for estates recharges, £0.2m for private use of lease cars. Budgets for other income have been rolled forward at the current values for the plan.

3.19. **Overall, budgeted income meets LCH expectations**. Whilst no income has been received specifically for community growth or for the mental health investments standard (for CAMHS and LMWS), the income received and planned demonstrates an adequate level of investment.

Expenditure Detail

3.20. Material changes to planned rolled forward expenditure include:

- Increase in the pay costs baseline in respect of incremental drift of £0.3m.
- Pay award at £3.6m representing 1.25% increase in employers NI contributions and a 2% national pay award.
- The balance to full year increase in costs associated with agreed investments.

3.21. Planned pay costs assume an in year saving of £5.9m for vacancies. This represents a 4.0% vacancy factor. This is an increase in expected savings of £0.5m on the prior year as a cost improvement.

3.22. At this time there are around 200 WTE vacancies across the Trust. Although efforts are being made to fill most of these vacancies, and temporary staff will be used, there will undoubtedly be a degree of lag in recruitment to existing and new posts. The planning assumption include £2.5m expenditure on bank staff.

3.23. Taking everything into account the judgement made in these budget proposals is that the recurrent vacancy factor at £5.9m is reasonable.

3.24. The Trust's has not yet been notified of an agency cap for 2022/23. The agency expenditure planned for 2022/23 is £3.6m is in line with the level of expenditure for 2021/22.

3.25. £1.4m is included in the plan for general inflation on non-pay expenditure; this is derived from the national inflation assumptions as applied to the Trust's expenditure profile. Of this £0.6m is a contribution towards efficiency savings leaving £0.8m for cost increases. In addition, the plan includes cost pressures for the new enteral feed contract of £0.4m and hyper inflation for energy of £0.3m (electricity inflation is currently 47% and gas costs are increasing by 84%) and rent/lease costs (currently facing an increase of 7.8%) of £0.5m.

3.26. New and increased budgets put before the Board/Committee include cost pressures and expenditure proposals agreed by the Senior Management Team. These are listed below:

Cost Pressure	Recurrent £k	Non-recurrent £k	Total £k
LD & Autism assessments	2,000		2,000
Mobile data charges	548		548
Rent / lease hyperinflation	500		500
Enteral Feeds	417		417
IFRS16 leases	309		309
Energy hyperinflation	300		300
Interpreting	173		173
Historic – ABU Management	134	15	149
Historic – Cardiac nursing posts	130		130
NT nursing posts grading	122		122
NHS Resolution premium	120		120
Covid costs		700	700
e-rostering		314	314
EPR development		134	134
<£100k	682	198	880
Total	**5,435**	**1,361**	**6,796**

3.27. Expenditure on significant project proposals includes:

Project Costs	£k
NT transformation	357
E allocation system	372
Tenders support	150
Total	**879**

3.28. The financial plan proposes the Trust starts the year with a net reserve total of £1.2m. This comprises £1.5m committed reserves (funds yet to be deployed to budgets) and £0.3m unidentified savings requirement for the impact of IFRS 16.

3.29. Committed reserves will be deployed to budgets as the Trust gets certainty of timing and/or expenditure values.

Breakdown of Reserves	£k	Rec/Non Rec	Status
Real Living Wage	30	R	Committed
O365 roll out	300	R	Committed
P11D	200	R	Committed
LSH & YOI contracts profit share to partners	270	R	Committed
Dental contract growth	55	R	Uncommitted
Tender support	150	NR	Committed
Contingency	500	NR	Uncommitted
Un-identified CIP/income expected	-309	R	Required to find
Total	**1,196**		

3.30. The need to deliver cost improvement programmes will continue to be a significant challenge for the Trust.

3.31. The efficiency expectation nationally for 2022/23 is 1.1%. The Trust's plans represent CIP savings of 1.5% of expenditure or £3.0m. This is the level of savings required for the Trust to achieve breakeven after the inflationary and cost pressures listed above have been included.

3.32. The CIP proposals for 2022/23 recognise the severe pressure that many of services have continued to face during 2022/23. For that reason, again there is no general CIP applied across the Trust or across business units. The 2022/23 CIPs seek to protect front line clinical delivery wherever possible.

CIP Scheme	£k	R/NR	Risk Rating
Pay (covid absence cover)	300	R	L
Pay increased vacancy factor	500	R	L
Travel & lease cars	500	R	L
Non pay inflation reserve	600	R	M
Estates	500	R	M
IT Kit	300	NR	L
Un-identified anticipated income for IFRS 16 implementation	309	R	H
Total	**3,009**		

3.33. The Trust is expecting reduced pay costs in respect of cover for covid absence. There is also an increase in the vacancy factor.

3.34. The CIP from the estates will lock in savings achieved in prior years. This is a medium risk given the general inflation rate which will put pressure on estates budgets.

3.35. Non pay inflation savings will be delivered directly from the inflation reserve and will not require actions from budget holders other than to manage their non-pay expenditure with no real terms increase. This is a medium risk given the increase in general inflation rates.

3.36. The reduction in travel costs reduces budgets for savings being achieved from working in different ways.

3.37. Other CIPs take advantage of pre-existing plans and identified opportunities.

3.38. The unidentified CIP of £309k to cover increased costs as a result of the implementation of IFRS16 is expected to be met by additional funding when negotiations between the Department of Health & Social Care and Her Majesty's Treasury have concluded.

4. Capital

4.1. The ICB receives a capital resource for the whole of West Yorkshire based on an aggregate of the formula calculation of resources to Trusts.

4.2. A new capital allocation formula is based on trusts' depreciation, gross asset values, backlog maintenance, prior year surpluses and specific national issues. LCH is disadvantaged by having made significant reductions to backlog

maintenance in recent years but benefits from the inclusion of financial performance between 2016/17 to 2019/20.

4.3. At the time of writing the ICB has allocated capital resources to Trusts based on the national calculations. In aggregate Trusts have identified need for capital resources significantly in excess of the resource available. Work is ongoing to resolve this position

4.4. LCHs calculated general allocation is £3.778m and the Trust has submitted a needs plan equal to that resource. In addition to this there is a national digital maturity allocation designed to level up organisations. The LCH notional 'fair share' of this funding is £204k. At present the ICS has yet to agree how the West Yorkshire pot will be allocated. Trusts have been asked to include their fair share in the plans but not commit to spending it until the allocations have been confirmed.

4.5. The capital budget proposal in the table below has a total £2.5m for estates expenditure including the completion of the refurbishment of Seacroft Clinic and £0.5m for back-log maintenance. All properties in use for patient care will continue to be maintained to the required standard.

4.6. There is £0.9m proposed for IT equipment and cyber security and £0.35m for clinical equipment expenditure; some of the clinical equipment expenditure will be timed for the second half of the year to ensure any unforeseen demands can be addressed.

Capex	Annual Plan £m
Estates General Maintenance	0.528
Estates Backlog Maintenance	2.000
Information Technology	0.900
Clinical Equipment	0.350
Digital levelling up and cyber risks	0.204
Total Capex	**3.982**

4.7. In addition, with the implementation of IFRS 16, the Trust will need to capitalise all new lease expenditure as these will be classified as finance leases rather than operating leases. This will require additional capital resource limit. The estimated impact of new leases on capital expenditure for 2022/23 is tabled below. The Department of Health & Social Care is in negotiation with Her Majesty's Treasury; until a decision is made it is unclear how the budgetary impact of IFRS 16 will need to be managed nationally. The national capital team has confirmed the ICB and Trust's performance will be assessed excluding the IFRS 16 impact.

Capex - IFRS 16	Annual Plan £m
New leases: lease cars	0.205
New property leases	1.191
Total Capex	**1.396**

5. Cash

5.1. The Trust's cash position remains very strong with a forecast £35m at the start of the year. This includes additional cash generated from historic surpluses and provider sustainability funds.

5.2. The Trust expects to achieve the better payments practice code in 2022/23.

6. Financial Risks

6.1. As most of the Trust's income is fixed, the risk to delivering break-even are principally around the control of expenditure. There are no significant risks to actual income other than penalties on contracts identified in this plan: police custody, sexual health and 0-19 PHINS contracts.

6.2. However, the way in which the Trust's income has been calculated, a development of the national calculation introduced at the start of the pandemic, does mean that the link between the traditional contract income from NHS Leeds CCG and LCH has been broken. Whilst further work is required to fully understand the consequences of this there is a risk that the commissioning system will identify that sufficient income has been received by LCH to afford the services "commissioned" by the CCG but not yet started. The costs of providing those services are not in our plans.

6.3. There are a number of risks around pay expenditure;

- The nationally agreed pay award may exceed the 2% currently built into the plan, indications are that a national contingency is being held for a pay award of up to 3%. (low risk)
- Recruitment to vacancies is successful and the Trust does not deliver the vacancy factor requirement. This is extremely unlikely in the current labour market. (low risk)
- The Trust has to repeat pay incentive initiatives to ensure safe staffing levels. (medium risk)

6.4. Although the cost pressures list above has identified hyperinflation costs on leases and energy there is a significant risk that that other non-pay inflation pressures are in excess of the overall planning assumption of 2.7% and lead to non-delivery of the £0.6m CIP requirement. (high risk)

6.5. No additional resources have been made available by the ICB to address waiting lists in Community services. However, given the anticipated level of vacancies it is possible that resources will become available in year to accelerate reduction of waiting lists. However, the fact that the resource becomes available through vacancy levels suggests that sourcing additional staffing to address waiting lists would be challenging. (medium risk)

6.6. The Trust enters the financial year with only a small financial contingency. (low risk)

6.7. The non-delivery of prior year cost saving plans remains a financial risk. The historic administration review savings have been identified and these will be removed from budgets for 2022/23. Within the financial plan the assumption is

that the following cost savings will be delivered in 2022/23. These relate to recurrent savings required but have not yet been attributed to specific budgets and therefore present an increased risk of non-delivery These include:

- £1.5m reduction in discretionary expenditure;
- £0.3m reduction in corporate services costs; and
- £0.15m procurement savings not delivered.

6.8. The level of risk in 2022/23 CIP delivery is shown in the CIP scheme table at 3.3.1. The Trust has a good record of delivering cost reduction on discretionary expenditure in-year and this would be the first port of call to cover the unidentified non-recurrent CIP requirement if the overall financial position was not on target during the year. Delivery of recurrent CIPs is essential to maintain a manageable underlying financial position. (low risk)

6.9. If the revenue impact of IFRS 16 isn't funded nationally this will have to be mitigated by an additional as yet unidentified CIP of £0.3m. Should this not be funded nationally the Trust would look to increase the vacancy factor non-recurrently to meet this cost. The capital budgetary impact will be huge nationally and it is anticipated there will be an increase in CDEL as a result of the implementation. (medium risk)

6.10. The Trust continues to face risks to its financial stability due to the competitive tendering of Trust services. During 2022/23 the contracts for 0-19 service £10.8m, Leeds Sexual Health service £5.8m and the Dental service £2.8m all come to an end, and it is expected the services will be re-tendered. The Trust has set aside £150k to support the work required for these tenders. (medium risk)

6.11. Based on the current known financial assumptions the underlying recurrent position is a Trust deficit of £1.9m. The fact that the non-recurrent covid income of £3.6m supports only £0.7m of non-recurrent costs means that non-recurrent income is supporting significant recurrent costs. As this income is reduced the recurrent costs will need to be met internally.

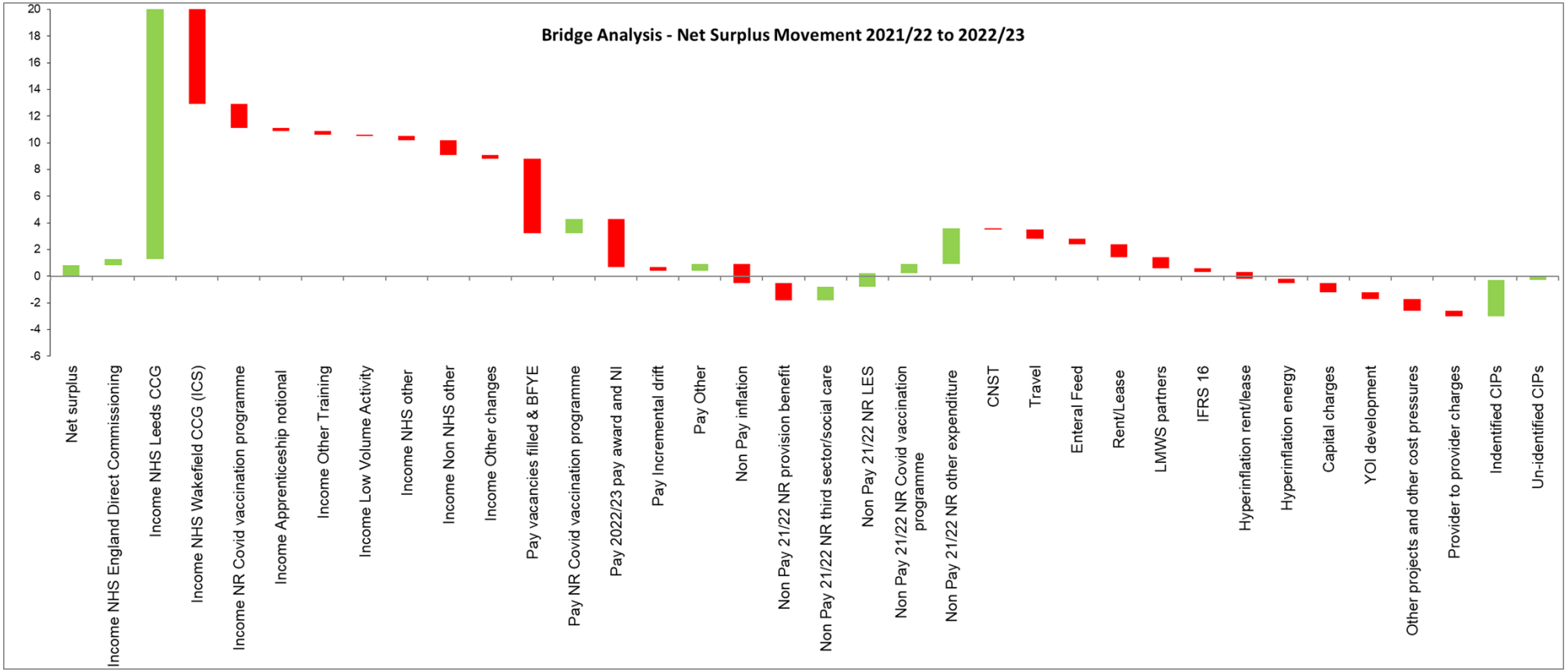
7. Conclusions

7.1. Leeds Community Healthcare has a strong financial position and has consistently met or exceeded all its statutory financial duties. For 2022/23 the Trust has a plan that underpins service delivery and its strategic objectives whilst demonstrating it can deliver its financial duties.

8. Recommendation

8.1. The Board is recommended to approve the proposed revenue and capital budgets for 2022/23.

Appendix A


Bridge Analysis - Net Surplus Movement 2021/22 to 2022/23
20
18
16
14
12
10
8
6
4
2
0
-2
-4
-6
Net surplus
Income NHS England Direct Commissioning
Income NHS Leeds CCG
Income NHS Wakefield CCG (ICS)
Income NR Covid vaccination programme
Income Apprenticeship notional
Income Other Training
Income Low Volume Activity
Income NHS other
Income Non NHS other
Income Other changes
Pay vacancies filled & BFYE
Pay NR Covid vaccination programme
Pay 2022/23 pay award and NI
Pay Incremental drift
Pay Other
Non Pay inflation
Non Pay 21/22 NR provision benefit
Non Pay 21/22 NR third sector/social care
Non Pay 21/22 NR LES
Non Pay 21/22 NR Covid vaccination programme
Non Pay 21/22 NR other expenditure
CNST
Travel
Enteral Feed
Rent/Lease
LMWS partners
IFRS 16
Hyperinflation rent/lease
Hyperinflation energy
Capital charges
YOI development
Other projects and other cost pressures
Provider to provider charges
Indentified CIPs
Un-identified CIPs

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (130ci)

Title: Key Performance Indicators 2022/23

Category of paper: for approval
History: **Quality Committee – 21 February 2022**
Business Committee – 23 February 2022

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

Executive summary (Purpose and main points)
The proposed high level indicators for inclusion in the 2022/23 Performance Brief were discussed at Quality Committee and Business Committee in February. Broadly the list of high-level indicators was agreed, and these are appended to this report for sign off.

Recommendations
The Board is asked to sign off the high level KPIs for 2022/23.

Key Performance Indicators 2022/23

Background

The proposed high level indicators for inclusion in the 2022/23 Performance Brief were discussed at Quality Committee and Business Committee in February. Broadly the list of high-level indicators was agreed and these are appended to this report for sign off.

However, the Committee's felt that there was further clarity needed on the indicators themselves, the purpose of the Performance Brief and the mechanism for monitoring and improving service level measures within the organisation. This paper has been written to provide further information and suggest a plan of action. The paper provides information in three areas:

1. The requirements for and purpose of the Performance Brief
2. Mechanisms for monitoring measures at service level
3. Development of listed high level indicators

The Requirements for and Purpose of the Performance Brief

There was some discussion in the Committees as to the purpose of the Performance Brief. There was general agreement that the report should provide assurance about performance within the organisation, but there was more variation in opinions regarding what form this assurance should take. Some parties preferred a model where issues and successes were reported by exception, others a model where everything was presented to provide a more rounded view of the organisation.

Th Performance Brief will continue to focus on performance against the KPIs agreed by the Board. It will continue to develop to increasingly consider trend data and Statistical Process Control Charts rather than comment on the latest month's data point.

Committees felt that there was not currently enough assurance to decrease the number of measures presented in the performance brief. Therefore a full list of high level indicators will continue to be presented. Commentary will focus on significant variation from target.

Mechanisms for Monitoring Measures at Service Level

Processes that clarify and further embed monitoring and management of service level measures will be developed. This will involve identification of the appropriate measures to be examined at service level, production of reporting those to services and embedding of the monitoring and management of those measures in existing performance processes.

Monitoring of indicators at an organisational level may take place in either QAIG or the Senior Operations Performance Panel depending on relevance and appropriateness. Issues and celebrations can then be escalated from those groups to committees and Board via the Performance Brief or other appropriate reports.

Development of High Level Indicators

As can be seen from the proposed list of high level indicators for 2022/23 at Appendix 1 there are a number of indicators that are still to be developed. Appendix 2 details the development progress and timelines for new and in development measures.

Health Equity

It is recognised that we need to ensure that the performance in each of our indicators is the same for all groups in the communities we serve. We do not plan to create individual measures for health equity. Instead the Health Equity and Business Intelligence Strategies lay out an approach to provide health equity “lenses” on each of our individual measures to allow all levels of the organisation to identify variation between patient groups and take action to decrease this. This work will progress and be monitored through implementation of those strategies.

Recommendation

The Board is asked to sign off the high level KPIs for 2022/23.

Appendix 1 – Proposed High Level Indicators for 2022/23

Revised High Level Indicator List for Performance Brief 2022/23

This document provides the list of indicators that will be examined within the Performance Brief. This list has been bought in line with the System Oversight Framework (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0693-nhs-system-oversight-framework-2021-22.pdf) . Additional indicators from local performance processes and national planning requirements have also been considered for inclusion.

Key:

Remains the same
Amended
Removed
New Measure
For development
RbE = Reported by Exception

Overarching	Resp. Dir.	Target - Annual	Frequency	Notes	Action
Overall CQC rating (provision of high-quality care)	TS	N/A	As updated		
Quality of leadership (CQC KLOE W1)	TS	N/A	As updated		

Safe - people are protected from abuse and avoidable harm	Resp. Dir.	Target - Annual	Frequency	Notes	Action
Potential under-reporting of patient safety incidents	SL	TBC	TBC	NB – not reported on previously, but suggested for inclusion Measure to be monitored via trend analysis at an individual team level and appropriate investigation undertaken. Therefore not included as an overall indicator	
Safer Staffing – Community Services	SL	TBC	TBC	Not ready for inclusion in 2022/23 due to delays due to the pandemic. Measure to be developed during 2022/23 for inclusion in 2023/24 performance brief. Twice yearly safer staffing reports will continue to be provided	
Patient Safety Incidents Reported in Month Reported as Harmful	SL	Value between UCL and LCL Variation outside that investigated and explained	M		
Serious Incident Rate	SL	Value between UCL and LCL Variation outside	M		

		that investigated and explained			
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	TBC	M		
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	M		
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	TBC	M		
Number of Falls Causing Harm	SL	TBC	TBC	Measure to be developed for April 2021/22 for inclusion in 2022/23 performance brief	
Number of Medication Errors Causing Harm	SL	TBC	TBC		
Reduction in Gram Negative Infections	SL	7%	TBC		
Number of teams who have completed Medicines Code Assurance Check 1st April 2020 versus total number of expected returns	RB	100%	Q		
Percentage of Incidents Applicable for DoC Dealt with Appropriately	*SL*	*100%*	*RbE*		
Attributed MRSA Bacteraemia - infection rate	*SL*	*0*	*RbE*		
Clostridium Difficule - infection rate	*SL*	*3*	*RbE*		
Never Event Incidence	*SL*	*0*	*RbE*		
CAS Alerts Outstanding	*SL*	*0*	*RbE*		
Data Quality Maturity Index (DQMI) - CSDS dataset score	*BM*	*TBC*	*RbE*		
Data Quality Maturity Index (DQMI) - IAPT dataset score	*BM*	*>=95%*	*RbE*		
Data Quality Maturity Index (DQMI) - MHMDS dataset score	*BM*	*>=95%*	*RbE*		

Caring - staff involve and treat people with compassion, kindness, dignity and respect	**Resp. Dir.**	**Target - Annual**	**Frequency**	**Notes**	**Action**
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%	M		
Total Number of Formal Complaints Received	SL	No Target	M	Health equity analysis of complaints to be carried out every 6 months and reported separately	
Number of Compliments Received	SL	No Target	M	To be removed	
Patient engagement, satisfaction and experience	SL	TBC	TBC	Not ready for inclusion in 2022/23 due to delays due to the pandemic. Measure to be developed during 2022/23 for inclusion in 2023/24 performance brief	
Mixed Sex Accommodation Breaches	*SL*	*0*	*RbE*	*No inpatient services so no longer relevant*	

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Resp. Dir.	Target - YTD	Frequency	Notes	Action
Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH	RB	100% by year end	Q		
Number of NICE guidelines with full compliance versus number of guidelines published in 2021/22 applicable to LCH	RB	No Target	Q		
Clinical Outcome Measures – Number of patients with a clinical outcome measure in use as part of their care package	RB	TBC	Q		
Clinical Outcome Measures – Number of services with a COMS project registered	RB	TBC	Q		
Clinical Outcome Measures - Percentage of services at stage 3; measures agreed and services have access to them	RB	75% by year end	Q	Replaced with COMs measures above.	
Clinical Outcome Measures - Percentage of services at stage 6; using measures with some patients some of the time	RB	60% by year end	Q		
Number of Unexpected Deaths in Bed Bases	*RB*	*No Target*	*RbE*	Monthly	
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload	*RB*	*No Target*	*RbE*	Monthly	
NCAPOP audits: number started year to date versus number applicable to LCH	RB	100% by year end	Q		
Priority 1&2 audits: number completed year to date versus number expected to be completed in 2020/21	RB	100% by year end	Q		
Total number of audits completed in quarter	RB	No Target	Q		
R&D - Number of patients recruited to portfolio and non-portfolio studies	RB	500 by year end	Q		
R&D - Number of research studies open in LCH	RB	No Target	Q		
Patients recruited into Studies	RB	100%	Q	Replaced with R&D measures above.	
Unplanned hospitalisation of patients under our care/Re-admission within 30 days of patients under our care.	RB	TBC	TBC	To be developed	
Improving recovery in the community - Stroke at 30 days and 6 months (numbers and degree of recovery)	RB	TBC	TBC	To be developed	
Improving recovery in the community - Fragility fractures degree of recovery and rehabilitation at 30 and 120 days.	RB	TBC	TBC		
Dental indicator	RB	TBC	TBC	To be developed	

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	Resp. Dir.	Target - YTD	Frequency	Notes	Action
Proportions of patient activities with an ethnicity code	SP	TBC	TBC	To be developed	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	M		
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	M		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	M		
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	M		
Number of children and young people accessing NHS funded mental health services	SP	TBC	M	To be baselined and targets defined	
CAMHS – Assessment and Consultation Waits	SP	TBC	M	To be developed	
CAMHS – Neurodevelopmental initial Waits	SP	TBC	M	To be developed	
CAMHS – Routine referral to treatment waiting times for children and young people with an eating disorder	SP	TBC	M	To be developed	
CAMHS – Urgent referral to treatment waiting times for children and young people with an eating disorder	SP	TBC	M	To be developed	
LMWS – Access Target; Local Measure (including PCMH)	SP	25%	M	Moved from financial sanctions	
IAPT - Number of patients starting screening within two weeks of referral	SP	TBC	M		
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	M		
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	M		
Number of referrals requiring a 2-hour urgent response	SP	TBC	M	To be developed	

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	Resp. Dir.	Target - YTD	Frequency	Notes	Action
Staff Turnover	LS/JA	<=14.5%	M		
Percentage of jobs advertised as flexible	LS/JA	100%	M		

Time to hire – working days from advert to start date	LS/JA	TBC	M		
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	M		
Stability Index	LS/JA	>=85%	M	To be removed- not regularly commented on or discussed and area covered by new indicators above	
Short term sickness absence rate (%)	LS/JA	<=3.0%	M	Target changed from 2.2% in the context of COVID infections	
Long term sickness absence rate (%)	LS/JA	<=3.5%	M		
Total sickness absence rate (Monthly) (%)	LS/JA	<=5.8% to 6.5%	M	Baseline sickness target to be 5.8% with an extended target of 6.5% to allow for COVID absenses	
Sickness absence (working days lost to sickness)	LS/JA	TBC	A	To be developed	
AfC Staff Appraisal Rate	LS/JA	>=90%	M		
Statutory and Mandatory Training Compliance	LS/JA	>=90%	M		
Aggregate score for NHS Staff Survey questions that measure perception of leadership culture	LS/JA	TBC	A*	Metric under development nationally to be included when launched	
People promise index	LS/JA	TBC	A*		
Health and wellbeing index	LS/JA	TBC	A*		
Acting to improve safety (safety culture theme in NHS Staff survey; questions 17a and 17b)	LS/JA	a)>=84% b)>=72%	A*	To be developed.	
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months (NHS Staff survey; questions 14 a to 14d)	LS/JA	a)<=26% b)<=8% c)<=13%	A*	To be developed	
Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties (NHS Staff survey; question 11d)	LS/JA	<=58%	A*	To be developed	
Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns (NHS Staff survey; question 4d)	LS/JA	>=64%	A*	To be developed	
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (NHS Staff survey; question 15)	LS/JA	>=63%	A*	To be developed	
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	LS/JA	>=60.0%	A*	Target changed from 52%	

Percentage of staff who are satisfied with the support they received from their immediate line manager	LS/JA	>=52.0%	A*	There are 9 questions in the survey that relate to line manager support- need clarity on which we want to measure	
Proportion of staff who say they have a positive experience of engagement (NHS Staff survey; question TBC)	LS/JA	TBC	A*	To be developed - As above- multiple questions give our 'engagement score'	
'RIDDOR' incidents reported to Health and Safety Executive	BM	No Target	M		
Percentage of minority ethnic staff in each of the AfC bands 1-9 and VSM (including exec. board members)	LS/JA	14% by 2023/24 and 18% by 2028/29	M		
Proportion of staff in senior leadership roles (8b and above) who are (a) from a BME background	LS/JA	TBC	TBC	To be developed	
Proportion of staff in senior leadership roles (8b and above) who are (b) women	LS/JA	TBC	TBC	To be developed	
Total agency cap (£k)	BM	TBC	M		
Percentage Spend on Temporary Staff	BM	No Target	M		

** It is not yet clear whether this measure will be included in the QSS. If it can be assessed quarterly then the measure will be included in the performance brief, if not a separate report will be prepared.*

Finance	Resp. Dir.	Target - YTD	Frequency	Notes	Action
Net surplus (-)/Deficit (+) (£m) - YTD	BM	TBC	M		
Performance against financial plan	BM	TBC	M	To be developed	
Capital expenditure in comparison to plan (£k)	BM	TBC	M		
CIP delivery (£k)	BM	TBC	M		
Underlying financial position	BM	TBC	TBC	To be developed	
Run rate expenditure	BM	TBC	TBC	To be developed	
Overall trend in reported financial position	BM	TBC	TBC	To be developed	

Measures with Financial Sanctions	Resp. Dir.	Threshold - YTD	Frequency	Notes	Action
LMWS – Access Target; Local Measure (including PCMH)	SP	25%	M	Moved to responsive domain	
LMWS - Number of IAPT patients being assessed within two weeks of referral	SP	TBC	M	Moved to responsive domain	
LMWS - Number of people from Black, Asian and Minority Ethnic (BAME) groups entering IAPT treatment (access)	SP	TBC	M	New measures as new incentives added to contract.	
LMWS - Number and % of people from BAME groups who have	SP	TBC	M	New measures as new incentives added to	

accessed IAPT treatment moving to recovery				contract.	
LMWS - % of older people (65+) entering IAPT treatment (access)	SP	TBC	M		
LMWS - Number and % of older people (65+) who have accessed IAPT treatment moving to recovery	SP	TBC	M		
T3WM - Percentage of patients currently waiting under 18 weeks	SP	>=92%	M		
LCPS - Number of Serious Incidents and Never Events not reported by email within 2 working days	SP	0	M		
LCPS - Number of Serious Incidents and Never Events where final investigation wasn't completed within 60 working days	SP	0	M		
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	0	M		
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	0	M		
0-19 - % of infants who had a face to face newborn visit within 14 days of birth.	SP	0	Q		
0-19 - % of 6-8 week reviews completed within 12 weeks of birth.	SP	0	Q		
0-19 - % of 12 month reviews completed within 12 months.	SP	>=87%	Q		
0-19 - Number of PBB Programmes commenced	SP	>=83%	Q		
0-19 - Number of HENRY Programmes commenced	SP	>=80%	Q		
0-19 - Percentage of actual staff in post against funded establishment	SP	95%	M		
0-19 - % of 0-19 staff (excluding SPA) co-located in Children's Centres	SP	42.5	Q		
0-19 - Roll Out of Chat Health to secondary schools	SP	>=95%	Q		
PolCust - % of calls attended within 60 minutes	SP	2225.25	M		
PolCust - Provision of a full rota	SP	>=90%	M		

Omitted Indicators

All indicators from previous year's Performance Brief and from the System Operating Framework have been included in the tables above.

Some measures from local performance processes and national planning guidance have been considered but omitted from the list of indicators above as they provide too granular a level of detail. These will be considered for inclusion as supporting information or in separate reporting in due course. These indicators are listed below:

Safe

- Potential under-reporting of patient safety incidents

- Number of harmful incidents
- Number of minimal/no harm incidents
- Quality Walk Rating

Caring

- Number of concerns

Responsive

- Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics
- RTT completed non-admitted pathways
- New RTT pathways (clock starts)
- Diagnostic activity levels
- 12-18 week waits
- 18+ week waits
- Percentage of activity delivered remotely via telephone
- Percentage of activity delivered remotely via video consultation
- Total number of patients waiting – consultant-led
- Total number of patients waiting – non-consultant-led
- Community services waiting list – children and young people
- Community services waiting list – adults
- Overall size of the waiting list (consultant-led and non consultant-led)
- Virtual ward capacity
- Total outpatient attendances (all TFC, consultant and non consultant-led, excluding diagnostic imaging)
    - of which face to face
    - of which telephone/video
- Total community attendances (all TFC, consultant and non consultant-led, excluding diagnostic imaging)
    - of which face to face
    - of which telephone/video
- Outpatient attendances (all TFC; consultant and non consultant-led, excluding diagnostic imaging) – first attendance face to face
- Outpatient attendances (all TFC; consultant and non consultant-led, excluding diagnostic imaging) – follow-up attendance face to face
- Outpatient attendances (all TFC; consultant and non consultant-led, excluding diagnostic imaging) – first telephone or video consultation
- Outpatient attendances (all TFC; consultant and non consultant-led, excluding diagnostic imaging) – follow-up telephone or video consultation
- Community attendances – first attendance face to face
- Community attendances – follow-up attendance face to face
- Community attendances – first telephone or video consultation
- Community attendances – follow-up telephone or video consultation
- Consultant-led first outpatient attendances (excluding diagnostic imaging)
- Consultant-led follow-up outpatient attendances (excluding diagnostic imaging)
- Total referrals (general and acute)
- Total GP referrals (general and acute)
- Total other referrals (general and acute)
- All activity
- Face to face contacts
- DNA rates
- LWMS – Number of Women accessing specialist community perinatal mental health services
- Completeness of accessible info/ comms needs

Well-led

- Total Workforce (WTE)
- Total Substantive (split into Registered nursing, midwifery and health visiting , Community Nursing staff, Critical Care / ICU Nursing, Registered scientific, therapeutic and technical

staff, Registered ambulance service staff, Support to clinical staff, Total NHS infrastructure support, Medical and dental, Any other staff)

- Total Bank (split into Registered nursing, midwifery and health visiting , Community Nursing staff, Critical Care / ICU Nursing, Registered scientific, therapeutic and technical staff, Registered ambulance service
- Total Agency (split into Registered nursing, midwifery and health visiting , Community Nursing staff, Critical Care / ICU Nursing, Registered scientific, therapeutic and technical staff, Registered ambulance service
- Demographic make-up of teams
- Staff feel they are able to deliver the care they aspire to deliver
- Staff would recommend LCH as a place to receive care
- Numbers of grievances/ FTSU/ performance conduct issues
- Leadership Development

Appendix 2 – Development progress and timelines for new and in development measures

Overarching	Resp. Dir.	Definition available	Data Available	Data Flow Established	Notes	Timeframe for inclusion*
Overall CQC rating (provision of high-quality care)	TS	Y	Y	N		April 2022
Quality of leadership (CQC KLOE W1)	TS	Y	Y	N		April 2022

Safe - people are protected from abuse and avoidable harm	Resp. Dir.	Definition available	Data Available	Data Flow Established	Notes	Timeframe for inclusion*
Safer Staffing – Community Services	SL	N	N	N	Examination of national guidance and interpretation of that needed to apply this appropriate to community services.	2023/24
Number of Falls Causing Harm	SL	Y	Y	N		Q1 2022/23
Number of Medication Errors Causing Harm	SL	Y	Y	N		Q1 2022/23
Reduction in Gram Negative Infections	SL	Y	Y	Y		April 2022

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Resp. Dir.	Definition available	Data Available	Data Flow Established	Notes	Timeframe for inclusion*
Patient engagement, satisfaction and experience	SL	N	N	N	This measure needs full definition and development.	2023/24

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Resp. Dir.	Definition available	Data Available	Data Flow Established	Notes	Timeframe for inclusion*
Clinical Outcome Measures – Number of patients with a clinical outcome measure in use as part of their care package	RB	Y	Y	N		Q1 2022/23
Clinical Outcome Measures – Number of services with a COMS project registered	RB	Y	Y	N		Q1 2022/23
R&D - Number of patients recruited to portfolio and non-portfolio studies	RB	Y	Y	N		Q1 2022/23
R&D - Number of research studies open in LCH	RB	Y	Y	N		Q1 2022/23

Unplanned hospitalisation of patients under our care/Re-admission within 30 days of patients under our care.	RB	N	N	N	Needs consideration as to whether a system-wide measure should be included here or one specific to LCH should be developed. Other relevant system measures should be considered for inclusion at the same time	Q3 2022/23
Improving recovery in the community - Stroke at 30 days and 6 months (numbers and degree of recovery)	RB	N	N	N		Q2 2022/23
Improving recovery in the community - Fragility fractures degree of recovery and rehabilitation at 30 and 120 days.	RB	N	N	N		Q2 2022/23
Dental indicator	RB	N	N	N		Q1 2022/23

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	**Resp. Dir.**	**Definition available**	**Data Available**	**Data Flow Established**	**Notes**	**Timeframe for inclusion***
Proportions of patient activities with an ethnicity code	SP	Y	Y	N		Q1 2022/23
Number of children and young people accessing NHS funded mental health services	SP	Y	Y	N		Q1 2022/23
CAMHS – Assessment and Consultation Waits	SP	Y	Y	N		April 2022
CAMHS – Neurodevelopmental initial Waits	SP	Y	Y	N		April 2022
CAMHS – Routine referral to treatment waiting times for children and young people with an eating disorder	SP	Y	Y	Y		April 2022
CAMHS – Urgent referral to treatment waiting times for children and young people with an eating disorder	SP	Y	Y	Y		April 2022
IAPT - Number of patients starting screening within two weeks of referral	SP	Y	Y	Y		April 2022
Number of referrals requiring a 2-hour urgent response	SP	Y	N	N	System development required to collate the information needed to measure this metric. This development will be managed via the UCR project	Q2 2022/23

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	Resp. Dir.	Definition available	Data Available	Data Flow Established	Notes	Timeframe for inclusion*
Percentage of jobs advertised as flexible	LS/JA	N	N	N		Q1 2022/23
Time to hire – working days from advert to start date	LS/JA	N	N	N		Q1 2022/23
Sickness absence (working days lost to sickness)	LS/JA	N	N	N		Q4 2022/23
Aggregate score for NHS Staff Survey questions that measure perception of leadership culture	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
People promise index	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Health and wellbeing index	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Acting to improve safety (safety culture theme in NHS Staff survey; questions 17a and 17b)	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months (NHS Staff survey; questions 14 a to 14d)	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties (NHS Staff survey; question 11d)	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns (NHS Staff survey; question 4d)	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (NHS Staff survey; question 15)	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23

Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Percentage of staff who are satisfied with the support they received from their immediate line manager	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Proportion of staff who say they have a positive experience of engagement (NHS Staff survey; question TBC)	LS/JA	N	N	N	Awaiting release of national definitions	Q2 2022/23
Proportion of staff in senior leadership roles (8b and above) who are (a) from a BME background	LS/JA	Y	N	N		Q1 2022/23
Proportion of staff in senior leadership roles (8b and above) who are (b) women	LS/JA	Y	N	N		Q1 2022/23

Finance	Resp. Dir.	Definition available	Data Available	Data Flow Established	Notes	Timeframe for inclusion*
Performance against financial plan	BM	N	N	N	Awaiting release of national definitions	Q2 2022/23
Underlying financial position	BM	N	N	N	Awaiting release of national definitions	Q2 2022/23
Run rate expenditure	BM	N	N	N	Awaiting release of national definitions	Q2 2022/23
Overall trend in reported financial position	BM	N	N	N	Awaiting release of national definitions	Q2 2022/23

Measures with Financial Sanctions	Resp. Dir.	Definition available	Data Available	Data Flow Established	Notes	Timeframe for inclusion*
LMWS - Number of people from Black, Asian and Minority Ethnic (BAME) groups entering IAPT treatment (access)	SP	Y	Y	Y		April 2022
LMWS - Number and % of people from BAME groups who have accessed IAPT treatment moving to recovery	SP	Y	Y	Y		April 2022
LMWS - % of older people (65+) entering IAPT treatment (access)	SP	Y	Y	Y		April 2022
LMWS - Number and % of older people (65+) who have accessed IAPT treatment moving to recovery	SP	Y	Y	Y		April 2022

* The timeframe given here is the period for which the measure will first be reported not the period in which the report is produced. For example if a timeline of April 2022 is given the measure will be included in the report produced in May 2022. If Q1 2022/23 is quoted it will be available in July 2022.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (130d)

Title: Draft revisions to Board Assurance Framework strategic risks 2022/23

Category of paper: for discussion and agreement
History: Not applicable

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

Executive summary (Purpose and main points)

"Strategic risks" are the risks that are most consequential to the organisation's ability to execute its strategies and achieve its objectives.

The content of the Board Assurance Framework (BAF) requires an annual review to ensure the Trust's strategic risks remain relevant**.** The Trust's priorities and objectives for the coming year have now been agreed, so this is an ideal time to review the BAF.

The Senior Management Team (SMT) reviewed the BAF strategic risks at its meeting on 9 March 2022 . This report proposes some revisions to the BAF strategic risks.

The main revisions recommended by SMT for the Board to consider are to:

- Revise strategic risk 1.5. As the Trust moves away from having an altered capacity due to the pandemic, the description should reflect the increasing demand on services and the risk of being unable to provide quality of care in a timely and equitable manner. (Executive Director of Nursing and AHPs / Quality Committee)

- Include a strategic risk (risk 2.8) that will describe the risk of not effectively managing and reducing the backlog / waiting lists that have built up during the pandemic. (Executive Director of Operations / Business Committee).

- Add a new climate emergency strategic risk: a risk that if the Trust does not transform to be more environmentally sustainable, then it will fail to play its part in achieving a carbon-neutral NHS.

- Merge risk 1.2 and 4.2 as both are pertaining to governance of partnerships and new care pathways. Quality Committee scrutiny of the quality aspects of partnership governance can be fed into the Business Committee's assessment of assurance.

- Merge risks 3.2 (equality and inclusion of staff) and 3.3 (engage and involve staff).

The risk scores for each of the BAF strategic risks have also been reviewed by SMT to ensure the score reflects the current level of risk. The table in section 5 of this report represents the Trust's (draft) risk profile and displays the risk score allocation (extreme, high, medium, or low) based on the proposed amendments to risks and scores.

Recommendations

The Board is asked to review the BAF strategic risks, consider the recommendations made by SMT and agreed any changes required for the 2022/23 version of the BAF.

Draft revisions to Board Assurance Framework strategic risks 2022/23

1 Introduction

The content of the BAF requires an annual review to ensure the strategic risks remain relevant**.** The Trust's priorities and objectives for the coming year have now been considered, so this is an ideal time to review the BAF.

When reviewing the strategic risks, the Board should examine the new risk environment it will be operating within including the increased focus on working in partnership, service back log / waiting lists, transformation, climate emergency, etc.

The Senior Management Team reviewed the BAF strategic risks at its meeting on 9 March 2022 and agreed to propose some amendments for the Board to consider. This report presents those proposed revisions to the BAF strategic risks associated with the Trust's strategic direction and its objectives.

2 What are strategic risks?

"Strategic risks" are the risks that are most consequential to the organisation's ability to execute its strategies and achieve its objectives. Strategic risk can disrupt a business's ability to accomplish its goals or even survive.

Strategic risk management is the process of recognising risks, identifying their causes and effects, and taking the relevant actions to mitigate them. Risks arise from internal and external factors. These factors can change year on year and a Board should examine the context and environment that it is currently operating within, as well as its strategic direction, and consider whether the strategic risks recorded on the BAF are still valid.

3 Suggested changes

Suggested changes to the 2022/23 BAF are as follows:

Objective 1: Deliver outstanding care

BAF Risk	2022/23 amendment	Current risk score Likelihood x consequence
RISK 1.1 If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective **(Exec Director of Nursing / Quality Committee)**		**Previous** 3 4 **12** **Current** 2 4 **8** This risk score has been lowered.

Risk 1.2 If there are insufficient clinical governance arrangements put in place as new care models develop and evolve, the impact will be on patient safety and quality of care provided. **(Exec Medical Director / Quality Committee)**	Propose that this risk is merged with Risk 4.2 (Partnership governance) and is assigned to the Business Committee for assurance but with scrutiny provided by both Quality and Business Committees in the case of new/revised partnership arrangements.	**Current** 3 3 **9**
RISK 1.3 If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm **(Exec Director of Nursing / Quality Committee)**		**Previous** 2 4 **8** **Current** 3 4 **12** This risk score has been increased.
RISK 1.4 If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve. **(Exec Director of Nursing / Quality Committee)**	No change to risk score or risk description proposed.	**Current** 4 3 **12**
Risk 1.5 If, as a result of the Trust's altered capacity due to the Covid-19 pandemic, the Trust cannot deliver services in a timely and equitable manner, then the impact will be further increases to waiting lists and the potential for harm to patients or complaints to the Trust. **(Exec Medical Director / Quality Committee)**	Propose that this risk description is updated to describe: *the increasing demand on services and the risk of being unable to provide quality of care in a timely and equitable manner. The impact will be potential harm to patients, additional pressure on staff and reputational damage.* **(Exec Director of Nursing and AHPs / Quality Committee)**	**Previous** 4 3 **12** **Current** 4 4 **16** This risk score has been Increased.
Risk 1.6 If the Trust does not optimise its services to reduce the impact of health inequalities and allow appropriate data capture to understand and address this, there will be a negative impact on patient outcomes, the Trust's resources and reputation. **(Exec Medical Director / Trust Board)**	No change to risk score or risk description proposed.	**Current** 4 3 **12**

Objective 2: Use our resources wisely and efficiently

BAF Risk	2022/23 amendment	Risk score			
Risk 2.1 If there is insufficient resource across the Trust to deliver major change programmes and their associated projects, then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised. **(Exec Director of Operations / Business Committee)**	No change to risk score or risk description proposed.	**Current**	3	3	**9**
RISK 2.2 If the Trust does not deliver contractual requirements, then it may be an indicator of patient care not being delivered at the required level or quality required by commissioners and adverse consequences for the immediate and longer-term financial position of the Trust. **(Exec Director of Operations / Business Committee)**	No change to risk score or risk description proposed.	**Current**	2	3	**6**
RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of accurate performance information, then it may fail to retain a competitive market position **(Exec Director of Finance and Resources / Business Committee)**	No change to risk score or risk description proposed.	**Current**	3	3	**9**
RISK 2.4 If the Trust does not maintain the security of its IT infrastructure, then there is a risk of being increasingly vulnerable to cyber-attacks causing disruption to services, patient safety risks, financial loss and reputational damage. **(Exec Director of Finance and Resources / Audit Committee)**	No change to risk score or risk description proposed.	**Current**	3	4	**12**
RISK 2.5 If the Trust does not deliver key financial targets agreed with NHS England through the ICS financial framework, then it will cause reputational	No change to risk score or risk description proposed.	**Current**	2	3	**6**

damage and raise questions of organisational governance **(Exec Director of Finance and Resources / Business Committee)**		
Risk 2.6 If the Trust does not invest and create the capacity and capability to respond to the increasing dependency on digital solutions then systems may be unreliable, underdeveloped, not used effectively, lack integrity or not procured. The impact will be on the delivery of patient care and on staff resources and wellbeing. **(Exec Director of Finance and Resources / Business Committee)**	No change to risk score or risk description proposed.	**Current** 4 3 **12**
ADDITIONAL RISK PROPOSED: **(2.7)** The Trust currently does not have a strategic risk about the climate emergency it recently declared.	Proposed risk description and ownership: "If the Trust does not prioritise the longer-term transformations that are needed to make the Trust more environmentally sustainable, then it will fail to play its part in achieving a carbon-neutral NHS. This will impact on population health, finances and reputation." **(Exec Director of Operations / Trust Board)**	Risk scores **Initial** 3 3 **9** **Current** 2 3 **6** **Target** 1 3 **3** These risk scores have been assessed in terms of statutory duty/inspection and reputation.
ADDITIONAL RISK PROPOSED: **(2.8)** The BAF currently does not have a strategic risk regarding the backlog / waiting lists.	Proposed risk description and ownership: 'If the Trust does not reduce the length of time that patients are waiting for appointments within our services, then the impact will be potential harm to patients, reputational damage and financial consequences'. As the remit for providing assurance on the 'Responsive' domain is with the Business Committee, the risk ownership and scrutiny is recommended to be with **Executive Director**	**Initial** 4 4 **16** **Current** 4 3 **12** **Target** 1 3 **3** These risk scores have been assessed in terms of patient safety, reputation and finance.

	of Operations / Business Committee.	

Objective 3: Ensure our workforce is able to deliver the best possible care in all of the communities that we work with

BAF Risk	2022/23 amendment	Risk score
RISK 3.1 If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development and a ~~*low*~~ *manageable* level of ~~***sickness***~~ absence) then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure. **(Director of Workforce / Business Committee)**	The risk description has been amended to remove 'sickness' as the defined reason for absence. There are numerous reasons for absence that can affect service capacity that need to be managed well.	**Previous** 4 3 **12** **Current** 4 4 **16** This risk score has been increased.
RISK 3.2 If the Trust does not create and embed a culture of equality and inclusion, then it will fail in its duty to attract and retain a diverse workforce that is representative of the communities it serves and will not reap the benefits of diverse thinking and representation. **(Director of Workforce / Trust Board)**	It is proposed that risks 3.2 and 3.3 are merged into one strategic risk: *'If the Trust does not engage with and involve staff and create and embed a culture of equality and inclusion, then it will fail in its duty to attract and retain a diverse and committed workforce and the impact may be low morale, difficulties recruiting and retaining staff and a less representative workforce.'*	**Current** 3 3 **9**
~~RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services **(CEO / Business Committee)**~~	It is proposed that risks 3.2 and 3.3 are merged into one strategic risk (see above).	~~**Current** 3 3 **9**~~ Risk to be merged.
RISK 3.4 If the Trust does not invest in developing managerial and leadership capability then this may impact on effective service delivery, staff retention and staff wellbeing **(Director of Workforce / Business Committee)**	No change to risk score or risk description proposed.	**Current** 3 3 **9**

Risk 3.5 If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related death, injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention. **(Exec Director of Finance and Resources / Business Committee)**	No change to risk score or risk description proposed.	**Current** 4 3 **12**
Risk 3.6 If the Trust is unable to maintain business continuity in the event of significant disruption, there is a risk that essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss **(Executive Director of Operations / Business Committee)**	No change to risk score or risk description proposed.	**Current** **3** 4 **12**

Objective 4: Work in partnership to deliver integrated care, care closer to home and reduce health inequalities

BAF Risk	2022/23 suggestion	Risk score
RISK 4.1 If the Trust does not play an active part in the collaboration across the health and care system (ICS and ICP), then the system may not achieve better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. **(CEO / Board)**	No change to risk score or risk description proposed.	**Current** 2 4 **8**
Risk 4.2 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and	No change to risk score or risk description proposed.	**Current** 3 3 **9**

relationships. **(Exec Director of Finance and Resources / Business Committee)**		

Once revisions are agreed at Trust Board, new strategic risks will be assigned to an executive director and to a committee or to the Board for oversight. Controls to manage the new strategic risks and the required sources of assurance will also need to be established.

4 Current share of strategic risks across the committees and Board

Strategic risks can be retained by the Board or delegated to committees which then have the responsibility to provide assurance to the Board on whether the strategic risk is being controlled (managed) or not, based on the evidence the Committee has seen and evaluated.

This is the current and proposed share of strategic risks:

Board / Committee	Delegation of BAF risks 2021/22	Delegation of BAF risks 2022/23 (draft)
Business Committee (BC)	11	11
Quality Committee (QC)	5	4
Audit Committee (AC)	1	1
Trust Board (TB)	3	4
	20	**20**

5 2022/23 strategic risk score allocation from extreme (red) to medium (yellow) (includes proposed amendments to risks and scores)

The table below represents the Trust's (draft) risk profile and displays the risk score allocation (extreme, high, medium, or low) based on the proposed amendments to risks and scores.

Table: draft risk profile 2022/23

Risk score								
16 →	1.5 Increased demand /timely and equitable care (QC)	3.1 Staff capacity (BC)						
12 →	1.3 Improve service quality (QC)	1.4 Engage patients and public (QC)	1.6 Reduce health inequity (TB)	2.4 Maintain cyber-security (AC)	2.6 Invest in digital (BC)	2.8 Waitlist / backlog management (BC)	3.5 Health & Safety systems (BC)	3.6 Maintain business continuity (BC)
9 →	2.1 Deliver Change Programmes (BC)	2.3 Productivity /efficiency (BC)	3.2 Staff equity & inclusion, engage & involve (TB)	3.4 Leadership capability (BC)	4.2 Partnership governance (BC)			
8 →	1.1 Quality assessment processes (QC)	4.1 Play active part in ICB/PBP (TB)						
6 →	2.2 Deliver contractual requirements (BC)	2.5 Deliver key financial targets (BC)	2.7 Climate emergency (TB)					

6 Risk assessment matrix

Strategic risks are assessed and scored using the Trust's Risk Assessment Matrix:

LIKELIHOOD / CONSEQUENCE	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Catastrophic (5)	5	10	15	20	25
Major (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Minor (2)	2	4	6	8	10
Negligible (1)	1	2	3	4	5

Key:

Risk Score	Risk Colour	Risk Level
1-3	Green	Low
4-6	Yellow	Medium
8-12	Amber	High
15-20	Red	Extreme

7 Recommendations

The Board is asked to review the BAF strategic risks, consider the recommendations made by SMT and agreed any changes required for the 2022/23 version of the BAF.

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (131a)

Title: Going Concern Consideration

Category of paper: for approval
History: Audit Committee – 11 March 2022

Responsible director: **Executive Director of Finance and Resources**
Report author: **Deputy Director of Finance and Resources**

Executive summary (Purpose and main points)
In preparing the annual accounts those charged with governance are specifically required to consider whether the Trust is a going concern so that financial statements are prepared on that basis. This report has been prepared to assist the Board with this consideration. The Audit Committee fully considered this paper at its meeting on 11 March 2022 and recommended that the Board approves the preparation of the 2021/22 annual accounts on a going concern basis.

Main issues for consideration
Considering the matters in this paper and an awareness of all relevant information it is concluded that there are no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern.

NHS bodies are considered to be going concerns unless there are plans to dissolve them.

The continuation of the provision of services is considered sufficient evidence to produce accounts on a going concern basis in the public sector.

Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept however these risks have been considered here to provide additional information and assurance to the Committee.

The Trust is in the early stages of agreeing the income allocation for 2022/23 with partners from the West Yorkshire Integrated Care Board (ICB). The draft planning submission on 18 February demonstrates the Trust should receive sufficient income to meet all it's out-goings. This work is expected to conclude to enable the ICB and provider organisations to submit a detailed draft plan to NHS England/Improvement by noon on 17 March. The plan will include both revenue and capital plans. These plans will need to affordable within the ICB financial envelopes; this is a joint responsibility for all organisations within the Integrated Care System (ICS).

If any material matters come to light between now and the approval of the accounts they will be drawn to the Board's attention.

Recommendations

The Board is recommended to approve the preparation of the 2021/22 annual accounts on a going concern basis.

Going Concern Consideration

1.0 PURPOSE OF THIS REPORT

1.1 This report provides information to the Board upon which the assessment of the concept of going concern can be made. Subject to the Board's approval, the accounts will be prepared on a going concern basis.

2.0 BACKGROUND

2.1 The going concern concept forms part of the completion of the Trust's accounts. It enables the external auditors to properly assess the Trust's accounts to ensure they are a "true and fair" reflection of the financial position at the end of the reporting period.

2.2 NHS trusts are considered to be going concerns unless there are plans to dissolve them. There are no plans to dissolve Leeds Community Healthcare and therefore the 2021/22 accounts should be on the basis of a going concern.

2.3 Accounting standard IAS 1, Presentation of Financial Statements, requires management to make an assessment of the Trust's ability to continue as a going concern and this paper considers the risks to the Trust's financial stability. The Treasury's Financial Reporting Manual (FReM) interprets IAS 1 in such a way that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.

2.4 In the UK, the period used by those charged with governance in making their assessment is usually at least one year from the date of approval of the financial statements.

2.5 The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

2.6 Where management are aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the Trust, these should be disclosed.

3.0 CONTENT

There are several areas of risk to be considered when assessing an organisation's financial standing and sustainability separate to the going concern consideration. The ones applicable to a NHS Trust are considered below.

3.1 The Trust's financial monitoring throughout 2021/22 provides evidence that financial duties and targets will be met or exceeded. The Trust is forecasting a small surplus by the end of March as agreed with the ICS. Historically, the Trust has achieved all its regulatory financial duties.

3.2 The Trust's financial performance is monitored externally by NHS England/Improvement through monthly reporting. The ICS receives monthly high-level updates on the financial position, revenue and capital, and there are monthly Director led meetings to discuss the West Yorkshire overall position. Internally, the Trust's financial performance has been monitored monthly by the Senior Management Team and by the Business Committee and the Board at each of their meetings.

3.3 The Trust has reported a use of resources risk rating of 1 since it was introduced in October 2016. Although no longer a key metric for NHS England/Improvement the Trust continues to review this and performance for 2021/22 has been rated at 1 where 1 represents the lowest risk rating for provider organisations.

3.4 The Trust expects to have a detailed income and expenditure revenue budget for the year approved by the Board on 26 March. A source an application capital plan will also be presented to the board for approval.

3.5 For 2021/22 the Trust will meet the ICS control total target for revenue performance.

3.6 The Trust has low levels of outstanding debt; most of the 2021/22 contract income has been paid monthly; this will continue for 2022/23.

3.7 The Trust's liquidity remains very strong with circa £40m forecast to be in the bank at year-end; over £44m at the end of January. The Trust is confident it has sufficient cash resources to meet all its liabilities in 2022/23.

3.8 The Board of Directors is an experienced team; there has been no turnover within the Executive or Non-Executive members of the Board during the financial year. This ensures continuity of governance arrangements.

3.9 The Board has inherently considered the matter of the Trust as a going concern, through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future. This is in line with the Group Accounting Manual January 2022 section 4.18-4.28.

3.10 The management team has no intention of applying to the Secretary of State for dissolution of the Trust.

3.11 The NHS has resumed its planning and contracting processes for 2022/23. These are being led by the ICS and the Trust is participating fully in the revenue and capital planning for 2022/23. NHS contracts will be signed with Commissioners for the first time in two years by the end of March. Draft income values have been agreed with Leeds CCG as part of the ICS process.

3.12 Contract extensions have been agreed with the Local Authority for the sexual health service and with Police Commissioners for the custody service.

3.13 Contracts for public health and health and justice services are under negotiation with NHS England.

3.14 The most recent CQC assessment of the Trust's service delivery rated services to be Good overall.

3.15 The management team is not aware of any operating or other issues that would prevent the annual accounts being prepared on a going concern basis.

3.16 It is expected that by the time the accounts are prepared NHS contracts will be signed and there will be no material uncertainty to be declared.

4 CONCLUSION

4.1 Considering the matters in this paper and an awareness of all relevant information it is concluded that there are no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern.

4.2 The going concern conclusion will be disclosed is the annual report.

4.3 If any material matters come to light between now and the approval of the accounts they will be drawn to the Board's attention.

5 RECOMMENDATIONS

5.1 The Board is recommended to approve the preparation of the 2021/22 annual accounts on a going concern basis.

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (131b)

Title: Declarations of interest and compliance with fit and proper person requirements made by directors for 2021/22

Category of paper: for information
History: Not applicable

Responsible director: Chief Executive
Report author: Board Administrator

Executive summary (Purpose and main points)

Board members: declarations of interest

As part of the actions to prepare the Trust's annual report and accounts, the Trust is also required to collate the data on any declarations of interest disclosed by directors during the course of the year. The full schedule of disclosures is then included as part of the annual report.

The Trust's policy on declarations of interest requires directors to declare any significant financial or personal interests that each member, or a close relative or associate (such as partner, child, or sibling) has in any business or other activity or pursuit which may compete (or intends to compete) for any contract or agreement to supply goods or services to the Trust. In addition, directors are asked to declare: any other substantial connection or position of trust with related organisations; any other commercial interest; any area of potential conflict and details of hospitality or gifts in excess of £35.

In February 2022, all directors were asked to review and update their declarations of interest and a schedule of disclosures for 2021/22 is appendix 1 to this report.

Board members: fit and proper persons requirements

The Health and Social Care Act 2008 (regulated activities) Regulations 2014 set out requirements by which all directors should be, and continue to be, fit and proper persons by nature of the fact they hold positions of significant responsibility and can maintain the confidence of public, patients and staff.

The regulations require directors to: be of good character, have the necessary qualifications, competence, skills and experience, be able by reason of their health (subject to reasonable adjustments) to properly perform tasks intrinsic to the position and not to be unfit to hold office on a range of grounds (eg undischarged bankruptcy, criminal convictions, inclusion on barred lists, serious misconduct in the course of carrying out a regulated activity etc).

NHS bodies are required to apply these requirements in two ways: pre-appointment checks and ongoing assurance (as an annual exercise). In February 2022, directors were asked to make a statement in relation to their compliance with the requirements. All directors have made a declaration that they comply with the 'fit and proper person test'. In addition, annual checks have been conducted to confirm former satisfactory background checks are still current, these include Google search, health and social care regulators' checks, disqualified directors, insolvency and bankruptcy registers.

Recommendations

Note the declarations made by directors for 20221/22 (in draft).

Leeds Community Healthcare NHS Trust
Director's declarations of interests for disclosure 2021/22

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Brodie Clark CBE (Trust Chair)	None	None	None	None	None	None	None	None
Thea Stein (CEO)	None	None	None	Trustee of Nuffield Trust CQC Executive reviewer	None	None	None	None
Helen Thomson	Helen Thomson Ltd	Director Helen Thomson Ltd	None	Trustee:Sue Ryder Council Member University of Huddersfield until August 2021	Trustee:Sue Ryder	None	None	None
Alison Lowe OBE	None	None	None	Chief Executive Touchstone until 6 August 2021 Trustee Citizens Advice Leeds	Trustee Citizens Advice Leeds	None	Deputy Mayor for Policing and Crime in West Yorkshire from 9 August 2021	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Richard Gladman	Director of Verbena Digital Ltd	Verbena Digital Ltd	Verbena Digital Ltd	None	None	None	None	None
Prof Ian Lewis	None	None	None	Trustee: Rossett School Harrogate	None	None	None	None
Khalil Rehman	NED @ Salix Homes Ltd	None	None	Director @Medisina Foundation Ltd	Advisory work for Touchstone Support Ltd	None	None	None
Rachel Booth (Associate Member)*	None	None	None	None	Full time employee of BUPA which contracts with NHS through its Cromwell Hospital, Dental and Care Homes business areas.	None	None	None
Bryan Machin	None	None	None	Trustee and Vice-chair of St Anne's Community Services. (Registered Charity, Housing	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
				Association and Company Limited by Guarantee)				
Dr Ruth Burnett	None	None	None	Medical Director Leeds GP Confederation Performs GP work at Crossley Street Surgery, Wetherby on an unpaid basis as part of Continuing Professional Development and maintaining registration.	None	None	None	None
Sam Prince	None	None	None	None	None	None	None	None
Steph Lawrence	None	None	None	Executive Director of Nursing and AHP's for Leeds GP Confederation. National Professional	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
				Advisor for Community Services for CQC since April 2021. Supporting a domiciliary home care agency since January 2022 – Be Caring who have contracts in Leeds, Liverpool, Manchester and Newcastle. I am supporting them with and providing advice around their governance processes including attending their Quality Committee every other month. Fellow of the Queens Nursing Institute.				

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Laura Smith*	None	None	None	Director of Workforce Leeds GP Confederation Leeds	None	None	None	None
Jenny Allen*	None	None	None	Director of Workforce Leeds GP Confederation Leeds Indirect interest – husband is a partner at KPMG KPMG bid and contract for contracts with NHS Providers Volunteering for Zarach, a Leeds based charity (February 2022) Trustee for Hollybank Trust.	Volunteering for Zarach, a Leeds based charity (February 2022)	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
				Husband is a Trustee for Age UK Leeds.				

***** Non-voting Board member
Board approved –
Audit Committee approved -

Leeds Community Healthcare NHS Trust

Trust Board Meeting: 31 March 2022

Agenda item number: 2021-22 (131c)

Title: Risk Appetite Statement review

Category of paper: for approval
History: SMT 24 November 2021
Audit Committee 10 December 2021

Responsible director: Chief Executive
Report author: Risk and Safety Manager

Executive summary (Purpose and main points)

The risk appetite assists decision-makers in understanding the degree of risk to which they are permitted to expose the Trust. It is good practice to review the risk appetite on a regular basis, as the environment in which the Trust and the wider NHS operates is a changing and challenging one.

It is often not possible to manage all risks at any point in time to the most desirable level, but the Trust should manage risks to a reasonable level.

The Trust's Risk Management Policy and Procedure stipulates that the risk appetite statement will be reviewed annually by the Senior Management Team and any proposed changes are to be approved by the Board.

The details of the Trust's current risk appetite statement are set out in this document.

SMT was asked to review the current statement (attached) and indicate any changes, paying particular attention to:

- the risk appetite categories (these are aligned to the Trust's strategic goals, with the addition of reputation).
- the levels of appetite contained in each category (as highlighted in bold): if the levels are still current and should any level be raised or lowered

SMT discussed the risk levels set out in the risk appetite statement. SMT concluded that the risk levels remained appropriate. Audit Committee has also reviewed the risk appetite and subsequently asked SMT to reconsider whether the current appetite level for patient safety risks was appropriate. This review has now taken place and it is proposed that the risk appetite statement remains unchanged.

Recommendations

The Board is recommended to:

- Review and approve the risk appetite statement

Trust Risk Appetite Statement

1. Introduction

Risk appetite is defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. The Trust has developed and documented its risk appetite statement in order to assist decision-makers in understanding the degree of risk to which they are permitted to expose the Trust to, whilst encouraging enterprise and innovation.

The Trust's risk appetite statement has been defined in relation to its four strategic goals. The Trust's risk appetite for reputational risk is also defined.

The statement of risk appetite is dynamic and its drafting is an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust will review its risk appetite at least annually.

2. Use of the Trust risk appetite

It should be acknowledged that the statement of risk appetite is a broad one, which enables better internal control and does not offer definitive answers to any specific risk management issue. When assessing and managing risks, managers should review the risk appetite statement to assist them in determining an acceptable risk target score (see section 4. risk appetite target scores) and set out the mitigating action required to achieve this.

No statement of risk appetite can encompass every eventuality and there may be exceptions, which mean that the Trust has valid reasons for setting a level of tolerance outside of the scope of the statement of risk appetite. In this case, the rationale will be formally documented and consideration will be given to incorporating changes as necessary in any future revision of the risk appetite statement.

3. Risk appetite statement

The Trust recognises that it is operating in a competitive healthcare market where safety, quality and viability are paramount and are of mutual benefit to stakeholders and the organisation alike. The Trust also recognises the importance of other health providers in the system and their impact on the organisation. The Trust stakeholders extend not only to other healthcare providers, but also to the public, suppliers of services to the Trust, the government and government bodies including regulators.

The organisation will manage clinical, financial and business risks in order to deliver its objectives in a controlled manner. The Trust's current risk appetite is set out overleaf:

RISK APPETITE STATEMENT

Quality

Delivering high quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, safe and effective services. It has a ***minimal* (low) appetite** to risk that could compromise the delivery of high quality, safe services.

Integrated working and operational performance

The Trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the Trust's current and future services. Working collaboratively requires a degree of risk to be accepted as the Trust develops joint strategic plans to deliver a stronger and more resilient local health service. The Trust has an ***open* (high) risk appetite** for developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.

The Trust is supportive of innovation and has an ***open* (high) risk appetite** in pursuing innovation and challenging current working practices without compromising the quality of patient care. In the implementation of changes, the Trust has a *cautious* (moderate) risk appetite.

Priority will be given to improvements that protect current operations and the Trust has a ***cautious* (moderate) risk appetite** for risk that may compromise the delivery of outcomes but that does not comprise the quality of patient care.

Workforce

The Trust is committed to recruiting and retaining the best staff. It has a ***minimal* (low) appetite** to risks concerning staff safety. It has a ***minimal* (low) risk appetite** for non-compliance with statutory and mandatory training requirements.

The Trust will ***avoid* (zero risk appetite)** noncompliance with NHS Employers Standards, employment fraud or lapses in professional qualifications. The Trust has an ***open* (high) risk appetite** to for learning and development opportunities which allows it scope to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work.

Finance

The Trust has a ***minimal* (low) appetite** to financial risk in respect of meeting its statutory duties of maintaining expenditure within the limits agreed by the Board in recognition of regulatory requirements.

The Board has an ***open* (high) appetite** to the financial risk associated with new expenditure plans for existing services as the benefits for patient care may justify the investment. For investment in new services, the Trust's risk appetite is ***cautious* (moderate)** if the benefits to existing patients cannot convincingly be demonstrated.

In terms of financial controls, the Trust's appetite is to ***avoid* risk *(*zero appetite*)*** of financial loss and it will put in place financial governance controls to avoid loss of cash or any other asset with significant financial value.

Reputation

The Trust has a ***cautious* (moderate) appetite** for risks relating to its reputation. Any actions or decisions that have a chance of significant repercussions on the reputation of the Trust and its employees will be subject to a rigorous risk assessment and will be signed off by a member of the Senior Management Team.

4. Risk appetite target scores

The risk appetite is defined by the 'Good Governance Institute risk appetite for NHS organisations' matrix, which Leeds Community Healthcare Trust has adopted. This has been aligned to the Trust's own risk assessment matrix as shown in the table below.

Good Governance Institute matrix	Risk appetite level	Risk target score (range)
Avoid: Avoidance of risk and uncertainty is a key organisational objective	**Zero**	**Nil**
Minimal: (As little as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential	**Low**	**1-3**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward	**Moderate**	**4-6**
Open: Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and VFM)	**High**	**8-12**
Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Extreme**	**15-20**
Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	**Extreme**	**25**

Public Board Meeting: 31 March 2022

Agenda item number: 2021-22 (132i)

Title: Leeds Community Healthcare NHS Trust: Green Plan 2022-2025

Category of paper: Approval

History:

- **Presented at Senior Management Team meeting: 16 March 2022**
- **Shared with all internal stakeholders who have a dedicated section. This includes procurement, estates and facilities, waste, workforce, finance, digital innovation, and medicines.**

Responsible director: Executive Director of Operations
Report author: Sustainability and Environmental Manager

Executive summary (Purpose and main points)
This Green Plan was created following the directive from NHSE&I Greener NHS programme, who outlined that all Trusts must have a detailed sustainability Green Plan which covers a 3-year period and clearly outlines the organisations current carbon status, ambitions, goals, and the projects required to achieve them.

The LCH Green Plan has 3 main sections:

Section One
- Background on sustainability throughout both LCH and the wider NHS.
- Structure of the sustainability team management framework.
- The current carbon emission profile of the trust.

Section Two
- The overall aims, goals and projects required to reach Net Zero.
- Specific and detailed project list for the next 3 years in the 4 main carbon emitting areas: procurement, estates and facilities, travel, and waste.

Section Three
- Staff engagement and sustainability movement across the Trust.
- Clarification on how sustainability progress against the Green Plan will be monitored and scrutinised.

This plan was created with input from a variety of different departments particularly procurement and estates and facilities. The sustainability team also liaised with staff through sustainability workshops which took place between November-December 2021. We used the NHS Greener Green Plan template which provided a framework for Trusts and outlined which elements were essential to include.

If approved at the Board meeting on the 31st March 2022, the plan will then be submitted to the West Yorkshire Sustainability ICS, who are currently collating all the Green Plans of West Yorkshire NHS organisations to submit to the central NHS Greener team.

Recommendations:

The sustainability team are submitting this Green Plan for Board review and approval, which will allow work to begin on the projects and for communication of a summarised version to staff throughout the Trust to take place.

Please could the board also confirm if the below proposed level of reporting is adequate with regards to the monitoring of the Green Plan:

- A quarterly sustainability board report written by the sustainability manager and submitted to the sustainability lead director: Sam Prince to inform on progress and update against the aims and targets outlined in the Green Plan.
- An annual sustainability report which will be produced at the end of the calendar year to update on our annual carbon emission and a review of the projects with proposed next steps for the upcoming year.

NHS
Leeds Community Healthcare
NHS Trust

Green Plan
2022-2025

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Foreword

Leeds Community Healthcare NHS Trust (LCH) has always prided itself on being an innovative, inclusive, and pro-active trust that puts both patient and staff at the heart of all its decisions. Climate change is one of the most prominent and urgent issues of our time and the effects would be far reaching not only for the population of Leeds, but nationally and globally. Here at LCH we recognise the importance of sustainability and how the decisions we make now will influence generations to come. Over the past two years the NHS has undergone the biggest changes of a generation following the Covid-19 pandemic. We now find ourselves in an opportunistic position to reduce the trusts carbon output and increase our sustainability practices at a far faster pace than previously expected. We are more aware than ever that we must focus our efforts into a variety of areas such as reducing unnecessary travel for our staff and patients, reduce our waste and ensure we reuse and recycle as best as possible. If LCH can adapt to these changes this will not only have a positive effect on our sustainability and longevity as a trust but also will have short and long-term financial benefits which is imperative in an age with increasing financial pressure and demand.

Our Green Plan will explore key areas where we feel real improvements can be made across our trust. As a large multi-faceted organisation which delivers a large variety of interventions and treatment across the whole of Leeds, we recognise that the impact of reducing our carbon and waste output could be significant. We will work collaboratively with our partners across both the social and health care sectors to collectively ensure our combined efforts are maximised and united in one vision of protecting the population we serve. We will strive to adhere and achieve the targets set out both nationally and locally taking a pragmatic and realistic approach to change.

The future is in our hands and as a trust we understand that everyone has a part to play across all departments. This Green Plan highlights how all the employees of our trust should work together to achieve our goals. Now is the time for action and LCH is fully committed to doing all it can to protect its service users and the wider population of Leeds.

Thea Stein

Chief Executive

Sam Prince

Operational Director

Sustainability Lead Director

Introduction

The detrimental effects of global warming and climate change if left unchecked pose the greatest unprecedented challenges we will face within our lifetime. LCH plays an important role in providing health and social care systems across the region of Leeds; and with this role comes a moral responsibility to both recognise and respond to the science and the intrinsic link between the effects of climate change and negative impact on public health.

LCH is a trust built of over 3000 employees delivering care within or as close to people's homes as possible, through a variety of disciplines including; nurses, therapists, pharmacist, non-registered and registered clinical staff - all supported by our corporate head office. Our vision is simple and clear *"We provide the best possible care in every community"* which we strive to achieve through working with children, adults, and families to deliver high quality care, being a good partner, developing and valuing our staff and using our resources wisely and efficiently.

Sustainable practice and reduction in our carbon emissions will not only reduce LCH's environmental impact and contributions towards climate change, but in turn will have positive effects on the health of the population we delivery care to. We know that certain areas within Leeds have extremely poor air quality, leading to an increased cluster of asthma and respiratory diagnoses, and by embedding sustainability practices throughout our trust we can contribute to improving air quality and therefore respiratory health. This is only one example, and it reminds us that we must consider the wider implications of changing to sustainable practices; to ultimately improve and protect public health alongside helping to improve the quality of life of our patients.

At LCH, we will foster and embed a sustainability consciousness across all our sectors and departments to maximise the effects we can have as an NHS trust. We are in a position where all our concerted efforts can make a huge difference; this is a message we will ingrain within the culture of all our colleagues at LCH. We will stand as ambassadors of change recognising the benefit of sustainable practices for both our staff and patients.

Considering the vast influencing reach of the NHS, alongside its scale, it should be one of the driving leaders for change. LCH declared a Climate Emergency on the 5 November 2021; leading to a commitment to reach Net Zero by 2045 in alignment with the Greener NHS ambitions. We have devised our ambitions and the format of this plan with guidance from the Greener NHS Strategy outlined within the *Delivery a Net Zero National Health Service* document.

From calculating our trusts total carbon emission for 2021, we have concluded there are 4 key areas which will need considerable efforts to reduce their emission, these consist of:

- Buildings and Estates
- Procurement
- Travel
- Waste

We will collaborate with our partners across the health and social sectors in Leeds such as Leeds City Council, the Clinical Commissioning Group, the West Yorkshire Integrated Care System (ICS) and other local health care providers to maximise our efforts. LCH is also part of The Leeds Health and Care Climate Commitment, which outlines our local climate ambition: *To be a climate resilient*

health and care system. To adapt, evolve, and act to improve the sustainability of the system, mitigate the impacts of climate change – especially within our communities that experience the poorest health outcomes – and better prepare us for future consequences of climate change.

We have listened to the population of Leeds who strongly feel issues such as the environment, loss of biodiversity and air pollution need to be addressed to benefit the health and wellbeing of the population. With this in mind, we intend to work alongside local environmental groups such as The Conservation Volunteers (TVC), who offer a range of conservation and community engagement projects. We believe this is the perfect opportunity to offer a volunteer scheme which will both educate and engage LCH staff beyond the workplace, while helping our environment.

Finally, the Covid-19 pandemic has caused a great deal of uncertainty within the country, but there is now an emerging opportunity to redesign services and processes to improve our sustainable practices and decrease our carbon emissions. This includes reduction in travel by digital consultations, support for hybrid model of home working and a reduction in the reliance on inefficient high carbon buildings throughout our estate.

During the global pandemic the NHS underwent huge challenges and changes, it pulled together all its employees and resources to adapt many service deliveries to respond to this health emergency. It demonstrated courage, leadership, determination, and empathy during a time that has been described as the worst health crisis since the Spanish flu in 1918. This phenomenal effort demonstrated to the public that there is strength and resilience within our health service. We must take all these notions and lessons learnt to help as best we can the next generational challenge of climate change. Now is the time to act and prove that LCH is a key player in mitigating and adapting to the effects climate change and show dedicated leadership to protect those who are most vulnerable across our society.

Drivers for Change

On the 5th of November 2021 the Leaders of LCH declared a Climate Emergency. This was a big step for sustainability throughout the trust as it demonstrated that the leaders at LCH were committed to doing all they can to support the potential difficult changes that we need to make to prevent the worst impacts of global warming and climate change. We have also committed to becoming a Net Zero organisation by 2045 in conjunction with the central NHS England and Improvement ambitions. Leeds City Council declared a climate emergency in March 2019 and like others throughout the country has made the ambitious aim to make the city carbon neutral by 2030. It is worth noting that we will strive to align our efforts with the West Yorkshire Sustainability ICS commitment to reach Net Zero by the ambitious date of 2038 for all emissions within Scope 1&2 *(refer to Appendix A for explanation of NHS Scopes).* The West Yorkshire region is making strong steady progression on its climate commitments and we at LCH will be alongside other major institutions across Leeds to continue this monumental effort.

The national and local response to the Covid-19 pandemic has created both opportunities and risks to the city's desire to tackle climate change and sustainability challenges. A reduction in commuting throughout the city has led to the suspension of the clean air charging zone and a renewed focus on re-greening the city centre. Furthermore, the rise in digital appointments has offered patients the opportunity of receiving care without the need to travel and lessen the demand for parking spaces. Whilst these opportunities are welcomed, it is extremely important that all NHS trusts make permanent decisions (where appropriate) to embed sustainable changes throughout their organisations, even when Covid-19 is no longer the threat it is now.

It is also important to recognise the risks to sustainable development driven by the Covid-19 pandemic. The vast increase in Personal Protective Equipment (PPE), and the single use/ waste disposal costs that come with its usage has created significant sustainability issues. LCH will work with its IPC department, staff, and suppliers to ensure that wherever possible the most sustainable options are selected, whilst maintaining the safety of our staff and patients.

We now stand on a precarious precipice where the actions we take in the next 5-10 years will ultimately shape the world around us for generations to come. Following the COP26 conference held in Glasgow 2021 we recognise we must continue striving forward with our pledges and actions to achieve Net Zero and embed sustainable practices throughout our health service.

Sustainability is Everyone's Business

As our sustainability department is relatively new LCH must ensure there are clear channels of communication and establish a management framework outlining responsibilities and accountability for each sustainability action. This will ensure staff are aware who is involved at every level, all the way from front line staff to members of the Board.

At the heart of the governance structure will be a new quarterly Sustainability Board, led by the Executive Director of Operations who will become the Sustainability Lead Director. The Sustainability Board will review performance against the Green Plan, escalate and resolve issues impacting on performance and help prepare the mid-year and annual review for Senior Management Team, Business Committee and Trust Board.

Sustainability Lead Director - Sam Prince: The role of the Sustainability Lead Director is to oversee the Green Plan and if needed modify any arrangements in line with ongoing developments. The Lead Director will:

- Chair the Sustainability Board and ensure that resources are in place to execute the aims outlined in this document.
- Work with other Executive/ Non-Executive Director colleagues to not only update and reassure the Senior Team, but to also ensure the plan has the support of the senior management team.
- Present quarterly report to the Board to update on progress and update against the aims and targets outlined in the Green Plan.

Sustainability and Environmental Manager: The role of the Sustainability and Environmental Manager is to lead and co-ordinate the proposed projects within the Green Plan. They will produce the quarterly report which will be presented to the Sustainability Board and will continuously review the outlined projects to ensure they are on the correct trajectory. The project manager will also be the face of sustainability for the trust, and the first point of contact for external organisations, senior management, and employees of the trust.

Sustainability Steering Group: The sustainability steering group will be made up of several key internal stakeholders who are responsible or involved in the delivery and implementation of the plan. This includes representation from workforce, buildings and estates, procurement, estates, infection prevention control, digital innovation, and waste. The role of the sustainability steering group is to manage and report on the Green Plan developments, but to also interface with carbon champions and engagement groups.

Carbon Champions: These are individuals who are sustainability leaders in their teams and localities that are passionate about sustainable change and who will use this enthusiasm to inspire others. The role of a carbon champion is to feed back to their team updates from the sustainability department and to communicate with the sustainability manager any arising concerns their teams are experiencing locally and offer sustainability solutions throughout the trust.

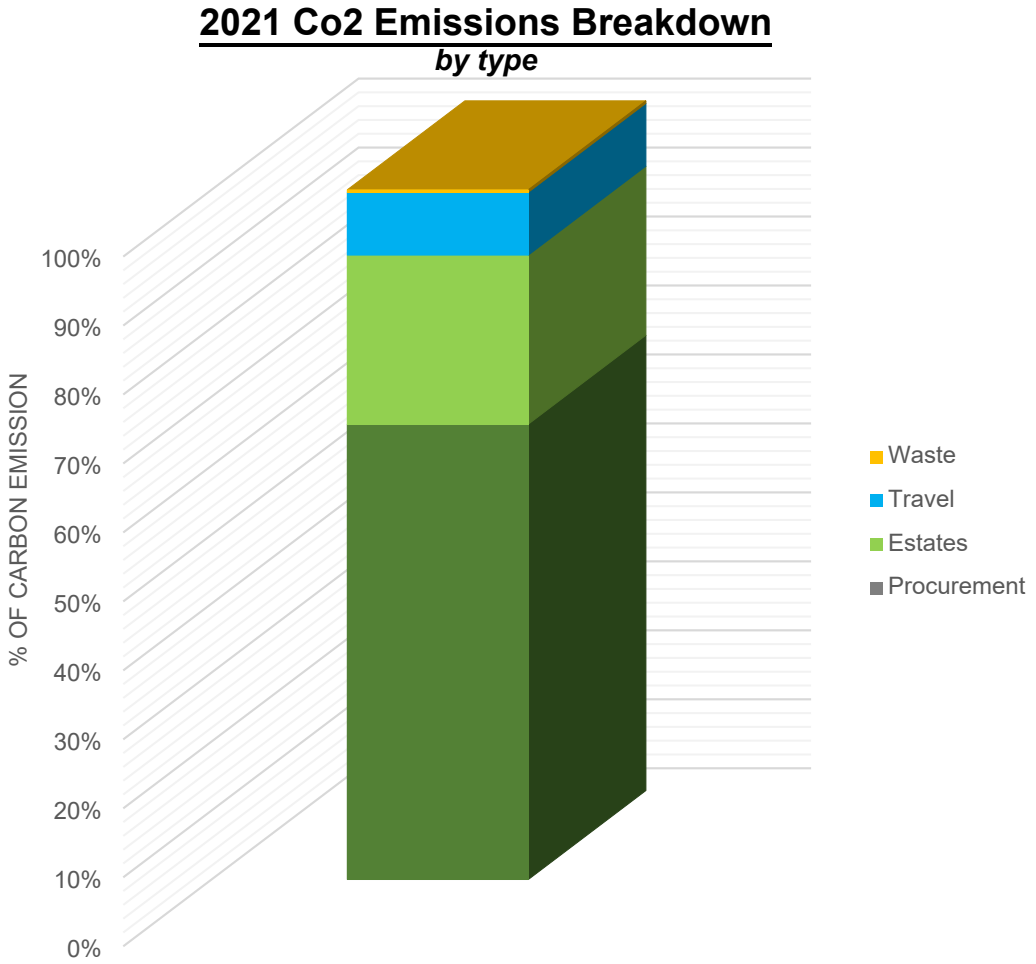
Staff Engagement Groups: These subgroups are led by the local Carbon Champions who will look at ways of locally implementing a variety of changes inspired from the Green Plan and communicate innovative ideas on how sustainability can be achieved in their departments / teams.

Current Carbon Emissions

During 2021 LCH calculated its total carbon emissions from 4 known carbon dense areas: Buildings and Estates, Travel, Procurement and Waste. The sustainability department used the DEFRA Carbon Factors calculations and methodology. There are important notions to consider when using this particular year as a baseline; the most noticeable is the effects from the COVID-19 pandemic. It is important to note that although there are significant changes in our emissions due to the pandemic, most notably in travel, we plan to take advantage of these opportunities and continue to decrease emissions by adopting new ways of working and delivery of care following the past 2 years.

The emissions output for LCH was recorded over 4 calendar quarters which are defined as the following:

Quarter	Months
Q1	January 1 – March 31
Q2	April 1 – May 31
Q3	June 1 – August 31
Q4	September 1 – December 31



Total Emissions Presented in co2e

Waste	Travel	Buildings and Estates	Procurement	Total
24.071 tco2e 24070.70 kgco2e	618.26 tco2e 618259.90 kgco2e	1663.56 tco2e 1663558.825 kgco2e	4481.02 tco2e 4481020.81 kgco2e	**6787 tco2e** **6786910.235 kgco2e**

During the month of February 2022 LCH worked with the company RSK to review and certify our data collection and methodology. The report has since been returned and confirmed both our calculations and results are all correct and the data is of a good standard. There are recommendations which highlight opportunity to enhance and continue to develop the quality of our data which we will take forward with future calculation. The finalised report sits with the sustainability team - for further or queries please contact them directly at lcht.sustainability@nhs.net

Carbon Emitters: Background

Waste

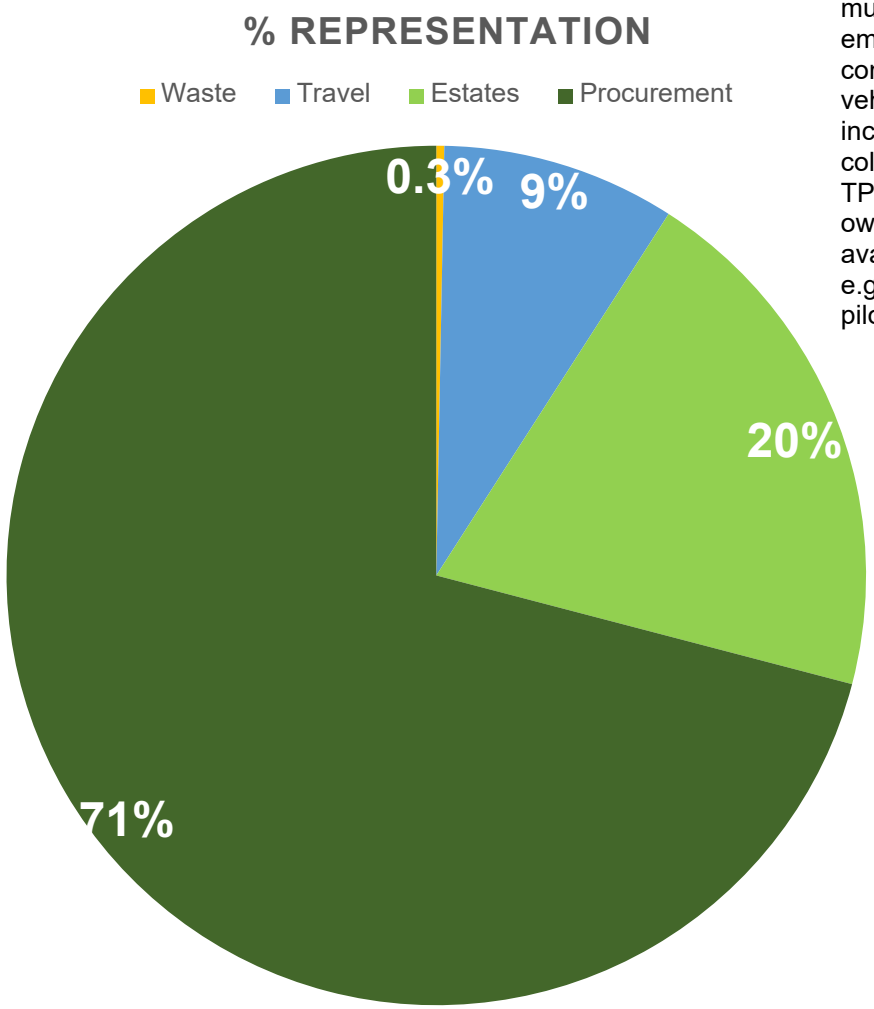
We currently have 3 waste streams within LCH these are:

- Domestic
- Clinical
- Sanitary

The management of the waste falls into 1 of 3 options: incineration, land fill or recycling. Landfill and incineration have the highest carbon emission factor with recycling having the lowest. This is important to note when contracting to waste providers. Waste is the lowest carbon emitter for the trust – however we need to improve our recycling awareness and facilities as it is a relatively simple achievable goal if we execute well. It is also an area that many staff feel passionate about and an area that many feel they can have a direct impact on.

Procurement

LCH works closely with our partners at Leeds and Yorkshire Partnership Foundation NHS trust for its procurement needs and so the initial step is to collaborate with our partners to achieve a clear and transparent procurement green makeover (this work has already been started). Procurement is the largest carbon emitter for the trust; as we rely on many outsourced products to ensure we can work effectively and safely. There is national guidance being released from NHSE&I procurement team to help trusts locally execute their goals and aims within this notoriously challenging carbon dense area.



Travel

As a community trust we have a large proportion of staff that will be required to travel to carry out their work. Therefore, LCH will need to take a multidimensional approach to transforming our emissions from travel. The solution will be a combination of options such as use of electric vehicles, promotion of public transport and incentives for active travel. We will explore collaborative working with the others including: TPN and Leeds City Council to formulate our own Travel Plan which will include deals available to staff and incentives for green travel: e.g. MCards, Cycle to Work Scheme and travel pilots such as Flexibus

Buildings and Estates

Throughout the 41 sites that the trust works from 26 are leased and 16 are owned by LCH. We previously set ourselves the target to reduce our energy consumption by 10% by 2022. This has likely been achieved by the results of the pandemic, but we must strive to continue with the downward trend of building energy use.

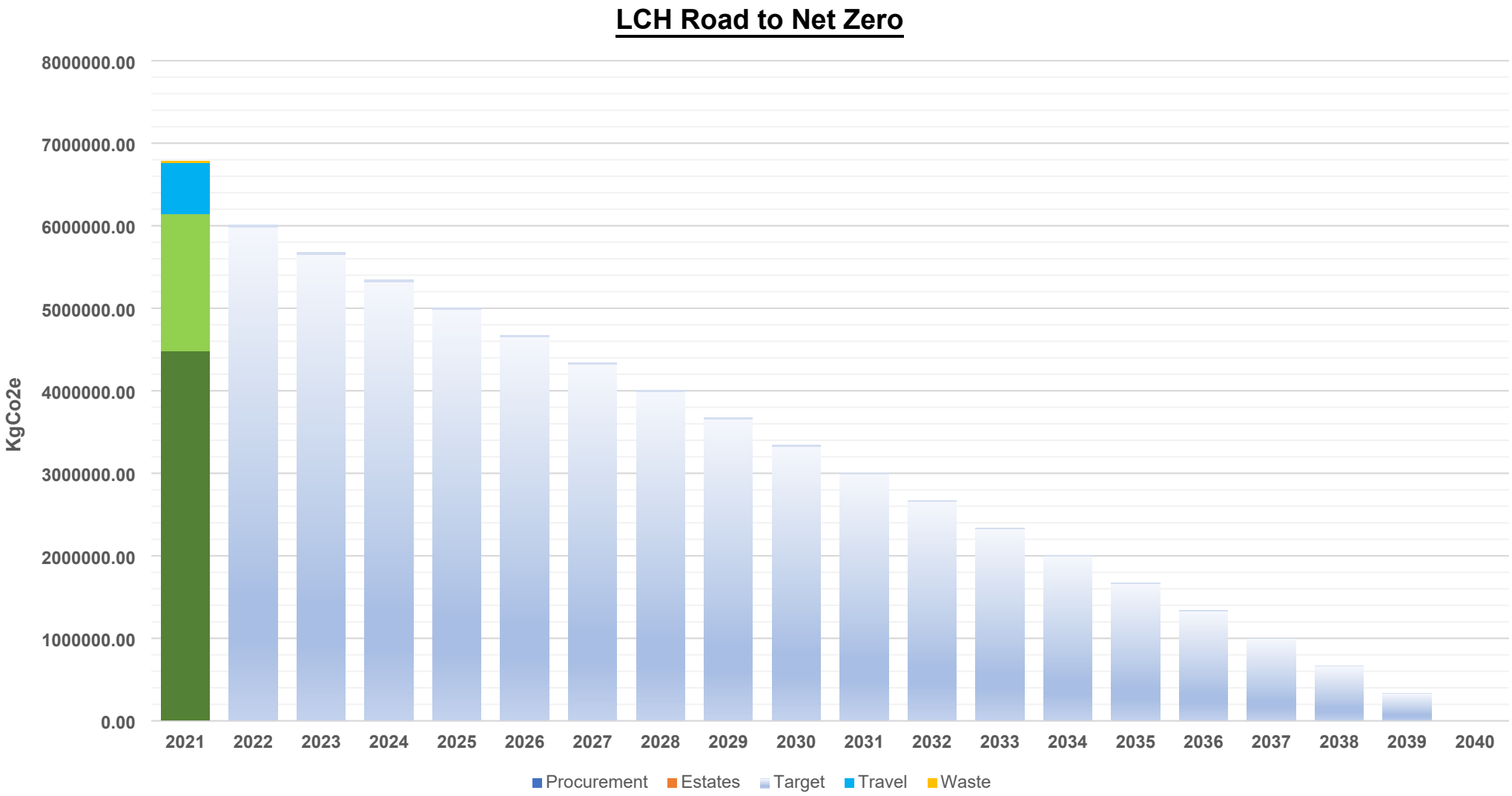
Following the pandemic, we are aware that many of our office-based staff will have moved to a hybrid model of home working. We will continue to encourage individuals to adopt this model of working and it will likely result in a review of the buildings we utilise across the city.

Even though energy usage will be recorded on a quarterly basis the messaging for staff will be coherent to all staff throughout the trust to help a downward trend of energy use throughout all sites.

Annual Average Carbon Reduction

From our total carbon emissions, we have been able to create a forecasted average carbon reduction graph. This highlights that on average we need to reduce our carbon emissions by **357 tCo2e per year to reach Net Zero by 2045.**

The graph below depicts a linear pattern, and it's worth noting we don't expect our carbon will decrease in such a structured / consistent pattern; however, it is useful to have a baseline figure and projection we can judge our performance against as we move forward on our Net Zero journey.



This chapter outlines our ambitious goals and aims along with the associated projects required to achieve them and reach Net Zero. These aims span across the 4 main emitting areas: Travel, Procurement, Buildings and Waste. The associated projects are categorised by their level of investment, both with regards to finance and level of resource. They were formed by consultation / collaboration with other NHS organisations, guidance from the Greener NHS programme and documents such as the *'Delivering a Net Zero Health Service'* and *NHS Long Term Plan.* Not all these projects will be undertaken in the next 3 years, some will take many years to plan and execute. The upcoming chapter *Project List 2022-2025* will outline the projects which will be commenced within the next 3 years.

Travel

LCH has a high travel carbon output, mainly due to our delivery of care model; care provided in or close to patients' home. LCH must think innovatively and embrace challenge to encourage green travel and drive down emissions in this area.

Goal / Ambition	Low Investment	Medium Investment	High Investment
Reduce our overall emissions as a trust gradually to reach Net Zero by 2045 Only offer electric vehicles (EV) or ultra-low emissions vehicles (ULVEs) through salary sacrifice and business lease schemes by **2025-2030** in alignment with government commitments to stop the selling of new petrol and diesel cars from 2030. Support individuals across the trust to transition to EV and strive towards a fully carbon neutral travel network as much as possible by 2040	Offer and promote Cycle to Work Scheme Promote hybrid working and use of technology such as MS Teams to reduce the need to meet and travel into the office. Embed this hybrid culture throughout the trust Promotion of public transport and benefits available to NHS staff Steadily reduce petrol and diesel cars available on lease and salary sacrifice schemes by gradually reducing the vehicle carbon cap until full transitioned to EV only. *Carbon cap is currently capped at 120 g/km.*	Create staff benefits / rewards for making a change to green modes of transport including cycling, walking, EV, and public transport Better utilisation of journey planning software to reduce unnecessary mileage for patient care around the city Build a cycling community and network within the trust with use of carbon champions and cycling enthusiast Create a named lead for green travel within the trust. Produce a business case to outline what that role would look like and appropriately conclude which department / remit this role would sit within.	Produce business case for use of EV LCH carpool lease agreement Develop a detailed EV charging point business case for the implementation of charging points throughout our sites and the city for staff Work closely with our partners; Leeds City Council to be part of public transport renovation. Be part of the conversation to improve cycle lanes and public transport throughout the city to encourage green travel. Work with the Council to establish a network of safe/ well-lit foot paths Ensure all sites have shower and changing room facilities, along with bike shelters / lockers for staff, visitors, and patients to encourage active travel Explore option of Green Transport Pool Scheme for commuting staff; explore EV, E-Bikes and E-Scooters.

Procurement

LCH is working closely with its procurement partner Leeds and York Partnership NHS Foundation Trust (LYPFT) to make meaningful and substantial changes throughout our procurement department.

Goal / Ambition	Low Investment	Medium Investment	High Investment
Only order from environmentally committed companies Significantly reduce all single use plastics throughout the trust Strive to eliminate use of all paper and need to photocopy throughout the trust. Where unable only use 100% recycled paper Have a sustainable circular process in place for the reuse of office equipment/ furniture	Complete full audit of procurement activities collaborating where necessary with NHS Supply Chain (main provider) to identify carbon "hot spot" areas in our procurement Significantly reduce and where able eliminate ordering of single use plastic products such as plastic disposable cups and stirrers. Ensure all paper products such as toilet roll, and paper towels are only made from recyclable materials Eliminate the need to print / photocopy onto paper by redesigning forms and common processes to digital options Sign up to a national/ regional recycling scheme for equipment/ furniture	Refine our electronic catalogue to ensure that where applicable sustainable alternative products are the first options when ordering supplies Use of main warehouse and storage to order in bulk and distribute locally to departments Centralise ordering to front of house to mimic PPE distribution to reduce habitual ordering and reduce waste	Prioritise purchasing products locally to reduce transport emissions and support local economy Only use suppliers who make a commitment to sustainable practice and demonstrate they have their own Net Zero plan and strategy Explore a recyclable option for face masks – continue to work with IPC department to explore alternatives to single use PPE where safe and appropriate

Buildings and Estates

Positive work has already been commenced within the estates department at LCH and from this point we will continue to move forward with a strong sustainable focus throughout this important department.

Goal / Ambition	Low Investment	Medium Investment	High Investment
To ensure all our retained sites are as energy efficient as possible and carbon neutral by 2040 in alignment with Greener NHS commitment Create a building climate adaptability plan for LCH owned buildings Implement a range of socio-technical interventions that will be required to optimise the LCH retained estate; for example real-time energy monitoring and control and senor lighting Work with landlords to ensure that buildings we are currently tenants in have Net Zero commitments and are aligned with our ambitions	Only purchase gas / electricity from green tariffs. We currently procure energy via the CCS national framework agreement and are currently committed to the certified REGO requirement set by Green Energy Supply in accordance with the national objectives set by NHS Greener Programme Identify buildings that cannot become more energy efficient and carry out an options appraisal on future usage Switch Me off campaigns / Every Watt Counts promotions to encourage energy use awareness to staff Work with landlords to implement estates-based schemes to lower emissions	Use existing capital programme schemes to opportunistically replace windows, thermostats, and lighting Install solar panels on our retained estate Implement a programme to replace all non-LED lighting in LCH buildings Re-greening of grounds surrounding buildings to create havens for wildlife Water saving devices / systems and investigation in to pipe flushing practices	Invest in boiler replacement programmes and installation of heat pumps across our retained estates Connect to hydrogen energy sources when / where available Reduce the number of buildings with low energy efficiency ratings through disposal / renovation Better heat management / conservation schemes across health buildings

Waste

LCH recognises that more can be done to reduce the amount of waste that the organisation produces, and how the waste that is produced is disposed. The trust already has established recycling facilities at all retained sites; however, more will be done to encourage staff to use the recycling facilities wherever possible, including the exploration of glass recycling. We also need to examine the ever-growing issue of disposable PPE with be dealt with without compromising on infection control measures.

Goal / Ambition	Low Investment	Medium Investment	High Investment
Overhaul the existing waste strategy and policy at LCH to ensure that the trusts waste is dealt with in the least carbon emitting way possible Explore single use PPE and until alternative is available ensure PPE is disposed in an eco-friendly manner	Introduce greater levels of recycling, including glass and food waste: Use existing contracts and local initiatives to increase recycling of food waste / compostable waste across our sites Use existing contracts and local initiatives to increase recycling of glass waste Avoid use of hazardous or other non-degradable chemicals in cleaning supplies Better labelling and training for staff to ensure that waste is not contaminated, and the correct waste streams are used	Outline to our waste providers that for tender we expect waste to be weighed and routes of disposal to be as sustainable as possible Reduce the amount of clinical waste that is burnt, by reclassifying and separating offensive waste Develop a waste strategy in line with audit advice / national standards. Recreate the waste policy in line with national standards and HTM Local adoption of Sterimelt as an option / opportunity to recycle plastic waste	On site waste disposal and energy creation schemes Council to have separate waste collections / processes for food, glass, cardboard, and plastic waste Purchase sustainable PPE when appropriate – ensure products are either recyclable or biodegradable

Project List for 2022-2025

Following consultation with the trust's Board the sustainability deparment was able to formulate a list of prioritised projects that were deemed realistic and achieveble over the next 3 years. It is worth noting that the projects which are listed above but not included in this chapeter will still be reviewed and considered as we continue along our sustainability journey.

Several of the proposed projects will span right across the next 3 years and beyond, wilst others will be started and completed in a relitively short period of time. It is likely that as one project starts additional work and tasks will arise as a result. This Green Plan acts as a guide and frmaework but it must be recgonised it will be continually developed and updated as we strive towards Net Zero and embark on sustainability practices.

The projects will be under constant review and scrutinty to allow for any challenges or barriers to be quickly identified and enable us to take a solution focused approached. It is also important to recognise that alongside the below proprosed projects the sustinability team and associated departments will continue to input data on a quarterly basis to forumulate our carbon emissions profile for each subsequent year. This will mean we have real time data as one of our performance indicators to judge against.

The projcts to take place between 2022-2025 are outlined in the Road Map below:

Priority projects over the next 1-3 years

Buildings and estates

2022-2023

- Continue to use green tariffs
- Switch off campaigns in-house to increase energy awareness
- Feasibility study identifying which LCH sites can't become carbon zero and formulate options appraisal for the future use of these buildings in accordance with our sustainability commitments

2023-2024

- Work with landlords to introduce sustainable projects
- Commit to opportunistically replacing windows, thermostats, and lighting through LCH buildings through capital projects, for example Seacroft
- Introduce light sensors in all suitable areas

2024-2025

- Re-greening the gardens/ outside areas of LCH buildings
- Start business case and exploration around the cost benefits and long-term benefits for replacing boilers throughout out LCH sites

Travel

2022-2023

- Continue to promote public transport and offer discounted Metro cards
- Maintain use of MS teams to avoid travel between meetings
- Continue to offer a choice of digital consultations for patients who prefer that flexibility
- Promotion of the electric vehicles available on the lease/ salary sacrifice scheme
- Commence a business case for the implementation and use of EV charging points across our city.

2023-2024

- Restrict the choice of lease/ salary sacrifice vehicles to low or zero emission options
- Improve cycle facilities in Trust buildings (lockers, shelters, showers)
- Implementation of plan to increase support for staff using EV; review business case of EV charging points and collaborate with council and other organisation to have a joined approach across the city and sectors.

2024-2025

- Explore option of Green Transport Pool Scheme for commuting staff; explore including EV, E-Bikes and E-Scooters.
- Trial / pilot journey planning software/ arrangements to reduce unnecessary journeys

Procurement

2022-2023

- Significantly reduce our need for paper and where unable move completely to 100% recycled paper
- Continue to significantly reduce and work towards eliminating single use plastics where possible

2023-2024

- Work with LYPFT to move to an electronic fleet of vans / lorries for logistics (shuttle/ stores etc)
- Buy recyclable PPE: where safe, IPC approved and available

2024-2025

- Introduce a condensed electronic catalogue to control procurement choices and promote the most sustainable options
- Buy local products/ service wherever possible
- Introduce procurement groups to establish preferences for certain products

Waste

2022-2023

- Better training/ awareness of recycling arrangements
- Replace harmful cleaning products
- Increase recycling options – cardboard, glass, food
- Review our clinical waste disposal routes following the re-classifications of offensive waste stream set out under new national guidance
- Review of Stockdale trial of food recycling

2023-2024

- General waste – review of procurement of contracts with emphasis on recycling/ sustainability
- Repair rather than replace furniture where possible
- Review of current glass and food recycling procedures and facilities at our sites

2024-2025

- Join a local/ national furniture recycling scheme
- On site waste disposal/ energy creation arrangements

Staff Engagement and Workforce Interactive Intranet Page

It is vital for our staff to be fully informed and engaged during our whole sustainability journey. It is essential that the employees of LCH are the facilitators of change with the support and guidance of the sustainability manager and carbon champions. The sustainability team recognises the need for good communication channels and that it needs to be simple and convenient for any member within LCH to access information / updates. From this notion a dedicated interactive Sustainability page was created on LCH intranet; MyLCH. Through the page users can keep updated with the department, directly submit queries, pledges, and link in with the sustainability team and receive prompt and timely responses and feedback.

Newsletter

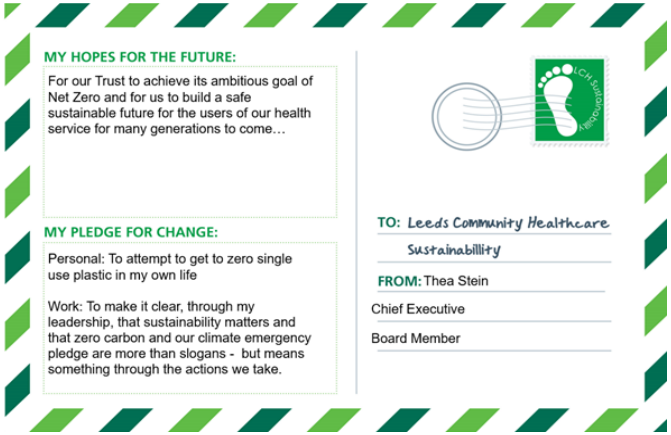
We have committed to the release of a monthly newsletter which will be circulated through both our communication team and intranet to update staff on our progress, ongoing projects' and importantly how to get involved locally in their teams. This will be a significant resource with communication to staff if there are any changes that may affect individuals' day to day working lives, for example a reduction in paper use through a new digital form. We will also tailor a more localised communication approach with teams if a sustainable change affects them directly. We will have an open communication channel for staff to submit any concerns or highlight challenges they are experiencing; this will be through an online question submission forum on our intranet platform which will always be linked within our newsletters.

Dear LCH… Pledge Campaign

We will encourage staff members to get involved with our *'Dear LCH…'* Sustainability Pledge Campaign. This will engage staff by encouraging them to pledge to make a sustainable change to their work to help LCH reach Net Zero. We also want to promote a safe space for staff to express their hopes for the future that can often seem unpredictable and full of existential crises. Communications and soft launch around the campaign began in January 2022 with a full launch to run in the Spring of 2022. When staff sign up to the movement, they will be part of a community of individuals who are passionate about sustainability and making a difference; they will also receive a bespoke Sustainability Pledge Pin to show they are part of LCH Sustainability movement. The *'Dear LCH…'* campaign will be a standing feature in the monthly newsletter and promoted on a regular basis through the sustainability management team. Pledges and commitments will be celebrated to encourage staff involvement. Senior management and Board Members will be encouraged to send a postcard to demonstrate the leaders of our institution are serious about their commitment to sustainability; this was demonstrated with our first postcard being sent by Chief Executive Thea Stein.

Carbon Champions

We plan to engage and involve passionate individuals through our Carbon Champion engagement-stream. This is an opportunity for individuals to help with the campaigns and encourage the longevity of the sustainably movement. We recognise that due to the scale of change and the number of sites / localities citywide we will need to formulate and promote self-sustaining groups where action and updates are configured locally with regular communication kept between the link of carbon champions and sustainability manager.



Sustainability Engagement Workshops

During the time between November – December 2021 the Sustainability department invited staff members to attend 4 engagement workshops to express their opinions and ideas for LCH sustainability. In total 63 members attended and the main themes that emerged and feedback can be referred to in Appendix B of this document.

Future Engagement and Campaigns

Moving into the future there are a variety of engagement methods we plan to utilise to empower staff to involve themselves with our journey to Net Zero.

Organised Sustainability Days: The following key days within the sustainability calendar will be promoted to create enthusiasm for our department and encourage teams to celebrate their sustainable achievements and inspire those who want to make change.

- Global Recycling Awareness Day: 18/03/2022
- Earth Day: 22/04/2022
- The Sustainability Day of Action: 08/06/2022
- The World Refill Day – reduction in plastic pollution: 16/06/2022

There will be additional dates confirmed as the year goes on and we will utilise these to celebrate progress made and continue to spark engagement for sustainable change.

Showcase for Success: We plan to orchestrate a showcase at some point during either 2022 or 2023 to celebrate the positive sustainable changes made throughout the trust. We plan to have a nominated system where people can let the sustainability team know of others who have made a difference. This will hopefully act as a positive movement following a challenge time, with many changes made to ensure continuous care throughout the pandemic also having significant sustainable benefit and impact.

Pledge of the Year: Following our *'Dear LCH…'* Pledge Campaign we explore the option of potentially having a '*Pledge of the Year*' competition and celebration to thank all those who have got involved and add an element of fun to the whole movement.

Training and Education

We will work with our organisational development team to develop an online training course on our ESR system for staff to complete on a voluntary basis. This could also be used as an indicator to identify those who wish to become more involved and to engage with the Carbon Champion work-stream. The training will outline key areas that staff are required to be aware of, update staff on obligations of the trust with regards to sustainability and actions arounds climate change and finally what they can do on an individual basis to help the trust achieve its ambitions goals.

As a department we intend to explore the implementation of a sustainability component within the trust's introduction package, where key areas of the trust provide a brief overview and introduction to new employees. This will instil the notion to all members joining the trust that sustainability is embedding right from the start of employment.

Finally, the option of carbon literacy training will be considered for certain specialist areas such as procurement / buildings and estates. It could also be considered for the enthusiastic individuals such as the Carbon Champions.

Medicines

At LCH we do have specialist clinicians throughout the trust who have prescribing rights, and therefore we do need to consider our impact with regards to the sustainable challenges around medicines. We currently have representation on the West Yorkshire Medicines & Pharmacy Sustainability Group who are currently developing their own Green Plan. This group are specifically looking into for the following topics:

- Wastage & waste
- Procurement
- Inhalation anaesthetics
- Respiratory prescribing
- Over prescribing
- Single use plastic

Any updates relevant to our trust in these areas will be communicated to the appropriate departments though our Head Provider of Medicine Management along with any support they require from the sustainability team.

Digital Innovation

In collaboration with the Digital Strategy Plan there have been key areas that have been identified which could have a direct effect on the trust's sustainability and felt relevant to be included within this Green Plan:

Electronic patient letters: This initiative links closely with our procurement aim to reduce the use of paper we currently use within LCH. The digital innovation team reviewed the use of the paper letters within the Children's business unit which equated to 17,500 letters per month, which in turn is approximately 210,000 paper letters annually. In junction with the trusts administrative review the team challenged the use of paper posted letters at all stages, with a desire to move to an opt-in e-mail patient electronical letter, which would have immediate savings in the areas of time, finance and reduction in paper. This move to electronic letter is still in pilot stage.

Telehealth: The rapid adoption of telehealth during the pandemic by the trust will be evaluated and where appropriate become a permanent feature LCH offers to appropriate patients. In numerous situations this will reduce the need for some physical patient contacts, saving on unnecessary travel and emissions for both staff visiting patients and patients attending clinics.

Visit Allocation and route planning: The Adult Business Unit (ABU) Neighbourhood Teams are deploying visit allocation software to automatically schedule their patient visits. Not only will this save staff time allocating, but the software will help to streamline the order of visits to improve travel efficiency, and reduce miles travelled.

Digital meeting tools: Microsoft teams: The uptake of Microsoft Teams during the pandemic has meant employees throughout the whole trust have had to quickly adapt to using this remote technology. The sustainability team will support the continued use of this technology and support adopting a hybrid model of home-office working which will reduce staff journeys.

Delivering the benefits: The digital strategy is making the commitment to ensure that sustainability benefits are captured and measured in all digital project plans.

Tracking Progress

One of the challenges around the Green Plan is understanding how to implement meaningful measures to enable us to accurately review our progress against. The NHS Operational Planning Contract 2020 has outlined that we need to radically reduce our carbon output over the next 4-5 years in keeping with the NHS Long Term Plan. The trust's start points for specific timelines and targets that we will have to aim towards are:

Travel: We will continue to monitor our progress in travel though collating data from expenses on a quarterly basis. This method of data collection does come with drawbacks; one of which is we are depending on data inputted by staff which may be missing mileage if people do not routinely input their mileage. It has also been acknowledged that at some point we will need to review how we will collect data for staff commute and patient mileage to and from outpatient appointments. During this year (2022) we will aim to start collating this data to further build a picture of our total carbon emissions from this area through a variety of methods including recruiting the Travel Network *'Annual Travel to Work Survey'.*

Buildings and Estates: We will monitor our energy use on a quarterly basis using both ERIC and manual data collection of gas, electric and water usage. A monitoring system will be implemented which will allow us to track and monitor our electrical demands and habits. Through this data we will also be able to compare different sites with regards to electric, gas and water use to identify hot spots of energy use in our different sites across the city.

Annual Carbon Emission Reporting: Following calculating our trusts carbon footprint in 2021, we then went onto have our method and results accredited by environmental company RSK. Following this accreditation, we will go forward using our current method of data collection to form our annual carbon data output.

Social Engagement and Satisfaction: By making the sustainability department visible and accessible we will monitor engagement through our social movement *'Dear LCH…'* Green Pledge Campaign and engagement of Carbon Champions. We will also aim to recirculate a further staff survey in 12 months' time to gather valuable feedback directly from staff to review if they feel real and significant change is being implemented.

Other key performance indicators will be developed over 2022/23 to ensure that we can communicate to the whole of our trust that progress being made.

Reporting

To ensure we can track progress as outline in the previous chapter we must have robust reporting tools which we can recruit. At LCH we plan to complete reporting and monitoring of key performance indicators on a monthly, quarterly, and annual basis.

Monthly

Data Collection: this will involve data collection across the key areas of focus to review if the changes we implement have a direct influence on our data and to enable us to highlight if there are no changes and enable us to quickly review or potentially change our strategy to remain on target.

Quarterly

We will report to the Sustainability Board on a Quarterly basis with an overview of our achievements, progression, and challenges through a quarterly Progress Report. These reports will be written by the sustainability manager with updates and input from the areas of key focal areas.

Greener NHS Data Collection: LCH adheres to commitments outlined by the Greener NHS Programme by completing a set questions the NHS Greener team report regularly against. These questions cover a broad spectrum of sustainability areas including estates, procurement, single use plastics, food, medicines and adaptations.

Annually

Carbon Emissions Report: the trusts' carbon emissions profile will be updated quarterly and reported on annually. We will work collaborative with our performance colleagues to build a LCH carbon emissions portal which will be developed on our reporting platform PIP. Until a portal is built carbon emissions will be calculated as they have for this Green Plan; manually using the DEFRA Carbon Factor calculation.

Sustainability Report: An annual sustainability report will be formulated at the end of each calendar year to summarise progress after 12 months. This report will be written by the sustainability manager and will cover the following:

- An up to date review of the trusts carbon emissions in the top 4 emitting areas
- Analysis of the work and progress of the proposed projects for that particular year
- Proposals for the upcoming year with regards to aims and a review of our progress against the Green Plan

Anchor Network Institute Progression Framework - Environment and Asserts: The use of this resource provides LCH with the ability to judge its progression against other Anchor Institutions across the city with regards to our sustainability commitments and actions. It acts as a useful tool to build connectivity across the city and highlights areas which can potentially be collaborated. We plan to complete the self-assessment on an annual basis in the Spring.

Green Plan: This plan will be regularly referred to throughout the next 3 years. It will be reviewed and updated with new goals and ambitions in 2025.

Finance

It is imperative that sustainability and finance work in partnership to ensure the long- and short-term cost benefits of the Green Plan are identified. It is also essential to identify how much funding and budget will be required to ensure the actions outlined in the Green Plan can be correctly executed. There will be a representative from finance on the steering group and also, we will have regular liaison with the Director of Finance through our quarterly board reports.

Sustainability is not just about reduction of carbon; it also has the potential to create significant cost benefits which has been proven from other innovative actions of trusts across the UK. The actions taken within this plan should bring about ultimate savings which in turn help towards to the financial health of the trust, even if initial upfront costs are required.

Costs of implementing the Green Plan

The projects for this Green Plan will in the main be supported by current departments as part of their existing portfolios, however there is a need for a dedicated Sustainability Manager to knit together all the different initiatives, and to be a central point of contact.

The costs of the post are likely to be in the region of £51,000 (Band 7 mid-point plus on costs), with a small non pay budget of around £10K for marketing/ promotional materials.

Other costs are likely to be linked to specific projects, where an invest to save business case will be used to ensure that sustainability projects improve our carbon performance and our financial position. It is important to state that there will be initial costs and investment required for some of the larger infrastructural changes, such as boiler replacements and renovation to inefficient buildings, however for these initial years the focus will be on significant planning and creation of business cases / options appraisals for these projects. Therefore, we pre-empt that any large upfront costs will not be necessarily required over the next 3 years period, however we will keep regular communication channels to our finance department to ensure if any costs are required, they are appropriately planned and discussed through options appraisals. By the time the 2026-2029 Green Plan is created we will have better clarity of costs associated with projects required for our Net Zero goals.

Likely Savings

Procurement: LCH currently spends around £49 million on non-pay expenditure (2019/20). Procurement groups will be established to review many of the most ordered products to ensure that the products offer not only best value, but sustainability. A key focus over the next year will be the reduction of single use plastic items (plastic cups, stirrers, plastic cutlery etc), which will have an impact on our sustainability practices and hopefully save financially in the long-term. We would also see long term savings in initiatives such as equipment refurbishment and reuse in walking aids and medical equipment. Similarly, there will be a focus on the amount of waste that is incinerated and identifying recyclable options will offer more affordable/ sustainable options such as in-house recycling schemes.

The use of paper in the trust will become a key sustainability solution focused issue. Most of the efforts will be around reducing the use of paper wherever possible, but there will always be some tasks/ processes where paper is required. LCH will ensure that recycled

paper is used wherever appropriate – however the reduction in overall paper use should result in saving.

Travel: During the pandemic we have already seen a significant reduction in the number of commuter mileage throughout the trust and consequently the number of official business mileage expenditure. The trust is continuing to promote where appropriate virtual meetings and patient consultations with a view to continue build on this area. The Green Plan will further support these initiatives by ensuring that in a post-Covid world, virtual sessions can continue to allow our staff and patients to connect with each other without unnecessary travel/ parking. This will help achieve both carbon reductions and financial savings (accepting that the rising cost of data will eat into mileage saved).

The Green Plan will also encourage greener travel such as cycling, walking and public transport which will also add to a percentage decrease of the trust's expenses and carbon usage.

Buildings: The trust spends approximately £7m on the buildings it owns/ leases (2019/20). The accompanying action plan highlights several ways in which the trust can reduce energy costs, and by implication the carbon account. Current initiatives are focussed on schemes where existing work is planned, and therefore the introduction of LED lighting, improved windows and heating systems will be done at opportunistic times. An example of this opportunitist building development is the recent rennovation plans for Seacroft Clinic which when fully renovated will have the following sustainable benefits incorporated:

- A complete switch to low energy LED PIR control lighting; meaning lights will switch off when rooms are unoccupied
- Recruit technology which automatically switches lights off when there is sufficient daylight.
- Improved insulation throughout the building
- PV solar array on the roof to generate energy on-site

Other work over the past year which has added to the sustainability of LCH is the replacement of the roofs at Bramley and Halton Clinics, as well as the 2nd floor roof at Morley Health Centre which includes thermal insulation in accordance with the requirements of Approved Document Part L of the Building Regulations which will have a positive impact on keeping the buildings warmer and reduce energy costs.

Future business cases will be more ambitious, targeting the least energy efficient buildings and by creating a local trust completion around energy efficient estate. As part of the 2022 capital works we comissioned a feasibility study into gas boiler replacement at one of our retained sites. This will result in a report detailing options for the future such as staying with natural gas, air source, heat pump, hydrogen.

Furthermore, by increasing staff awareness and best practice through training and campaigns we will improve managing our energy and water use on sites. Increasing efficiency and utilisation of the trusts' most efficient buildings will have a big impact on the financial and carbon balance sheet.

The Green Plan acknowledges that in line with all other NHS organisations, the trust will use energy companies that only supply renewable energy. It is unlikely that these tariffs will be the cheapest

tariffs available, but the renewable energy is produced, the likelihood of cheaper bills will eventually pass through.

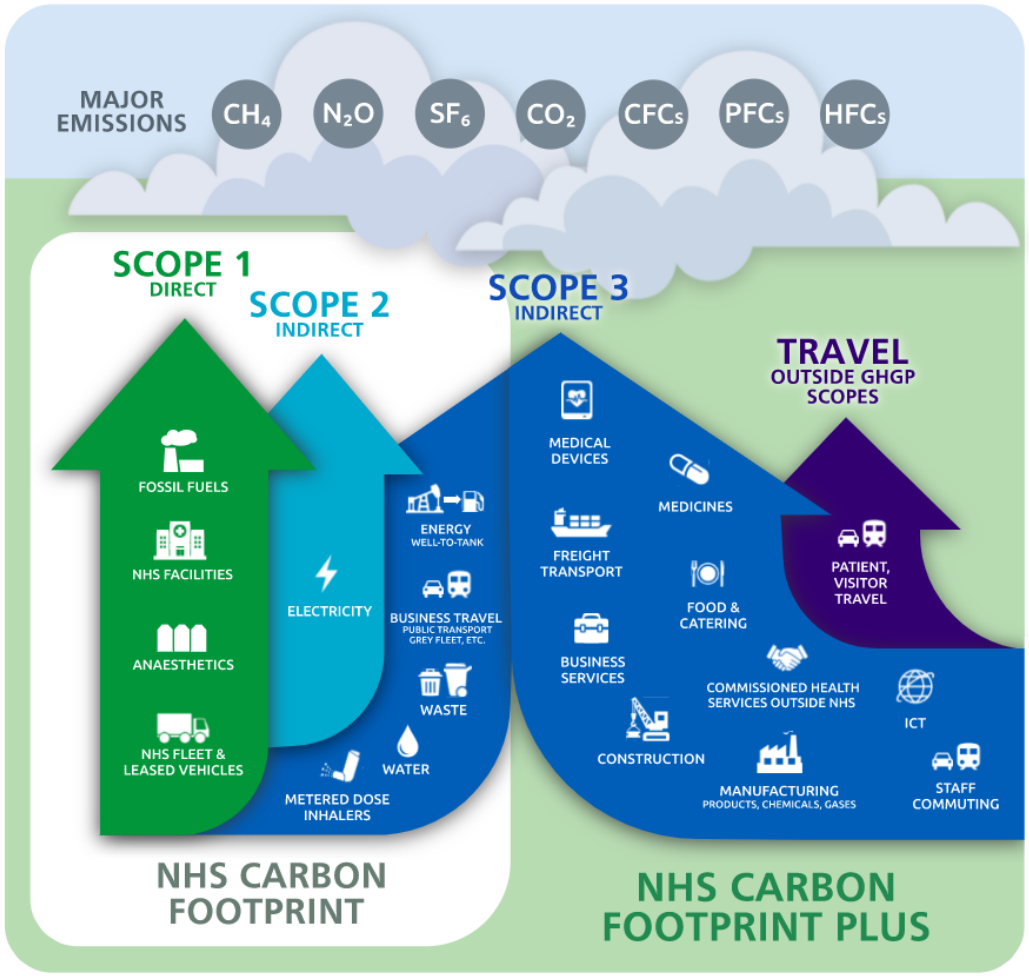
Grants: Over this 3-year period we will also take the opportunity to review the variety of grants available to our trust and the NHS. The sustainability team will be spending time reviewing these grants and creating business cases and bids to support our projects across the 4 main carbon emitting areas.

Risk

It is imperative to the execution of the Green Plan that risks in specific areas are recognised, monitored and if need be, escalated through the relevant channels of the sustainability chain of command. Throughout the Green Plan there are several risks that have been identified:

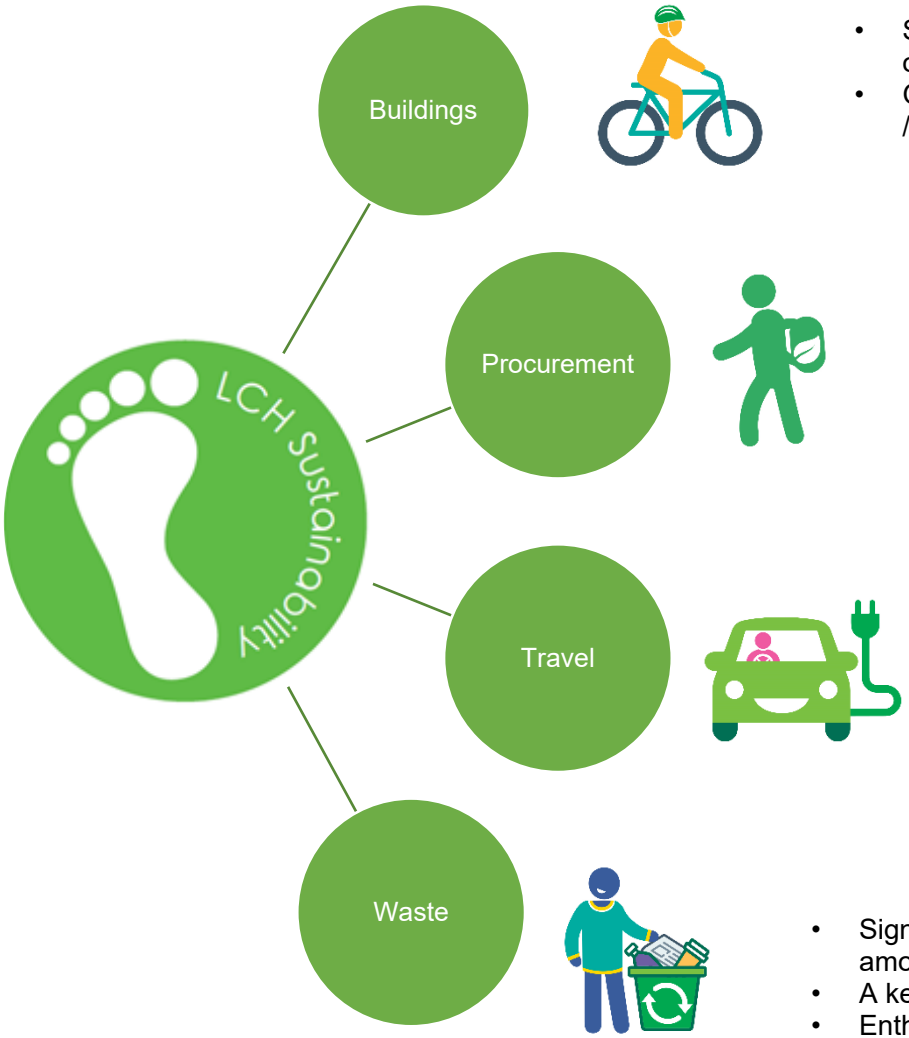
- **Unachievable targets**: We must ensure that realistic goals and targets are set within the Green Plan and that they can be translated into the different departments. We must consider the wider historical contracts, practices, and the potential clinical implications of our actions. For example, a change to a cleaning product must be beneficial in the realms of finance, procurement, and infection prevention control before confirming the swap and purchasing.
- **Inability to meet targets set internally and externally:** To ensure that our internal and external targets are met they will need to be reviewed and evaluated monthly. The presence of the sustainability steering group will be a key meeting for progress to be evaluated and ensure that projects are kept on track. We also need to be aware of wider issues and challenges the NHS faces nationally and acknowledge these may have an impact on our targets.
- **Finance:** We will ensure there is a thorough financial report and summary section within our annual sustainability report, which is reviewed by senior manager to ensure all financial status is reviewed and appropriately scrutinised.
- **Adaptation to our healthcare structure**: As the issue of climate change and the challenges it brings becomes more apparent, we have a responsibility as a large organisation and healthcare provider to adapt and change appropriately. It is important that climate adaptability is embedded into all aspects of the trust to prepare for the effect of changing climate even within the target of 1.5-degree cap of global warming.
- **Effects of climate change on public**: We will acknowledge and recognise the impacts of climate change and how they may have a direct impact on the public health. From the recent flooding across Yorkshire to increasing frequency of heat waves, it is essential as a trust we realise that strains on the health care system will be more prominent as extreme weathers increase in frequency. Adequate planning and resilience for extremely weather events will need to be factored into business continuity plans across the trust.

Appendix 1: Definition of Scopes within the NHS



NHS Greener (2020), *Delivering a 'Net Zero' National Health Service*, Available at: https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/

Appendix 2: Workshop Feedback 2021



- Staff feel we need to have a full review of all our estates to establish the energy efficiency of our buildings, with specific focus on heat systems
- Green travel facilities to be improved and available at every LCH sites; bike shelters / lock ups / showers and changing rooms

- Mimic and adopt the success of the PPE ordering and distribution method of ordering across the trust
- Support for an eco-key on products available through NHS supplies to indicate which product have the environmental impact
- Reduce single use plastics
- An increased range of alternative products available through NHS supplies

- Infrastructure needs to be in place before complete move to EV, ie charging points at health centres and throughout the city
- More competitive / affordable pricing and choice of ULEV and EV vehicles on salary sacrifice and lease scheme
- Benefits and rewards for those using modes of green / active travel such as cycling
- Explore options and appetite for an EV LCH fleet rather than a ask for staff to use personal EV vehicles
- Encourage home working and smart digital ways of patient contact / communication where possible

- Significant concern with single use PPE and how the trust is currently disposing the copious amounts currently required
- A keen drive to reduce our overall consumption which would lead to decrease waste
- Enthusiasm for campaigns to increase awareness of difference bins and correct recycling
- Aim to ultimately be a zero-paper trust
- Produce creative ways to build a circular waste process for furniture and equipment

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (133i)

Title: Performance Brief February 2022

Category of paper: for assurance
History: Quality Committee – 21 March 2022
Business Committee – 23 March 2022

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 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 and discusses actions to address waiting list backlogs; these were considered in detail at this months Quality and business Committees. Performance against many of the indicators has been adversely affected by the continuing impact of the pandemic on services and the Trust's normal business.

Recommendations
The Board is recommended to note present levels of performance against KPIs.

Performance Brief – February 2022

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.

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 – 21st March 2022
Business Committee – 23rd March 2022
Trust Board – 31st March 2022

Recommendations

The Board is recommended to:

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

Main Issues for Consideration

This report continues to provide analysis and commentary on performance against the KPIs for the year. KPI performance must continue to be seen through the prism of the Trust's response to Covid-19 and the severe pressures facing the NHS nationally and locally. There are significant pressures in many services and this report notes and comments on the impact on KPI performance, particularly in the well-led domain in terms of the impact on staff. The Board is very aware of all actions being taken to look after our staff. The Trust is not seeing impacts on the safe and caring KPIs suggesting that the quality of care is being maintained. However, the impact of the service pressures on care, noted in mortality reviews, is beginning to become apparent, if not translating into harm incidents as seen in this report. The Trust continues to do all it can to continue to deliver the best possible care for our patients and work with partners to in the city and wherever we provide services. []

In the **safe** domain there are no significant concerns on in performance against the KPIs. The report notes the themes that are highlighted by the review work that is undergone by corporate and business unit teams working together. The important learning is noted as is the continuing focus on embedding and sharing learning.

In the **caring** domain, we note the fact that 82% of a small number of respondents rated their care as good or very good. We know this is limited so additional surveys are developed and used to provide richer information. The domain report provides good examples of how services use patient feedback.

In the **responsive** domain performance against the waiting list standards is still below expectations. There have been 2 patients waiting for more than 52 weeks for care in the Community Gynaecology service. In both cases the cause will be at least partially due to backlogs built up in wave 1 of the pandemic and laborious referral and administrative processes within the service relating to the interface with LTHT.

In March, both the Business Committee and Quality Committee have considered, in detail, the current situation for people waiting for care. It remains challenging to balance need to reduce the LCH waiting list and waiting times, support the Leeds system 'flow' and look after our staff.

A detailed update was provided at Business Committee on the services where challenges remain and the actions being taken to improve the position. The services with particular challenges are discussed in the responsive domain report. For health equity reporting, new reports are available that split patients waiting for care into populations by ethnicity and deprivation; these reports are to be considered alongside back log modelling for priority services to ensure at risk groups are not further disadvantaged by recovery approaches.

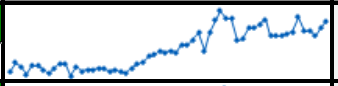
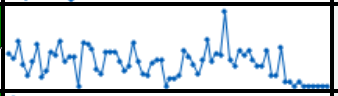
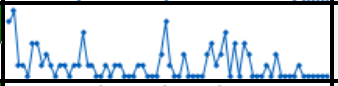
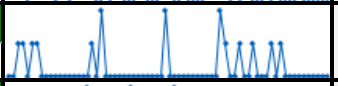
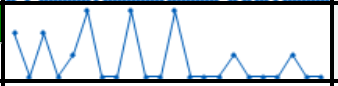
The **Well Led** domain section shows some small improvement in performance on a number of KPIs, including long and short term sickness, and appraisal rates. Turnover has seen a further deterioration in performance. The report notes the continuing and relentless focus on improving these indicators. The pandemic and its associated challenges has correlated with heightened absence amongst our workforce, with high levels of absence correlating with surges in the pandemic. The overall sickness absence for January peaked at over 8% (latest data), and has dropped in February 2022 to 6.8%, consisting of 4.6% long term absence mainly due to stress, anxiety and depression and short term absence at 2.2%.

The Trust will achieve all its key **financial** targets.

Safe – February 2022

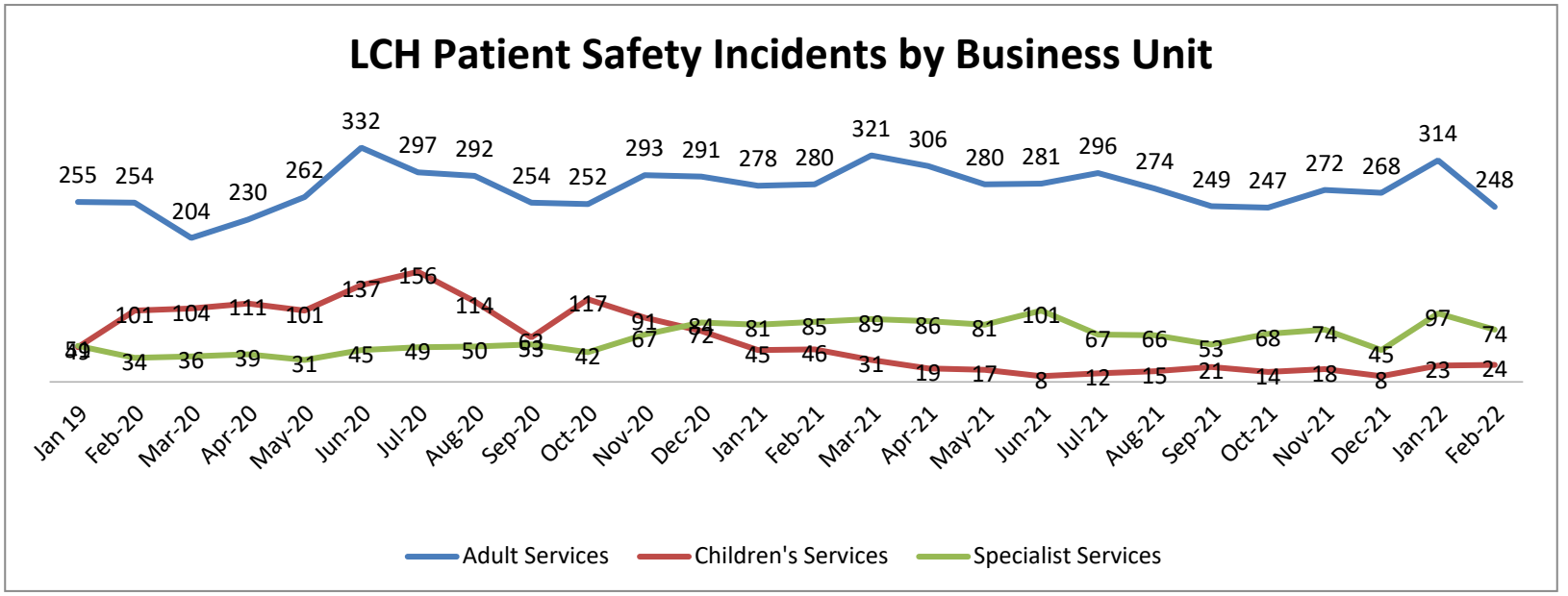
By safe, we mean that people are protected from abuse and avoidable harm

NHS
Leeds Community Healthcare
NHS Trust

Safe - people are protected from abuse and avoidable harm	Responsible Director	Target - YTD	Forecast	Financial Year	Q1	Q2	Q3	Jan	Feb	Time Series	Series Data From
Patient Safety Incidents Reported in Month Reported as Harmful	SL	1.42 to 2.09	●	2021/22	1.74	1.96	1.83	2.11	1.92		Apr-17
				2020/21	2.12	1.97	1.83	2.03	2.14		
Serious Incident Rate	SL	0 to 0.1	●	2021/22	0.01	0.00	0.00	0.00	0.00		Apr-17
				2020/21	0.05	0.06	0.05	0.02	0.02		
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	7	●	2021/22	1	1	0	0	0		Apr-16
				2020/21	3	5	1	0	2		
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	●	2021/22	0	0	0	0	0		Apr-16
				2020/21	1	1	0	1	0		
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	9	●	2021/22	2	1	1	0	0		Apr-20
				2020/21	4	4	3	0	0		
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%	73%	83%				

LCH Patient Safety Incidents by Month and Business Unit

There were 1,175 incidents recorded in Datix in January and February 2022. Of these, 764 (65%) were recorded as LCH patient safety incidents, split by Business Unit as shown in the following chart.



The rise in LCH patient safety incidents reported in January was followed by a fall in February. No variation in the recent trend is observed.

The higher reporting teams in ABU in January were reviewed by the Quality Lead with no specific trends noted.

The increase in January and decrease in February, in Specialist Business Unit relates to self-harming incidents in Wetherby Young Offenders Institute and discussed further later in this domain section.

LCH Patient Safety Incidents by Month and Level of Harm

Month	LCH Patient Safety Incidents by Severity			Total
	Low and No Harm	Moderate Harm	Major Harm	
Nov 21	327 (89.8%)	30 (8.3%)	7 (1.9%)	364
Dec 21	280 (87.2%)	38 (11.8%)	3 (1.0%)	321
Jan 22	378 (89.6%)	36(8.5%)	8(1.9%)	422
Feb 22	306 (89.5%)	33 (9.6%)	3 (0.9%)	342

**December 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

No significant changes in the number of moderate harm incidents are noted over the last four months. The moderate harm incident categories for January and February are shown right:

Category	Number
Unstageable Pressure Ulcers	27
Category 3 Pressure Ulcers	15
Deep Tissue Injury	4
Meatal Tear	6
Falls	6
Implementation of care, assessments, treatment, or procedure	3
Medical device incidents	2
Abusive, violent, or self-harming behaviour	4
Medication	1
Delay Treatment	1

Summary of Major Harm Incidents

Eleven major harm incidents were recorded this reporting period. On further review, the abusive, violent, self-harming behaviour and one of the PU incidents was found to have been miscategorised and downgraded to minimal and moderate harm, respectively. The remaining PU incidents were examined at the Rapid Review Meeting, one identifying lapses in care and the other with no contributory lapses in care.

Of the seven falls incidents recorded, four were found to have no lapses in care; one was found to have no contributory lapses in care but learning for Teams was identified, and two have review dates in March 2022.

Category	Number
Pressure Ulcer (PU)	3
Falls	7
Abusive, violent, self-harming behaviour	1

Rapid Review Meeting Outcomes for January / February 2022

Eighty-five incidents were reviewed at the Rapid Review Meeting. The meeting is chaired by the Quality Leads and attended by the Assistant Director of Nursing and Clinical Governance, Assistant Director of AHPs, and Head of Clinical Governance. The outcomes were:

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
85	66 (77.6%)	0 (0.0%)	7 (8.3%)	9 (10.6%)	3 (3.5%)

Serious Incident Investigations January / February 2022

Of the 85 incidents reviewed at the Rapid Review Meeting, 7 incidents progressed to serious incidents and were reported on the Strategic Executive Information System (StEIS):

Service	Incident Type	Description
Morley Neighbourhood Team	Fall	Fall in hoist resulting in a fractured spine in the Lumbar region.
Seacroft Neighbourhood Team	Pressure Ulcer	Unstageable
Seacroft Neighbourhood Team	Pressure Ulcer	Category 4 to sacrum
Kippax Neighbourhood Team	Pressure Ulcer	Unstageable
Meanwood Neighbourhood Team	Pressure Ulcer	Category 3
Woodsley Neighbourhood Team	Fall	Fractured left neck of Humerus
Children and Adolescent Health Service (CAMHS)	Information Governance	Patient letter sent to Father's address instead of Mother and child resulting in harm to the child.

All remain under investigation; the learning will be shared in the six-monthly Serious Incident report.

Early learning from the incidents in Seacroft highlighted some recurrent themes regarding the incorrect level of staff visiting, for example, non-registered staff visiting patients with high category wounds and a lack of senior clinician oversight. The Service has now redeployed a Senior Nurse from the Chapeltown Neighbourhood Team to support the Cluster.

SI Training and Documentation Compliance Deep Dive

In 2019, the Care Quality Commission (CQC) had asked how the Trust is assured that SI investigators have been appropriately trained to undertake investigations. The patient safety team manage a live register of all staff members undertaking SI training. In addition, the SI documentation template asks the SI investigators to confirm they have attended the Trust SI Training.

The patient safety team have reviewed the completed documentation and crossed referenced with the live register to confirm compliance in investigations in the last twelve months. It has been confirmed that all investigators had either a lead or supporting investigator allocated who had completed the LCH training.

National Reporting Compliance

StEIS reporting has been completed for all relevant incidents within the required 48 hours of the Rapid Review Meeting decision.

LCH was compliant with 5 (71%) of 7 incidents in terms of meeting the Duty of Candour regulation There were two incidents where Duty of Candour was delayed, one of these was because of patient re-admission to a community care bed resulting in delayed contact. The remaining incident required multi-agency investigation which led to complex discussions around which investigation process would enable the maximum learning, although a serious incident was declared there was ongoing discussion whether the mortality process would provide the most appropriate learning, this led to confusion in whether the legal duty of candour process applied.

There continues to be a variation with application of the agreed Duty of Candour process. To improve compliance, this process will be recirculated to all teams and services accompanied by a manager discussion. There will also be further conversations within teams to identify any further issues with the process.

Central Alert System (CAS) Notifications

There were 12 Central Alert System (CAS) notifications in the period. They are all on track to complete within timescale. They will be closed at a planned meeting between the Head of Clinical Governance, the Quality Leads and the Incident Manager, as is the process to ensure collective approval prior to closure.

Business Units Updates by Exception

Adult Business Unit (ABU)

There were 548 patient safety incidents recorded for ABU in January / February 2022 compared to 540 incidents in November / December 2021.

Moderate Harm Incidents

Incident Type	Number
Skin Damage	63
Falls	6
Medication	1
Treatment and Procedure	3

Implementation of Care	2
Clinical Assessment	1

Key issues
There have been delays with referral to Podiatry from ABU and with staff compliance with the lower limb care pathways identified from Serious Incident learning. In late March a meeting was planned between The Head of Clinical Governance, ABU & SBU Quality Leads, Clinical Pathway Lead for Tissue Viability Service and the Clinical Head of Service for Podiatry to discuss how to embed learning. Additionally, a relaunch of the Lower Limb Clinical Care Framework is scheduled for March 2022, including a lower limb specific wound assessment template to support improvements to this area of care.

Themes
Incorrect category of pressure ulcer incidents and harm levels remain a consistent theme. There is ongoing discussion within the Patient Safety Team to increase access to Datix user training by developing a podcast training video to share with services. This will also be shared via Mid-day Brief and the Patient Safety My LCH page.

There is also a planned remodelling of Datix to include prompts to support staff in incident reporting and categorisation

Serious Incident/Internal Concise actions overdue
There are two Serious Incident actions overdue compared to eleven in the last reporting period with deadlines in February 2022 and November 2021. The reduction is the result of further engagement from the Incident and Risk Assurance Manager by working more closely with services to provide support for the Quality Leads to review and close overdue actions. The actions will be reviewed within the Business Units via the Quality Lead's Business Unit report and escalated to the Executive Director of Nursing and AHP's for approval should an extension be required.

Children's Business Unit (CBU)

There were 47 patient safety incidents reported in January / February 2022, an increase of 21 (44%), compared to November / December 2021, when incidents reported were lower than usual.

There were 46 minimal harm incidents and one Category 3 Pressure Ulcer to the anterior pelvis, which was assessed as a moderate harm incident. The incident related to an 18-year-old who has been receiving end of life care from the service; concluded with no lapses in care found at the Rapid Review Meeting.

Themes
There is an emerging theme of information governance incidents within CAMHS, this has been discussed with the Head of Service (HOS), and a deep dive has commenced for all IG incidents recorded between September 2021 to January 2022 by the HOS, supported by the Quality Lead. One incident recorded as moderate harm, reported in December 2021 has progressed to an SI and reported on StEIS in January 2022. Early learning from the SI identified a lack of adherence to the Patient Identification Policy. There is an action for the policy to be recirculated by the Head of Service (HOS) with a follow up action to meet with all mangers and the administration leads to share learning from the incident.

Specialist Business Unit (SBU)

During January & February 2022 there were 164 no harm incidents reported, and 5 moderate harm incidents recorded of which 3 concluded with no lapses in care and 2 have review dates in March 2022.

Key issues

Between November 2021 – January 2022 the Service saw a rise in incidents in Wetherby Young Offenders Institute (WYOI). Twenty four of thirty-one incidents are related to the Abusive, Violent and Self-Harming Behaviour category, of which, seventeen incidents are attributed to two young people.
The Service has met with the Governor to review the prison protocol and Standard Operating Procedure (SOP) for ingestion of foreign objects. Child protection referrals, for both young people, have been submitted, due to ingestion of the same object on three separate occasions, this will be escalated for further investigation if required by the Prison Service.

The risk assessments have been shared with the wider team for appropriate support and the self-harm pathway is being reviewed by the CAMHS Team. Following the Rapid Review Meeting of the moderate harm incidents, the Service has initiated a case review for one of these young people. The incidents and risk assessment will be monitored by the Service and Patient Safety Team.

Themes

The Community Intravenous Antibiotic Service (CIVAS) reported three incidents relating to a faulty bioconnector in a patients picc - line, this has been escalated to the manufacturer. This continues to be monitored by the Service and the Clinical Governance Team, led by the Quality Lead of the Service and the Medical Device Safety Officer. This has been shared across the Business Units by the Quality Leads to monitor for further incidents.

SI/RCA Actions Overdue

Four overdue (Leeds Mental Wellbeing Service –1 & Wetherby Young Offenders Institute -3). A positive improvement from last reporting period of 22. An extension has been agreed with the Head of Service and the Executive Director for Nursing and AHP for the LMWS action, and the remaining three will be reviewed within the Quality Lead Business Unit reports.

Outcome of MSK and Rehabilitation Deep Dive

The deep dive concluded that there was no reported patient safety incident within Datix in relation to the waiting times in MSK.

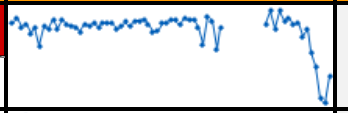
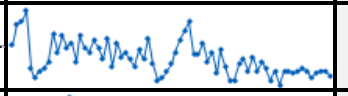
This review identified a theme relating to the importance of managing the patients' expectations in relation to clinical judgement and when virtual treatment is offered, the appropriate documentation is completed regarding the discussion with the patient.

It is recommended that the Service explore how to improve patient experience to the theme highlighted in this report, create an action plan, and share through the Business Unit Quality report.

Caring – February 2022

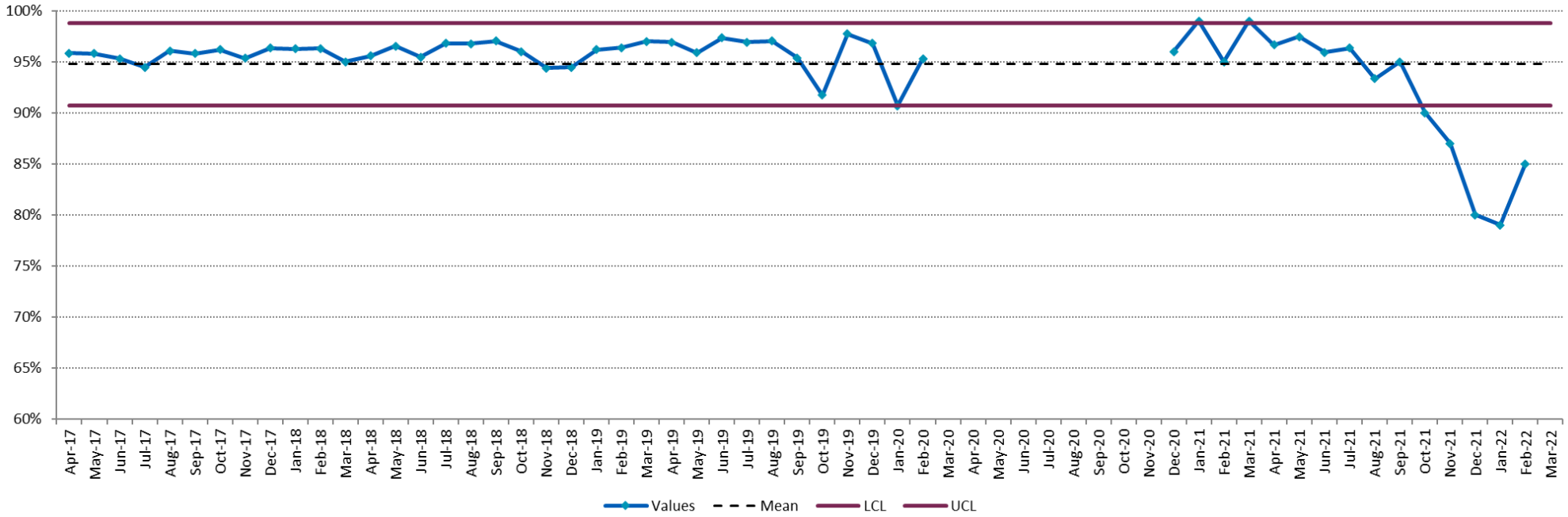
By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect

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	Q2	Q3	Jan	Feb	Time Series	Series Data From
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%	●	2021/22	96.7%	93.9%	85.9%	79.0%	85.0%		Apr-16
				2020/21	-	-	95.7%	99.1%	95.2%		
Total Number of Formal Complaints Received	SL	No Target		2021/22	**23**	**25**	**20**	**8**	**6**		Apr-16
				2020/21	19	35	29	4	8		
Number of Compliments Received	SL	No Target		2021/22	**237**	**180**	**216**	**64**	**82**		Apr-19
				2020/21	148	244	261	86	66		

Friends and Family Test (FFT)

In January and February 2022, there were 558 responses to the FFT, of whom 82% of community patients/service users reporting their experience as good or very good. Whilst an improvement is noted in February the position remains somewhat below the norm.



Note: FFT on hold April - December 2020 due to Covid 19 pandemic changes on services

In addition to the FFT, services continue to develop specific surveys with support of the Patient Experience Team. These surveys complement the FFT and allow focused feedback and insights from patients and carers. Examples of survey's implemented in January and February 2022 were:

- 0-19 PHINS seeking feedback on the Care of the Next Infant (CONI) Programme which is a support service for bereaved parents or parents who might have a specific reason to be anxious about the arrival of their next child. The service is keen to understand what elements of the programme are most helpful and what would improve it.
- Children's Speech & Language Therapy are wanting feedback from parents/carers to help the service develop even better ways to share their services and resources.
- The Adult Dietetics Easy Read Survey is enabling patients with learning disabilities who have accessed the service, to provide feedback.

- Leeds Sexual Health Website Survey (Standard & Easy Read) is asking patients to give feedback around their experience of accessing the service website.

The last two surveys have been developed with support from the Trust's Learning Disabilities Lead.

Impact from FFT Feedback

Leeds Community Musculoskeletal and Rehabilitation Service (MSK) have received comments regarding the lack of face-to-face appointments, difficulties with virtual or telephone appointments, lack of communication, and arrangement of appointments. The service is aware of these issues and developing the following service improvements;

- reviewing how they manage patients' expectations around appointments and how options are discussed and shared with patients.
- planning an Always Event project on how virtual and telephone appointments are offered.

Leeds Child and Adolescent Mental Health Service received feedback relating to a poster in the waiting area at Kirkstall Health Centre being inappropriate. The service Engagement Champion has reviewed the feedback with Youth Board colleagues, and CAMHS service managers. This resulted in the poster being removed from all waiting areas. The feedback has been shared with other children's services and future posters will be reviewed by young people who use waiting room areas before being displayed.

Ongoing Patient Experience Activity Supported by Patient Experience Team

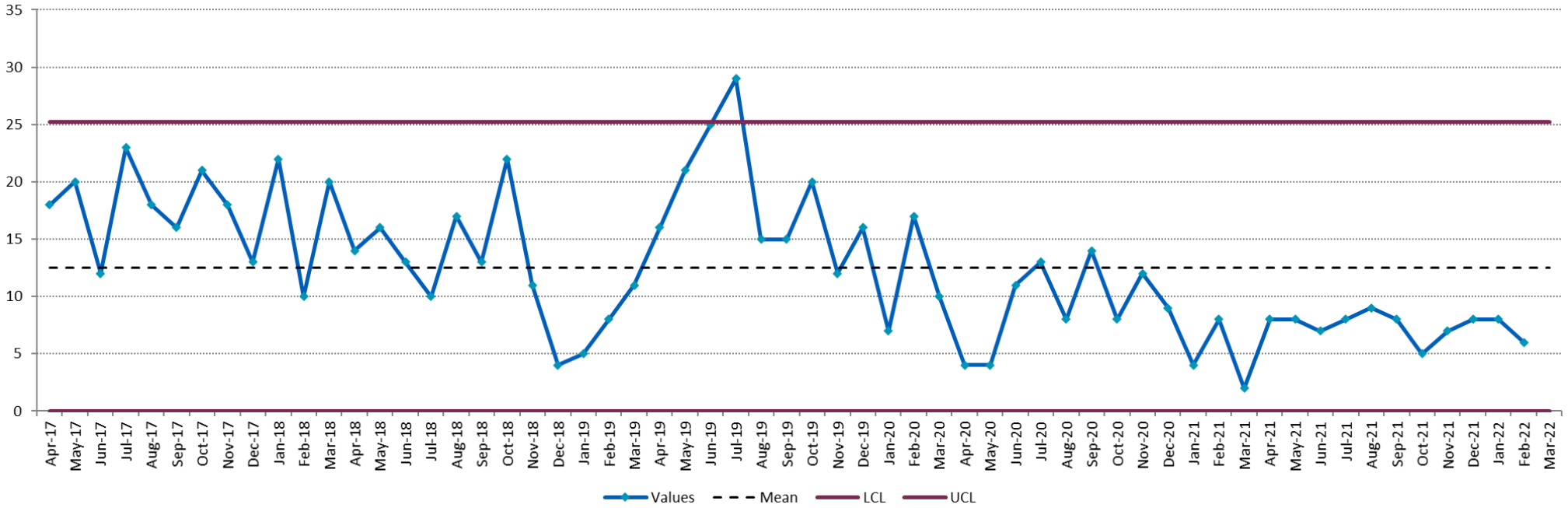
Long Covid Service Patient Involvement Group: The Leeds Long Covid Rehabilitation Service (LCS) are developing a Patient, Carer and Public Involvement (PCPI) Group for persons with a Long COVID diagnosis, their carers, and members of the public with an interest in the condition. It is hoped this new patient involvement group will co-produce the design, development, and evaluation of LCS interventions and service provision. The service is in the process of contacting patients and carers for expressions of interest in joining the group.

Engagement Champions Network: The Engagement Champions Network continues to meet monthly. The March 2022 meeting will include colleagues from BASIS Yorkshire, providing a development session around the health needs of sex workers, the barriers they may face in accessing services and how to improve services for sex workers

Always Events: All new Always Events remain paused until April 2022.

Complaints

There were 14 new complaints received in January and February 2022, consistent with the past 12 months as demonstrated in the table below. All were acknowledged within three working days,



In January and February 2022, 24 complaints were closed, of which 3 were withdrawn by the complainant following discussion with the service and 2 were complainants asking follow-up questions.

Of the 19 new complaints responded to in January and February, 100% were responded to within 180 days, the average being 44 days. 12 out of 19 met the internal Trust target of 40 working days.

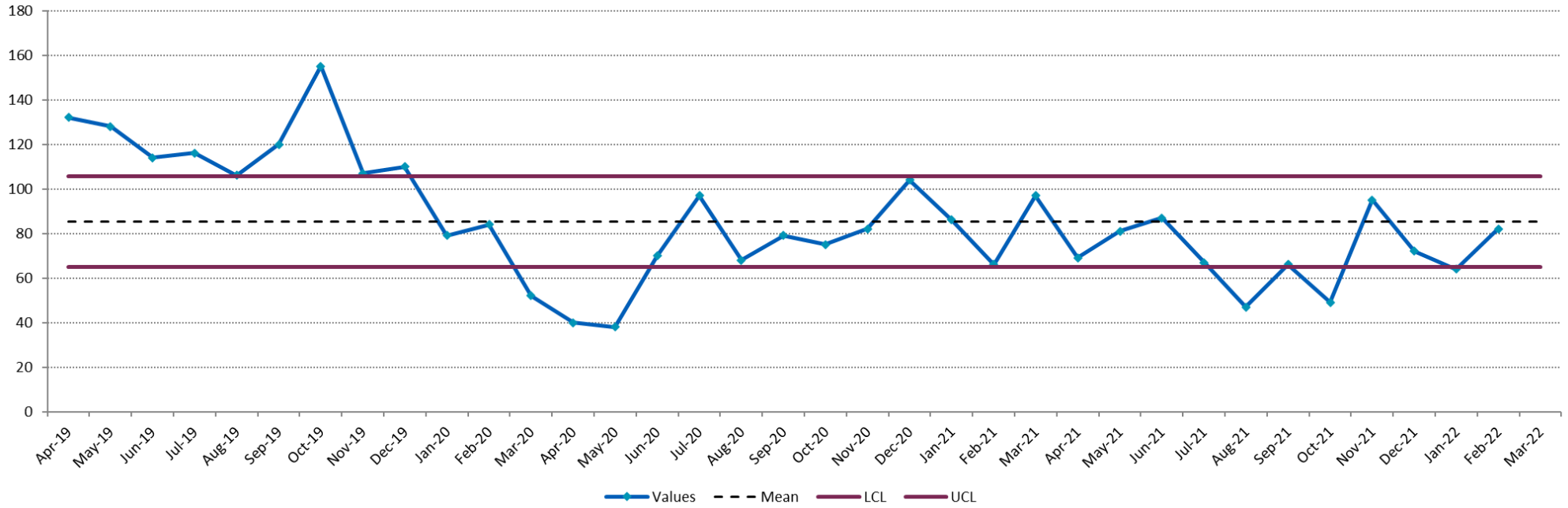
12 of the 19 complaints responded to were partially or fully upheld following investigation. The key theme from the closed complaints continues to be the need to improve on communication with patients, families, and carers, ensuring they fully understand the language used by practitioners.

Concerns

There were 119 concerns received in January and February 2022 of which 34 were received by the Leeds Sexual Health Service in relation to accessing appointments via the telephone system. Systems have been improved and additional focus given to answering calls; an improvement in the number of concerns should be seen in the next report.

Compliments

The table below demonstrates the number of compliments received since April 2019. There were 164 compliments received in January and February 2022, a decrease in previous months in line with FFT findings. The highest number of compliments (49 or 30%) were in regarding to the Neighbourhood Teams.



Claims

There was one potential claim received in January and February 2022 that is in the information gathering stage. Should this progress, the detail will be shared at next report. There have been no updates on the current and potential claims, there are ten claims in progress.

Covid-19 related concerns

In January and February 2022, the Trust received seven concerns where the Covid-19 pandemic was mentioned as a factor. All concerns related to provision of appointments (Podiatry, Leeds Sexual Health Services, LCS and the 0-19 PHIN Service). All concerns have been resolved with the patient and their carer/parent.

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.

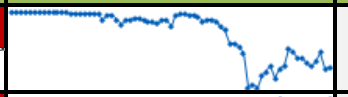
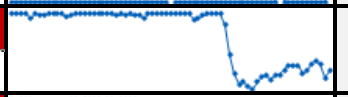
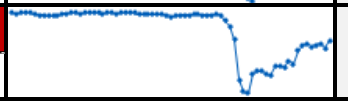
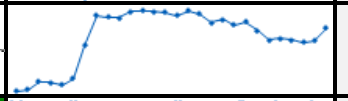
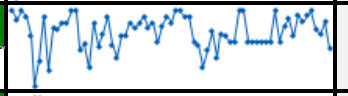
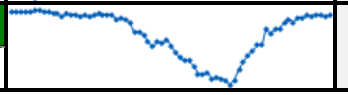
Leeds Community Healthcare NHS Trust

Narrative on the effective domain is provided quarterly and therefore will be included in the next narrative report.

Responsive – February 2022

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

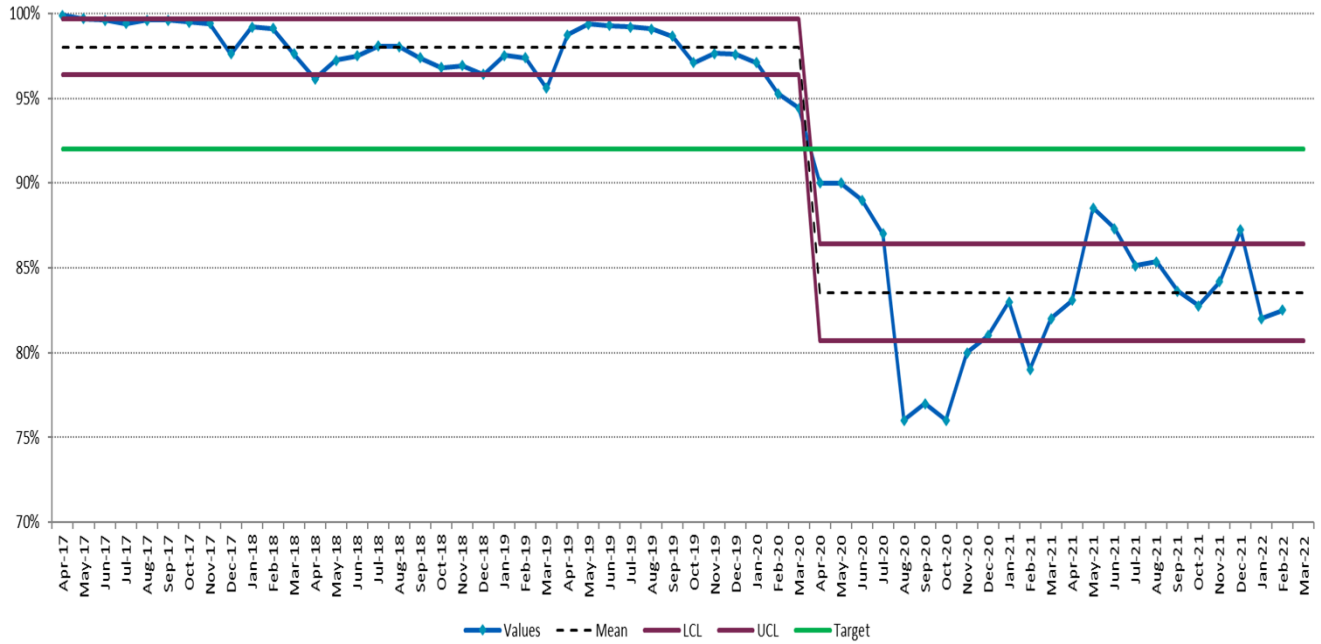
Leeds Community Healthcare NHS Trust

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	Q2	Q3	Jan	Feb	Time Series	Series Data From
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	●	2021/22	87.3%	83.6%	87.2%	82.0%	82.5%		Apr-16
				2020/21	88.7%	76.5%	80.6%	82.9%	79.3%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	●	2021/22	0	0	0	0	2		Apr-16
				2020/21	0	0	0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	●	2021/22	43.7%	38.8%	44.7%	30.6%	38.4%		Apr-16
				2020/21	24.1%	19.4%	33.4%	29.1%	32.6%		
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	●	2021/22	76.1%	85.4%	85.3%	83.2%	86.5%		Apr-16
				2020/21	69.2%	71.9%	71.7%	71.3%	75.1%		
LMWS – Access Target; Local Measure (including PCMH)	SP	22256	●	2021/22	7610	7473	7380	2515	2360		Nov-19
				2020/21							
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	SP	No Target		2021/22	73.8%	66.3%	57.7%	73.8%	66.3%		Nov-19
				2020/21							
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	●	2021/22	99.5%	99.8%	99.6%	99.6%	98.8%		Apr-16
				2020/21	99.3%	99.3%	99.1%	99.4%	99.7%		
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	●	2021/22	89.6%	93.6%	95.3%	94.2%	95.5%		Apr-16
				2020/21	37.9%	58.1%	73.2%	78.9%	82.2%		

Consultant-Led Waiting Times

Performance against the 18-week referral to treatment standard is below expectations with 82 % of patients being seen within the 18-week standard (target 92%). There equates to 391 patients waiting more than 18 weeks. The services seeing less than 92% patients within 18 weeks are Gynaecology, PND and CPC.

	Dec 2021						Jan 2022					
Specialty	Pct Currently Waiting Under 18Weeks	Total	Waiting Over 18Wks	Average Wait (weeks)	Median Wait (weeks)	95th Percentile	Pct Currently Waiting Under 18Weeks	Total	Waiting Over 18Wks	Average Wait (weeks)	Median Wait (weeks)	95th Percentile
CH - P AUD	98.1%	1002	19	7.6	7.0	16.0	94.4%	1183	66	9.2	8.7	18.6
CPC (CHICS)	87.7%	228	28	9.0	7.4	23.8	81.9%	210	38	10.7	8.9	26.5
GAN	100.0%	3	0	6.3	7.3	7.4	100.0%	6	0	1.3	0.7	2.6
Gynaecology	2.9%	35	34	27.5	27.6	32.4	27.0%	189	138	21.6	23.4	30.0
PND	73.6%	595	157	12.3	11.4	25.0	74.5%	584	149	13.1	13.0	26.6
Total	87.2%	**1863**	**238**				82.0%	**2172**	**391**			



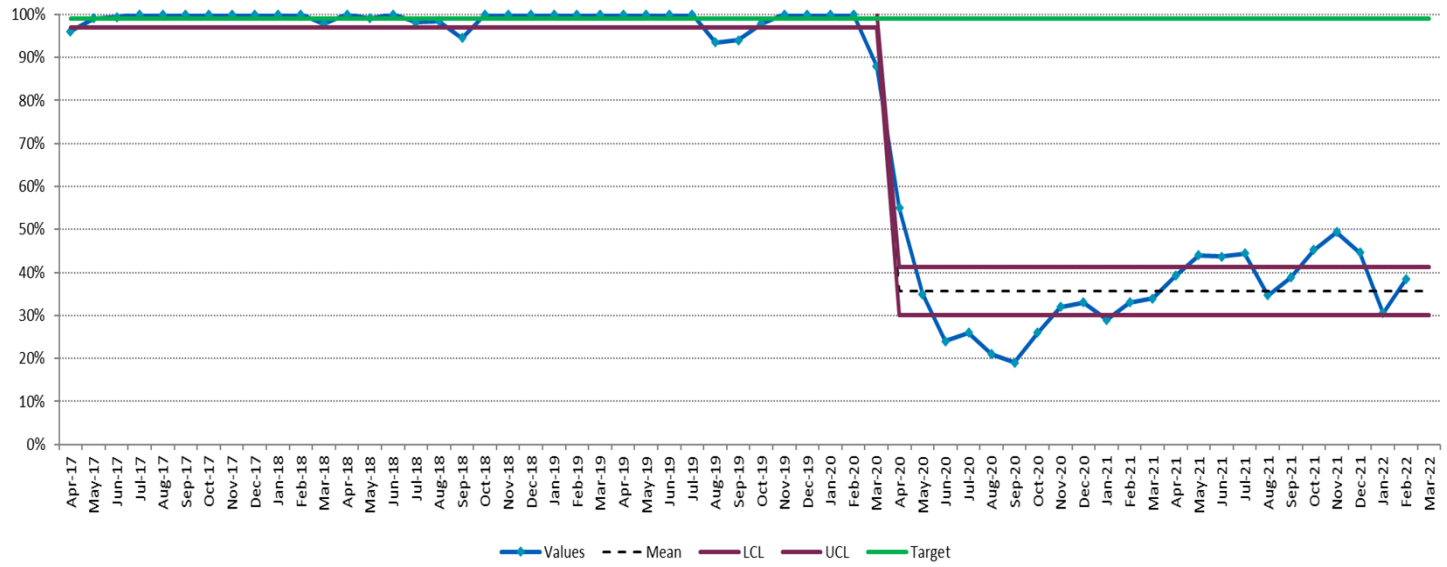
The SPC chart shows a highly variable pattern of performance in relation to consultant-led waits. Of significance in the graph above is a period between August 2020 and April 2021 where performance was below the mean. This will be the impact of the first wave of COVID. Since then there has been comparatively and significantly good performance in May and June 2021 and in December 2021. These periods align with periods of relative stability prior to subsequent waves of COVID infections. This indicates that when services are not under pressure due to COVID the measures they put in place to improve waiting times for patients are working. Performance remains significantly below target.

Number of Patients Waiting More than 52 Weeks

Two patients have waited more than 52 weeks for care. Both of these patients are waiting for the Community Gynaecology service. One has now been seen by the service and had a completed wait time of 52.9 weeks. In the case of the second, numerous attempts have been made to contact the patient by telephone to book an appointment with no success. A letter has now been sent offering an appointment on 17th March. In both cases the cause will be at least partially due to backlogs built up in wave 1 of the pandemic and laborious referral and administrative processes within the service relating to the interface with LTHT. More detail on these is provided in the waiting list paper that will be submitted separately this month.

Diagnostic Waiting Times (DM01)

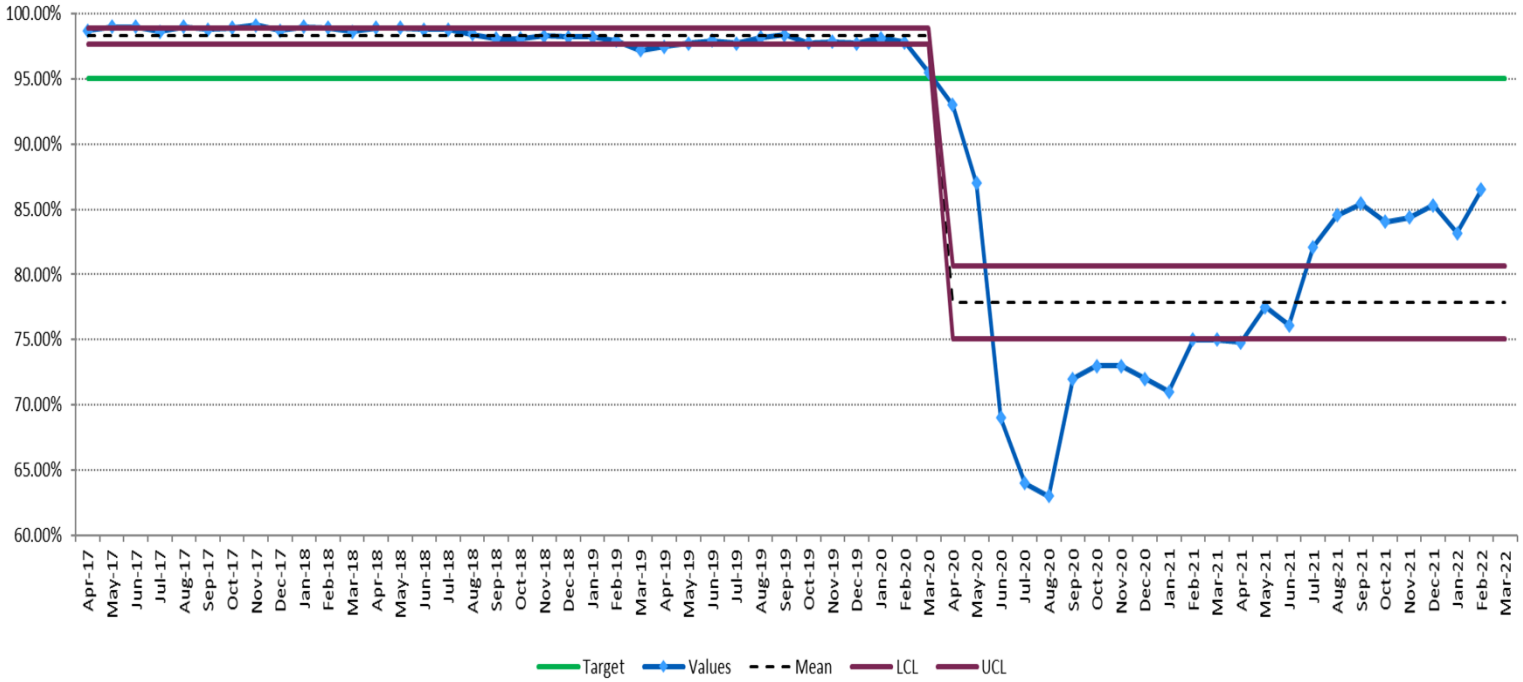
Audiology has not met the DM01 6-week standard for diagnostic tests in February, achieving 38.4% (against a target of 99%). Further information on this service is provided in the waiting list backlog paper that will be submitted separately this month.



Broadly the pattern shown in the SPC chart for diagnostic waiting times is similar to that for consultant-led waits. The initial wave of COVID infection is apparent between April 2020 and March 2021 and there are periods of good performance that precede subsequent COVID waves showing that when pressure allows the service is putting in place processes that allow recovery of waiting times.

Non-Consultant Led Waiting Times

The SPC chart shows significant recent improvement in the number of patients waiting more than 18 weeks for care. This improvement coincides with the work on and funding for initiatives to clear the waiting list backlogs and therefore demonstrates that the measures are working. Whilst performance against this measure has improved the Trust continues to consistently under-perform against the target.



Improving Access to Psychological Therapies

Performance remains good against all IAPT measures. The service has recently started to exceed the monthly access targets due to the contribution of activity from the Healthy Minds Service to the IAPT access targets.

Waiting List Backlog

The Trust is beginning to emerge from a period of significant pressure on services due to the emergence of the Omicron COVID variant. The Trust has successfully maintained its services throughout this period, but resources have necessarily been diverted to this causing an increase in waiting times.

An exercise has commenced to address the national requirements to develop a plan for the reduction in community service waiting lists. Specifically, Community Services providers are asked to:

- develop a trajectory for reducing waiting lists
- prioritise patients on waiting lists
- significantly reduce the number of patients waiting for community services
- consider transforming service pathways and models to improve effectiveness and productivity

A paper was presented to Business Committee in February that drew out themes, highlighted several services of interest and made commitments to complete the following:

- Validate current waiting lists both from a Service and Business Intelligence perspective with a view to a comprehensive and accurate report being presented to Business Committee in March 2022
- Continue discussion with each service to agree a recovery plan and realistic timescales for improvement
- Consider the information available in the health equity reporting and if indicated changes to prioritisation will be made

In March, both the Business Committee and Quality Committee have further considered, in detail, the current situation for people waiting for care. It remains challenging to balance need to reduce the LCH waiting list and waiting times, support the Leeds system 'flow' and look after our staff.

A detailed update was provided at Business Committee on the services where challenges remain and the actions being taken to improve the position. In the Specialist Business Unit those services are Community Gynaecology, Respiratory, MSK, Podiatry and Speech and Language Therapy. The Children's Business Unit has highlighted that the full impact of COVID has yet to be seen; services are seeing an increase in reported developmental difficulties as children have been unable to attend nursery or school settings. There have been particularly large increases in demand for Autism and Neurodevelopment Assessments for children and young people, for all ages, which impacts several pathways within the Business Unit. There has also been increased demand for SLT and in anxiety in children. Work on demand predictions will commence with commissioners. In the Adult Business Unit the focus is on waits for therapy input in the Neighbourhood Teams.

For health equity reporting, new reports are available that split patients waiting for care into populations by ethnicity and deprivation; these reports are to be considered alongside back log modelling for priority services to ensure at risk groups are not further disadvantaged by recovery approaches. Information on whether patients require interpreters is not well collected at referral. This can result in patients being sent letters they don't understand and them not receiving the service they require. An improvement project to improve the recording of interpreter need at the point of referral has commenced

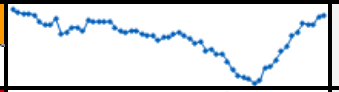
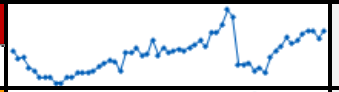
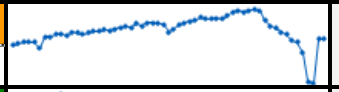
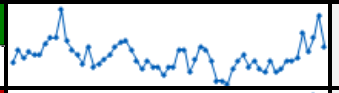
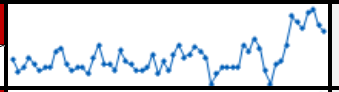
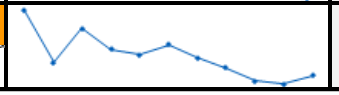
Actions planned in the coming months are:

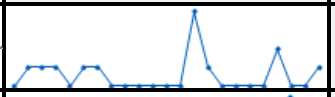
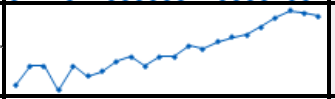
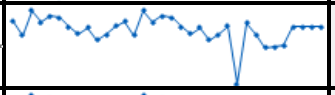
- explore how temporary posts used to support waiting list reduction can be funded from vacancies or other routes
- explore different ways of working to manage demand
- incentives will be offered to encourage additional clinics to be held out of hours to increase capacity. However, it should be noted that there has been little interest to date in working additional hours.
- discussion with staff in the organisation will continue to identify any other approaches to backlog reduction
- consideration will be given to funding outsourced capacity to support services

Well-Led – February 2022

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

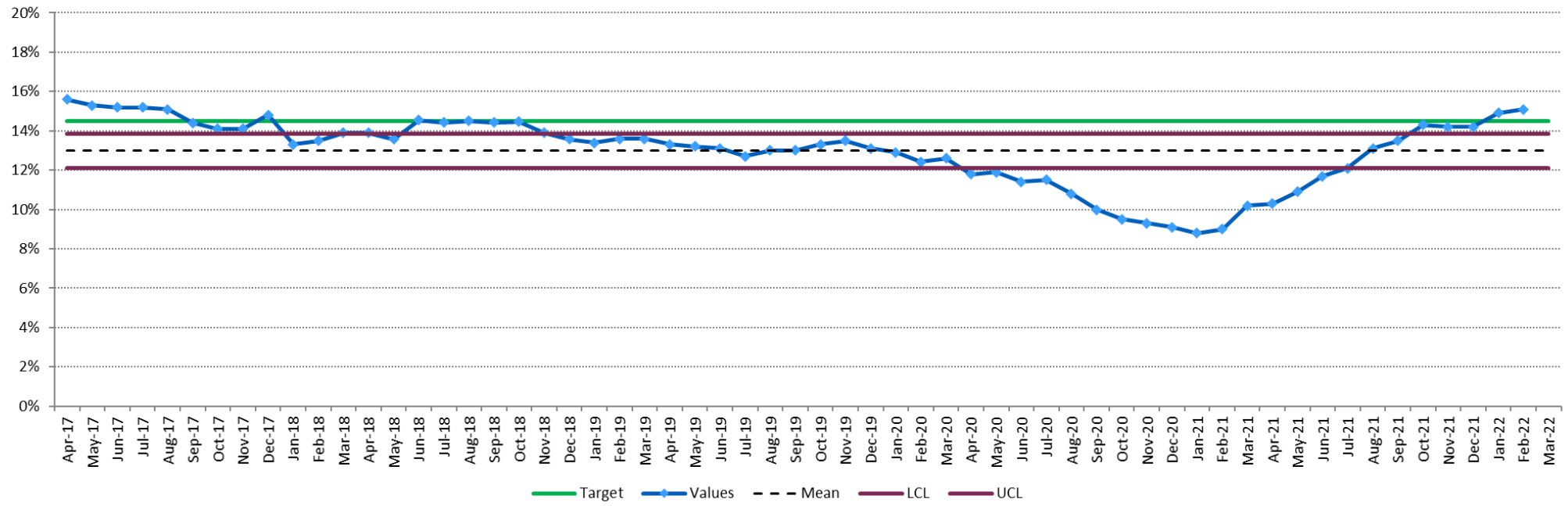
Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Responsible Director	Target - YTD	Forecast	Financial Year	Q1	Q2	Q3	Jan	Feb	Time Series	Series Data From
Staff Turnover	LS/JA	<=14.5%	●	2021/22	11.7%	13.5%	14.2%	14.9%	15.1%		Apr-17
				2020/21	11.4%	10.0%	9.1%	8.8%	9.0%		
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	●	2021/22	18.8%	19.9%	21.9%	20.4%	22.0%		Apr-17
				2020/21	21.6%	24.9%	15.1%	13.6%	14.2%		
Stability Index	LS/JA	>=85%	●	2021/22	85.8%	83.8%	75.5%	84.3%	84.3%		Apr-17
				2020/21	88.6%	89.9%	90.2%	90.4%	90.1%		
Short term sickness absence rate (%)	LS/JA	<=2.2%	●	2021/22	1.4%	1.8%	2.5%	3.3%	2.2%		Apr-17
				2020/21	1.0%	1.4%	1.5%	1.7%	1.4%		
Long term sickness absence rate (%)	LS/JA	<=3.6%	●	2021/22	3.7%	4.9%	5.3%	4.8%	4.6%		Apr-17
				2020/21	3.9%	3.4%	3.8%	3.9%	4.2%		
Total sickness absence rate (Monthly) (%)	LS/JA	<=5.8%	●	2021/22	5.1%	6.7%	7.8%	8.1%	6.8%		Apr-16
				2020/21	4.3%	4.9%	5.5%	6.1%	5.5%		
AfC Staff Appraisal Rate	LS/JA	>=90%	●	2021/22	72.9%	70.6%	74.8%	74.7%	77.5%		Apr-16
				2020/21	81.8%	83.6%	79.6%	78.4%	77.3%		
Statutory and Mandatory Training Compliance	LS/JA	>=90%	●	2021/22	89.2%	88.6%	87.2%	87.1%	87.4%		Apr-21
				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	Q2	Q3	Jan	Feb	Time Series	Series Data From
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	**8**	**0**	**2**	**0**	**1**		Apr-16
				2020/21	2	2	1	0	0		
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	LS/JA	No Target		2021/22	**5.5%**	**6.3%**	**8.4%**	**7.6%**	**8.4%**		Aug-18
				2020/21	10.9%	10.7%	11.1%	11.0%	11.1%		
Total agency cap (£k)	BM			2021/22	**690**	**705**	**1077**	**359**			Apr-19
				2020/21	2546	550	557	240	207		
Percentage Spend on Temporary Staff	BM	No Target		2021/22	**4.8%**	**4.5%**	**5.2%**	**5.7%**			Apr-19
				2020/21	5.0%	3.9%	4.0%	4.3%	4.3%		

Staff Turnover

Significant change of a deteriorating nature

Consistently falling short of the target



Staff turnover has seen values above the upper control limit since October 2021 and the number of staff leaving the organisation within 12 months has been above the mean since May 2021. This indicates a significant change.

During the height of the pandemic, as turnover rates reduced significantly it was anticipated that there would be a rise in turnover due to a recovery in the labour market, increasing employment rates, a decrease in unemployment rates and a shortage of registered professionals nationally. This has been our experience, with turnover now above target.

A range of resourcing initiatives to increase supply as well as several capacity enhancing incentives have been implemented to help stabilise the trust through the winter months, but with increasing turnover rates and a reduction in recruitment fill rates, are presenting a challenge which requires a different

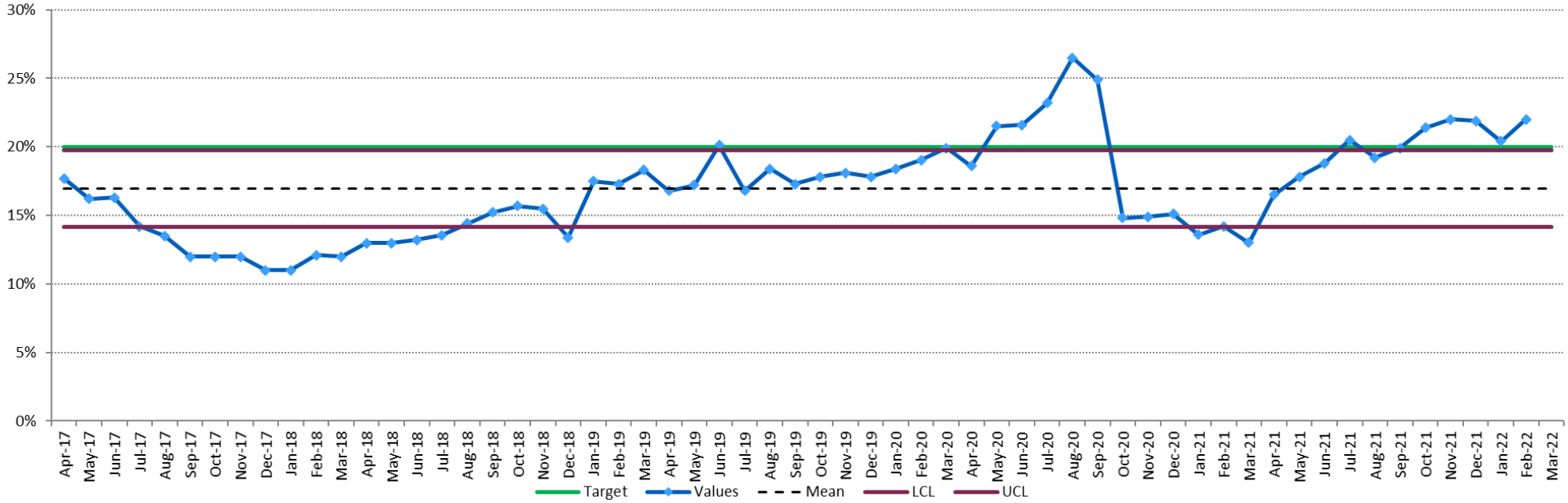
approach to traditional recruitment methods. We have implemented a new NHS Jobs system which supports streamlined recruitment processes, targeted social media campaigns, developed new entry level apprenticeships which are being promoted in our local communities to narrow inequalities and working with our partners on a city-wide attraction campaign to develop a One Leeds Workforce talent pipeline.

Turnover rates for the nursing and midwifery staff group are high at 16.8% which is resulting in higher vacancy rates in this staff group. The main reasons for leaving are due to voluntary resignation (reasons not known), work life balance and promotion. We are responding to this through a range of recruitment initiatives such as international recruitment and development of a health care support worker apprentice role.

Reduce the number of staff leaving the organisation within 12 months

Significant change of a deteriorating nature

Inconsistently passing and failing the target



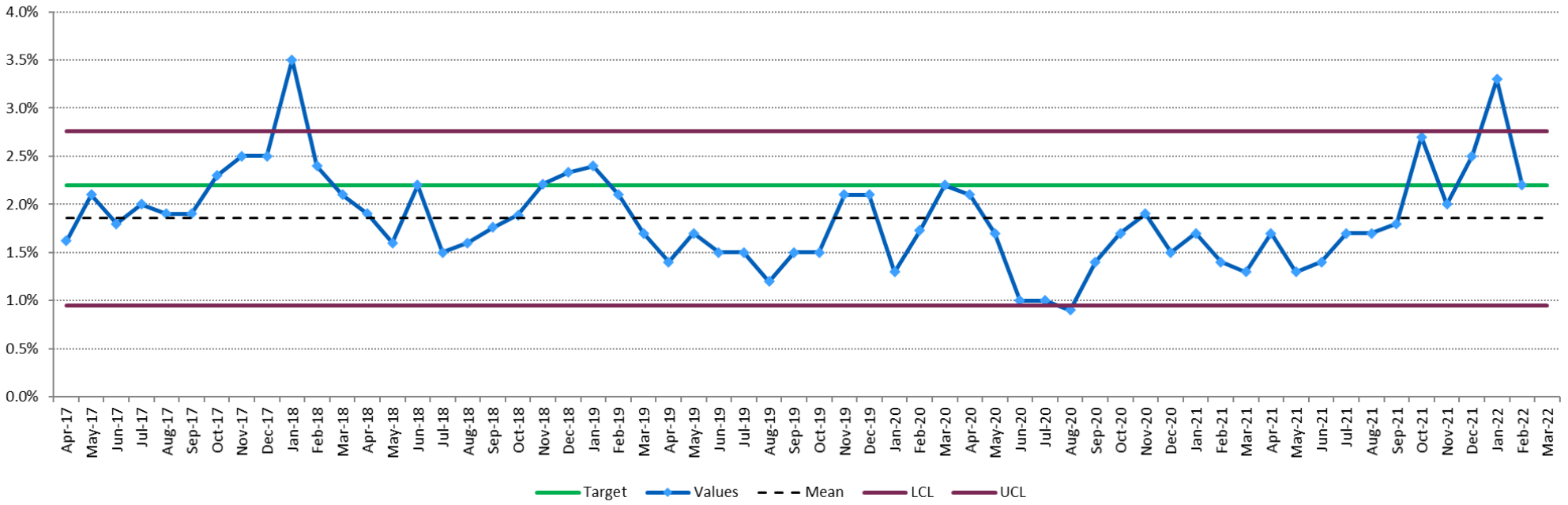
Leavers within the first 12 months of employment remains a concern with the main reasons for leaving being promotion, voluntary resignation (reason not known), work life balance. To support a reduction in these leavers, a new starters forum has been established. This is hosted by the Chief Executive with the

Director of Workforce and Chair of the Race Equality Network (REN) and aims to connect new starters to each other as well as understand their experiences and solve any challenges.
In addition to this, we are working to improve our induction and onboarding processes, so candidates and new starters are contacted regularly during the recruitment process and in the first months of employment. We are also reviewing the onboarding information and resources available for managers and staff and creating a user-friendly checklist to improve the onboarding and induction processes as this is key to improving employee satisfaction and retention.

Short term sickness absence rate (%)

No significant change

Inconsistently passing and failing the target

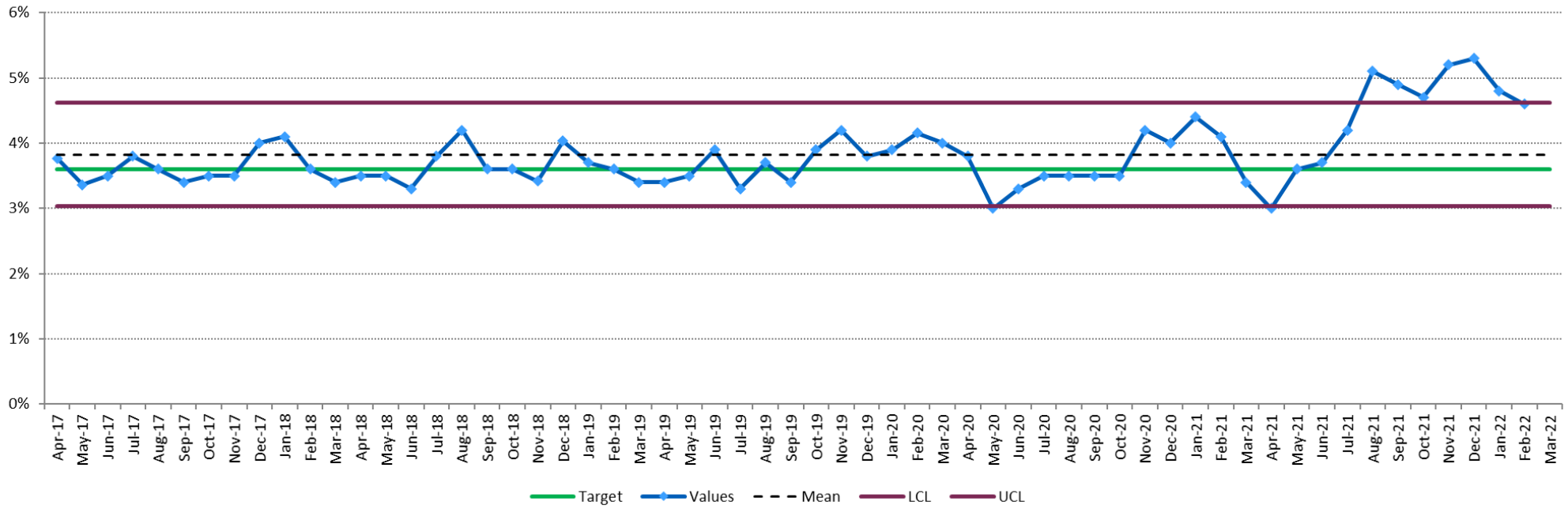


During October 2021 we saw a sharp increase in short term absence particularly linked to “cold / flu” which more than doubled from 0.3% to 0.7%, which we would normally have expected later on in the year. More recently in January, short term absence peaked above the upper control limit, due to covid related absences.

Long term sickness absence rate (%)

Significant change of a deteriorating nature

Consistently falling short of the target



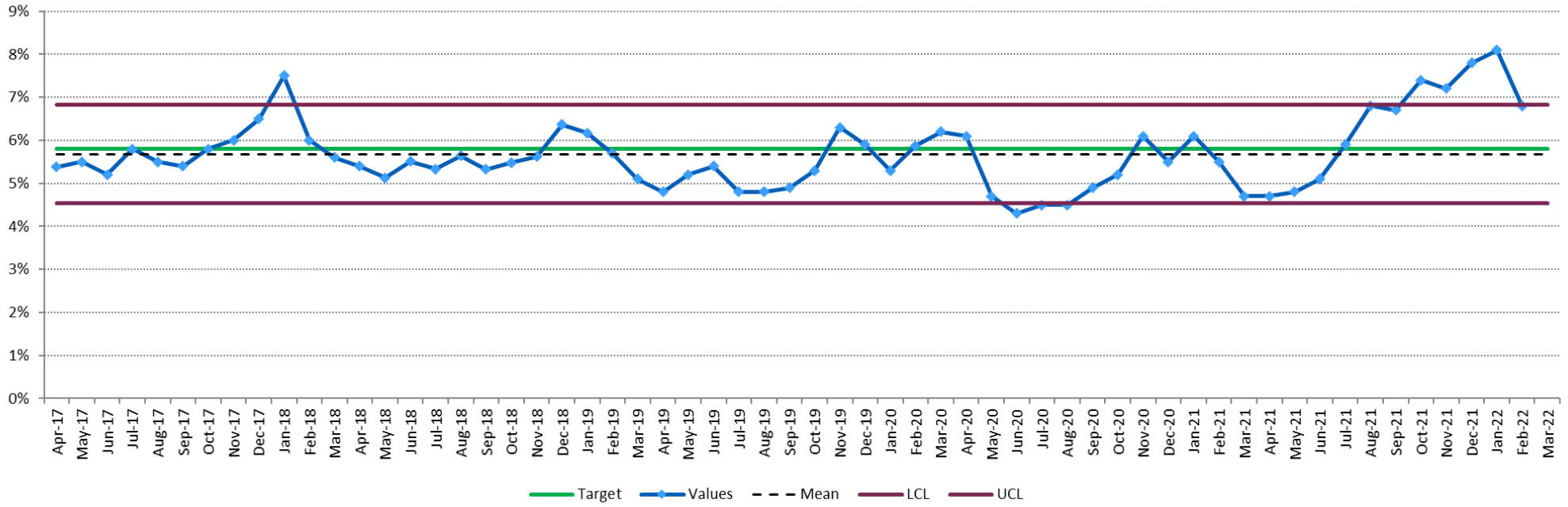
Long term sickness absence has been above the upper control limit since August 2021. The most prevalent reason for long term sickness absence remains “anxiety / stress / depression”, and we continue to focus on psychological support and emotional wellbeing as a key plank of our health and wellbeing agenda.

Targeted support is being offered by the HR Business Partners to the Business Units.

Total sickness absence rate (Monthly) (%)

Significant change of a deteriorating nature

Consistently falling short of the target

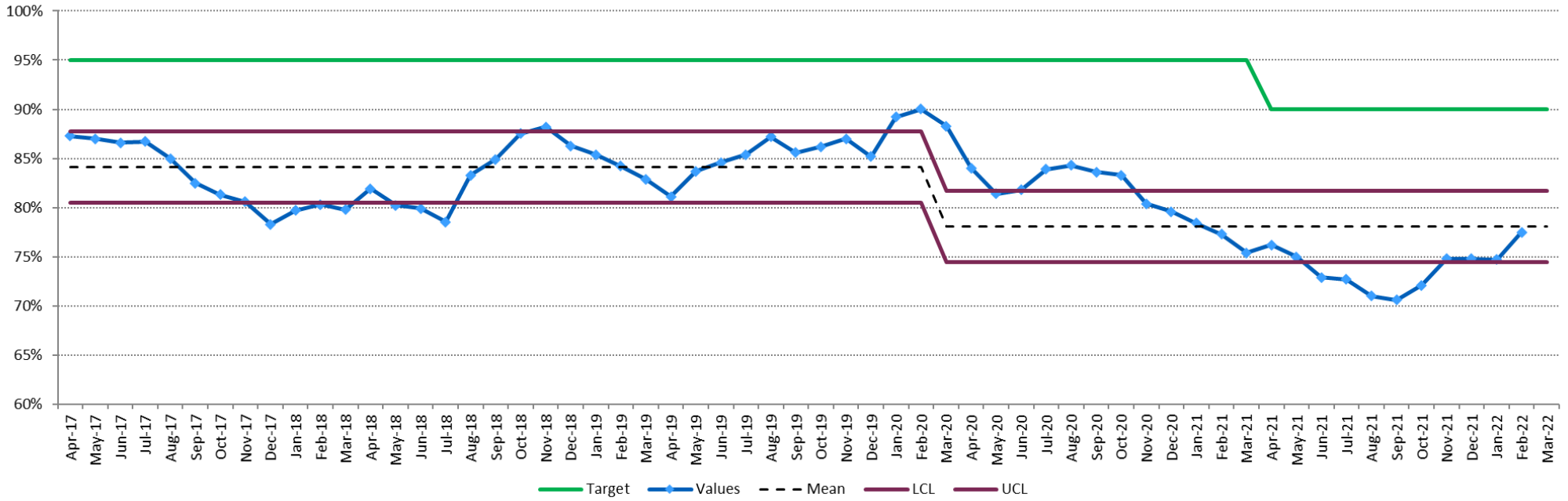


Total sickness absence has been above the upper control limit since August 2021 and there is a run of 7 points above the mean, principally, driven by increases in long term sickness absence. Sickness absence continues to be actively managed with the appropriate support being provided either through the management chain in addition to occupational health advice and/or via additional health and well-being interventions, such as the Employee Assistance Programme, the Long COVID Pathway and access to Leeds Mental Wellbeing Service. HWB continues to be a high priority and staff who are absent are actively supported.

AfC Staff Appraisal Rate

Significant change of a deteriorating nature

Consistently falling short of the target



Appraisal rates have been declining since August 2020 and consistently below the control limit since February 2021. This is all against a backdrop of the pandemic, two difficult winters and two rounds of redeployment/mutual aid. Since February 2021, Neighbourhood Teams have been consistently the biggest factor; representing nearly half of all outstanding appraisals. Since September 2021 they have been supported to recover with volunteers holding 186 reviews, with a further 50 planned to take place by end March 2022. This is starting to make some impact on the overall appraisal rates. Support will continue to be provided to support all Business Units with the aim of returning performance beyond the lower control limit.

Statutory and Mandatory Training Compliance

An SPC chart cannot be produced for this measure due to a recent change in the method of measurement. Despite the lengthy pandemic, staff have managed to maintain stat/man training levels to over 87% Jan 2022, and whilst slightly below target at present, this is broadly reflective with the pattern of compliance during the last 2 years.

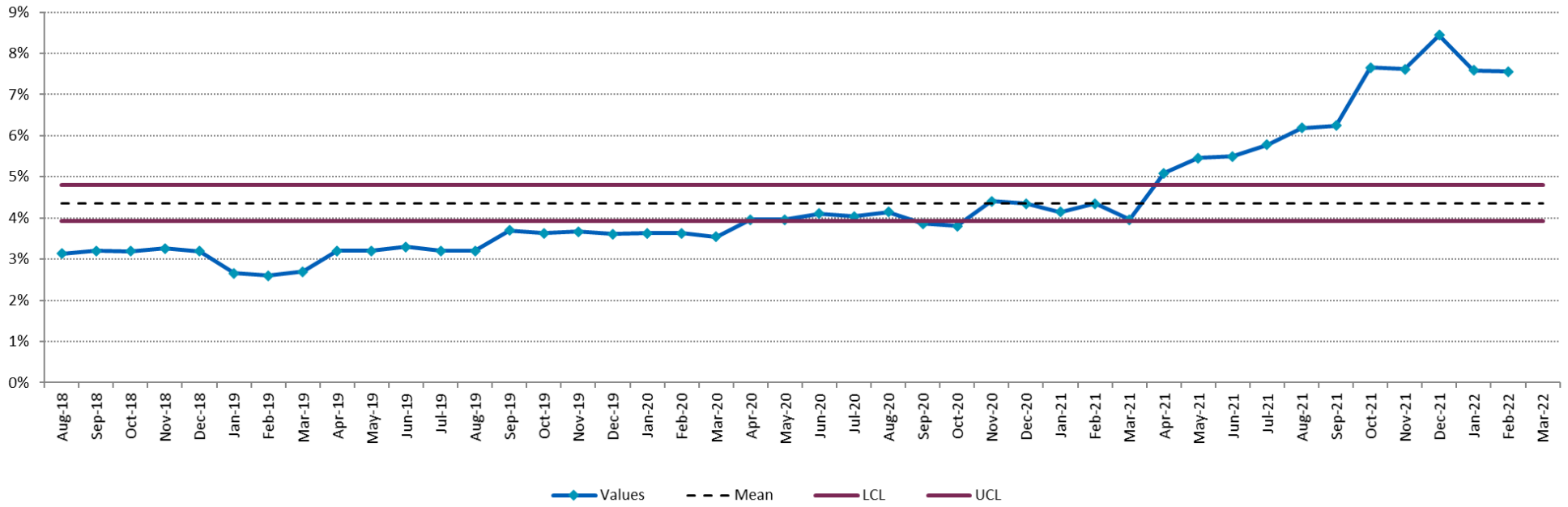
Percentage of Staff that would recommend LCH as a place of work (Quarterly Staff Survey QSS)

The Quarterly staff survey is completed on a quarterly basis in 3 quarter of the year. As such it is not possible to derive an SPC for this measure as not enough data points are available to show a representative selection.

This question is also asked in the annual staff survey which takes place in quarter 3. The results in Q2 showed 61% recommended LCH as a place to work and although this dipped slightly to 59% when staff were asked the question in the annual survey it rose again to 61% in Q4 QSS. The trend data shows a gradual decline since 2019 when the result was 69% recommending.

WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM

Significant change of an improving nature



Since March 2021, there has been a steady and significant improvement in the overall percentage of BME staff within the Trust, (currently 11.9%). Of note, is that of the 9.7% of staff we employ in Bands 8-9 and VSM, 7.6% are BME staff. This mainly falls within the Specialist Business Unit. A follow up conversation will be taking place with the General Manager of SBU to understand their approach, and whether this can be replicated elsewhere in the Trust.

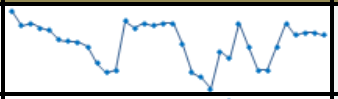
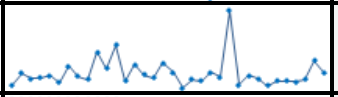
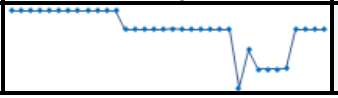
One of the WRES Actions was to improve the quality of the equality data held on ESR. This has identified 20 staff within Bands 8 -9 & VSM who are recorded on ESR as Null/Not stated. Communication will continue with those staff encouraging them to declare their ethnicity.

Finance – February 2022

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

Leeds Community Healthcare NHS Trust

Information for the finance domain was not available at the time fo report production and will therefore be tabled at the meeting.

Finance	Responsible Director	Target - YTD	Forecast	Financial Year	Q1	Q2	Q3	Jan	Feb		Series Data From
Net surplus (-)/Deficit (+) (£m) - YTD	BM	0.0		2021/22	-2.0	0.0	-0.4	-0.5	-0.7		Apr-19
Capital expenditure in comparison to plan (£k)	BM	2899		2021/22	228	75	399	157	838		Apr-19
CIP delivery (£k)	BM	655		2021/22	132	133	400	133	931		Apr-19

The Trust contines on the amended finance regime introduced by NHS England in 2020/21 to support the NHS in dealing with the Covid-19 pandemic. The Trust has block income arrangements in place with NHS Leeds CCG, NHS England direct commissioning and the Integrated Care System (ICS) which provide the majority of the Trust's income. Non NHS commissioning income remains unaffected and is based on contracts in place. The Leeds health organisations have worked together and with partners in social care and other sectors to maximise use of Leeds' NHS resources in the second half of the financial year.

Income & Expenditure (I&E) Summary

The Trust agreed an overall breakeven plan for 2021/22 with the West Yorkshire ICS leadership team.

To the end of February **year to date** the Trust has a surplus of £0.7m. The **forecast** for the year is a surplus of £0.8m. The main driver of the surplus is the underspendings on pay sue to vacancies; both for substantive roles and for the agreed additional staff costs to support waiting list activity.

Income

At the end of February clinical income is £0.9m less than planned levels, the majority of this is due to a timing issue in respect of an adjustment to the income from NHS Leeds. There is a reduction in income for police custody and 0-19 services where penalties in the contracts have been applied. The timing issue for NHS Leeds CCG income will be resolved in March leaving just a £0.2m shortfall in income due to the penalties.

Non patient care income is above budget, the majority of this is for training income from Health Education England and supports increased expenditure. Covid vaccination programme income is less than expected, this is because costs have been lower than originally expected. The Trust is only re-imbursed for additional costs incurred for the vaccination programme.

Pay and Non-pay Expenditure & Vacancies

Pay expenditure year to date is £118.8m which is less than expected; driven by the levels of vacancies, slippage on plans to address backlogs and the reversal of a provision made last year for expected redundancy costs which have not materialised.

There were net 244 vacancies in February of which 46 of the vacancies are in respect of additional resource identified for waiting list work meaning 198 vacancies are in respect of business as usual.

The vacancies are in the following business units:

Business unit	Total WTE vacancies	Waiting List posts vacant	BAU posts vacnt
Specialist	-93	-38	-54
Children's	-50	-6	-44
Adult's	-70		-70
Operational Management	-19		-19
Corporate	-13	-2	-11
Estates	-2		-2
Covid	3		3
Total Vacancies	**-244**	**-46**	**-198**

In terms of assessing organisational capacity the increasing vacancy levels are somewhat mitigated by agency staff costs increasing by circa 50% on average in the second half of the year over the average for the first half of the year.

This vacancy and financial picture on pay is consistent with the information about service pressures that the Board will discuss elsewhere on its agenda.

Non-pay, excluding reserves and non-recurrent (table 3), is £968k underspent at the end of February. This is being driven by;

- clinical supplies and services where the costs of the backlog work is generally timed towards the end of the financial year;
- on establishment expenses where there is underspending on planned costs for travel, training and meeting rooms hire; and
- premises rent and other estates maintenance where savings have accrued and costs are not evenly spread throughout the financial year.

Delivery of Cost Improvement Plans

The Trust has planned CIPs of £265k for H1 and £800k for H2 in line with the national planning expectations. These are non-recurrent. The £265k has been delivered through estate savings and the £800k is being delivered through additional vacancy factor in year.

Capital Expenditure

The Trust's original plan was to spend £3.7m on capital for 2021/22; the forecast outturn is £3.3m expenditure, as agreed with the ICS. Year to date expenditure is £0.8m which is £2.3m less than was planned to the end of February, this is mostly in respect of estates expenditure. The estates work is expected to conclude mid-March.

Cash

The Trust's cash position remains very strong with £40.6m 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.

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (134)

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

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Category of paper: for assurance
History: Senior Management Team 16 March 2022

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

Executive summary (Purpose and main points)

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

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

Board Assurance Framework
The Board Assurance Framework (BAF) summary at Appendix A gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by the committees. This informs the Board about the likelihood of delivery on its strategic objectives, as do the risk register themes.

Levels of assurance have been provided to the Board for thirteen out of the 20 strategic (BAF) risks during January and February 2022, with reasonable assurance given to twelve strategic risks and limited assurance given to one risk. The Board should note that BAF Risk 3.5 (Health and Safety Compliance) received only limited assurance. The Committee took some assurance from the Health and Safety compliance report but noted there were important issues and risk to mitigate.

Risk themes
The strongest theme found across the whole risk register is staff capacity, the second strongest theme is related to the lack of and/or implementation of suitable processes and procedures, and the third is Information Technology (IT) systems.

Risk movement

No risks with a score of 15 or more (extreme) have been added to the risk register. There are 15 risks scoring 12 (very high).

Recommendations

The Board is recommended to**:**

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

1 Introduction

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

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

1.3 The report provides a description of risk movement since the last register report was received by the Board (February 2022), including any new risks, risks with increased or decreased scores and newly closed risks.

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

2 Background

2.1 This paper has previously been considered by the Senior Management Team (SMT) at its meeting on 16 March 2022.

3 Board Assurance Framework Summary

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

Definitions:

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

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

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

3.4 Levels of assurance have been provided to the Board for thirteen out of the 20 strategic (BAF) risks during January and February 2022, with reasonable assurance given to twelve strategic risks and limited assurance given to one risk. Details of the committees' commentary about specific risks is provided at Appendix A (please also refer to the Chairs' assurance reports in the Board papers pack).

3.5 The Board should note that BAF Risk 3.5 (Health and Safety Compliance) received only limited assurance, having reviewed a number of sources of assurance including a health and safety compliance report, the premises assurance model report and the Health and Safety Group minutes. The Business Committee took some assurance from the Health and Safety compliance report but noted there were important issues and risk to mitigate. The Committee has requested additional sources of assurance, including inviting members of the Risk and Safety Team to attend the Committee meeting in March 2022 to provide further information.

Risk 3.5 is 'If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention.'

4 Risks by theme

4.1 For this report, the 61 risks currently on the risk register (the 'here and now' risks) have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a more holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

4.2 Themes within the current risk register are as follows:

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

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

Specifically:
Five risks are concerned with vacancies and difficulties recruiting to posts[1]
Ten risks are related to staff capacity due to an increase in service demand[2]
Two risks are related to services being paused in response to COVID 19, resulting in an increased workload and increased waiting times[3]
One risk is concerned with sickness absence[4]

The second strongest risk theme is related to the lack of and/or implementation of suitable processes and procedures[5]. This includes the application of local safety standards for invasive procedures (LocSSIP) across teams, the application of 'constant supervision' at WYOI, maintenance of the electronic healthcare records relating to adopted patients, lack of an assurance process for patient safety incidents, uncoordinated response to incidents, recording patient contract methods, assessment of pre-term children and inconsistent criteria at care homes.

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[1] 1021,1057,1060,772,950
[2] 1047,957,913,904,877, 1033, 1074, 954, 1048
[3] 1036,984
[4] 874
[5] 1055,981,792,1071,1028,1023,1077,952, 842

There is also a risk theme relating to Information Technology (IT) systems which are not sufficient to meet the requirements of the Trust or the services which use them[6]

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

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

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

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

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

Risk register theme: Staff capacity
BAF Risk 3.1 having suitable and sufficient staff capacity and capability and reduced levels of sickness

Risk register theme: lack of and/or implementation of suitable processes and procedures
BAF Risk 1.1 Having effective systems and processes for assessing the quality of service delivery
BAF Risk 1.3 Maintaining and continuing to improve service quality

Risk register theme: Information Technology (IT) systems
BAF Risk 2.4 maintaining the security of IT infrastructure
BAF Risk 2.6 investing and creating the capacity and capability to respond to the increasing dependency on digital solutions

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

[6] 1041, 974, 1040 1017 961, 1025,963,1050

5 Risk register movement

5.1 There are no risks scoring 15 (extreme) or above on the risk register as of 5 March 2022

6 New or escalated risks (scoring 15+)

6.1 There are no new risks scoring 15+ that have been added to the risk register since February 2022.

6.2 No risks have been escalated to a score of 15+ since February 2022.

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

7.1 No risks have been de-escalated below 15 since February 2022

8 Summary of risks scoring 12 (high)

8.1 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not contained to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12.

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

ID	Description	Rating (current)
874	Sickness levels – Neighbourhood Teams	12
877	Risk of reduced quality of patient care in Neighbourhood Teams due to an imbalance of capacity and demand	12
913	Increasing numbers of referrals for complex communication assessments in Integrated Children's Additional Needs Service (ICAN)	12
954	Diabetes service waiting times	12
957	Increased demand for the Adult Speech and Language Therapy service	12
979	Resourcing for the 0-19 service	12
981	Application of constant supervision at WYOI	12
982	Provision of Educarers in Specialist Inclusion Learning Centres	12
1017	Delay to improving the Electronic Patient Record system (EPR)	12
1041	PCMIS (patient information system) used by LMWS does not have the functionalist to run a system capture of all safeguarding cases	12
1047	Increased volume of callers into the Leeds Sexual Health appointment line due to no walk-in service	12
1057	Inability to deliver service at WYOI due to reduced staffing levels	12
1067	Introduction of female children into the secure estate (WYOI)	12

ID	Description	Rating (current)
1070	Capacity pressures in Neighbourhood Teams impacting on ability to deliver full range of clinical supervision and annual appraisals	12
1085	Resus training skill and compliance	12

9 New or escalated risks (scoring 12)

9.1 No new risks scoring 12 have been added to the risk register since February 2022

10 Risk profile - all risks

10.1 The total number of risks on the risk register is currently 61. Of these there are 17 open clinical risks on the Trust's risk register and 44 open non-clinical risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk:

Risk profile across the Trust

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	0	0	0	0	0
4 - Major	0	1	4	0	0	5
3 - Moderate	0	13	17	11	0	41
2 - Minor	1	1	10	1	2	15
1 - Negligible	0	0	0	0	0	0
Total	1	15	31	12	2	61

11 Impact:

11.1 Quality

Risks recorded on the Trust's risk register are regularly scrutinised to ensure they remain current. Risk owners are encouraged to devise action plans to mitigate the risk and to review the actions, risk scores and provide a succinct and timely update statement.

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

11.2 Resources

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

12 Recommendations

The Board is recommended to**:**

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

Appendix A. Board Assurance Framework levels of assurance

Details of strategic risks (description, ownership, scores) +B3:I12+B3:N24								Level of Assurance				
Risk		Risk ownership		Risk score				Committee agreed level of assurance				Additional Information
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	SL	QC	3	4	**12**				✓		Limited assurance was agreed in relation to CIVAS information (February 2022)
	Risk 1.2 If there are insufficient clinical governance arrangements put in place as new care models develop and evolve, the impact will be on patient safety and quality of care provided.	RB	QC	3	3	**9**				✓		Limited assurance was agreed in relation to the CAMHS pathway given the quality impact on recruitment challenges (February 2022)
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm.	SL	QC	2	4	**8**				✓		Quality Committee acknowledged the challenging circumstances across the Trust and the wider health and care system (January 2022)
	RISK 1.4 If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve.	SL	QC	4	3	**12**				✓		
	RISK 1.5 If, as a result of the Trust's altered capacity due to the Covid-19 pandemic, the Trust cannot deliver services in a timely and equitable manner, then the impact will be further increases to waiting lists, sub-optimal outcomes for patients and complaints to the Trust.	RB	QC	4	3	**12**				✓		
	RISK 1.6 If the Trust does not optimise its services to reduce the impact of health inequalities, and allow appropriate data capture to understand and address this, there will be a negative impact on patient outcomes, the Trust's resources and reputation.	RB	TB	4	3	**12**						
Provide sustainable services	**RISK 2.1** If there is insufficient resource across the Trust to deliver major change programmes and their associated projects, then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	3	3	**9**				✓		
	RISK 2.2 If the Trust does not deliver contractual requirements, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	2	3	**6**						
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	BM	BC	3	3	**9**				✓		
	Risk 2.4 If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage.	BM	AC	3	4	**12**						
	RISK 2.5 If the Trust does not deliver key financial targets agreed with NHS England through the ICS financial framework then it will cause reputational damage and raise questions of organisational governance	BM	BC	2	3	**6**				✓		
	RISK 2.6 If the Trust does not invest and create the capacity and capability to respond to the increasing dependency on digital solutions then systems may be unreliable, under developed, not used effectively, lack integrity or not procured. The impact will be on the delivery of patient care and on staff resources and wellbeing	BM	BC	4	3	**12**				✓		

Recruit, develop and retain the staff we need now and for the future	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development , and a low level of sickness absence) then it may not maintain quality and transform services.	JA/LS	BC	4	3	**12**				✓		The very high-risk rating reflects the continuing difficulties in creating the right staffing capacity across all services.
	RISK 3.2 If the Trust does not create and embed a culture of equality and inclusion, then it will fail in its duty to attract and retain a diverse workforce that is representative of the communities it serves, and will not reap the benefits of diverse thinking and representation.	JA/LS	TB	3	3	**9**						
	RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services.	TS	BC	3	3	**9**				✓		
	RISK 3.4 If the Trust does not invest in developing managerial and leadership capability then this may impact on effective service delivery, staff retention and staff wellbeing.	JA/LS	BC	3	3	**9**						
	Risk 3.5 If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention.	BM	BC	4	3	**12**			✓			The Committee took some assurance from the Health and Safety compliance report but noted there were important issues and risk to mitigate.
	Risk 3.6 If the Trust is unable to maintain business continuity in the event of significant disruption, there is a risk that essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss	SP	BC	3	4	**12**				✓		
Work in partnership to deliver integrated care and care closer to home	**RISK 4.1** If the Trust does not play an active part in the collaboration across the health and care system (ICS and ICP), then the system may not achieve better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.	TS	TB	2	4	**8**						
	RISK 4.2 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationship.	BM	BC	3	3	**9**						

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (135)

Title: 2021 Staff Survey Results

Category of paper: for information
History: SMT 16 March 2022

Responsible director: Director of Workforce
Report author: Head of Organisational Development & Improvement

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Executive summary (Purpose and main points)

This report provides the Trust Board with an update on the 2021 Staff Survey organisational results. This includes a comparison of 2021 Staff Survey results compared to our 2020 results, how we benchmark internally and with comparative community trusts nationwide. The report also outlines the approach for the dissemination of the information to our key stakeholders.

Finally, the report sets out how the organisation proposes to use the intelligence from the Staff Survey results to strengthen our ongoing and encompassing approach to staff engagement and provide further focussed areas for continuing improvement.

The report includes

- 2021 organisation wide results.
- Benchmark comparisons with Community Trusts nationwide
- Proposed next steps in terms of both dissemination of these results and plans to work with them at a local Business Unit and service level.

Recommendations

- Note the release of 2021 Staff Survey results and findings to date; and endorse the proposed approach to the dissemination and use of the above.

2021 Staff Survey Results – Trust Board update

Background:

The 2021 Staff Survey ran from October-November 2021. We have now, 3 weeks later than in 2020, received information from both our organisational survey provider Quality Health, and the National Survey Coordination Centre. This includes:

- An organisation level overview report from Quality Health
- Access to an online portal where we can extract data to produce reports with a breakdown by business unit, service and teams
- National benchmarking report (National Survey Coordination Centre) with other comparable community trusts (group data only, not by individual named Trust)

As the staff survey data was under embargo until 30th March 2022, at the point of writing we do not have the detail of how we compare with other individual trusts nationally in the wider NHS- we only have our 'comparator community trust sector' data.

For the Survey 2021 onwards, the questions are aligned to the People Promise. Over future years this will provide trend data, and this year helps us understand both the areas we are improving in and sustaining, and our areas for focus.

The People Promise sets out, in the words of staff, the things that would most improve their working experience and is made up of 7 elements:

We are compassionate and inclusive
We are recognised and rewarded
We each have a voice that counts
We are safe and healthy
We are always learning
We work flexibly
We are a team

Each grouping of questions in the survey aligns to one of the promises. The results are now measured against each of the elements and against two of the themes reported in previous years- Staff Engagement and Morale

LCH Response rate and Measures of Engagement

The overall response rate for the 2021 survey was 52% (1629 responses)- 7% higher than 2020.
We will reflect on the response rates in our discussions with the business units and identify the key actions we can take to boost the response rate for the 2022 survey.

The levels of staff engagement and morale are:
(NB breakdown by business unit for Morale was not available prior to this year)

	Engagement 2020	Engagement 2021	Morale 2020	Morale 2021	
LCH	**7.2**	**6.9**	**6.0**	**5.8**	
ABU	**7.0**	**6.8**	**NA**	**5.4**	
CBU	**6.9**	**6.8**	**NA**	**5.6**	
SBU	**7.4**	**7.0**	**NA**	**5.8**	

The Levels of Engagement score at LCH is now at the same level as 2017 at 6.9. The engagement score is significant as it is used to compare each NHS Trust with others and is the score used by the CQC in their Well Led assessments. Whilst we maintained a score of 7.2 for the years 2019-20 the effects of the pandemic, and in particular the prolonged pressure on provider services, has impacted both the engagement and morale of our staff. We can see this has affected staff from Nursing and Allied Health Professional groups in particular with scores of 5.5 and 5.6 respectively for Morale.

Additional, quarterly, engagement scores are now available via the Quarterly Staff Survey (QSS), which replaced the previous staff-focused Family and Friends Test (FFT) with effect from July 2021. For quarters 2 (July 2021) and 4 (January 2022) the engagement score was 6.7 and 6.5 respectively. It is normal for the quarterly survey to have fewer respondents compared to the annual survey which took place in Q3: 1231 in Q2 and 906 in Q4.

2021 Staff Survey Analysis

An overall snapshot of the Staff Survey comparing 2021 results with 2020 results shows that 19 questions recorded an improved score since 2020, 35 declined and 9 stayed at the same level. The 2021 Staff Survey also contained a number of new questions on health and well-being, learning and development and colleague support.

This section of the report provides analysis of the results by People Promise element.

1.We are Compassionate and Inclusive

In this grouping the questions asked relate to the importance of, and difference that, roles and the organisation make to patients, the recommendation of LCH as a place to work and receive care, some new immediate manager questions and questions on fairness and discrimination.

Related to the above a new question in the survey ‘I think that my organisation respects individual differences’ (e.g., cultural difference, working styles, ideas etc) produced a highly creditable score of 79% (Community Trust Sector average 77%) which is a result to be proud of.

The question ‘does your organisation act fairly with regard to career progression regardless of ethnic background, gender ...’ stayed at the same level as in 2020 at 63% (Community Trust Sector average 64%)

The ‘’my organisation acts on concerns raised by patients” dipped slightly from 2020 (81.2%) to 80.6% which is the same as 2019 (80.7%) (Community Trust average 80.4)
‘Care of patients is my organisations top priority’ dipped from 83% in 2020 to 80% this year (Community Sector average is 80%)

In a new question for 2021‘The people I work with are polite and treat each other with respect’ showed a good score of 80% (sector average 80%)

The questions on advocacy ‘I would recommend my organisation as a place to work’ has declined from 68% in 2020 to 59% in 2021 (sector average 65%) and ‘if a friend or relative needed care… has declined from 76% in 2020 to 70% (sector average 77%).

2. We are recognised and rewarded

This grouping includes the questions on the recognition and value the organisation gives and a question on pay, alongside people showing appreciation to one another and the value shown by your immediate manager.

The question ‘my immediate manager values my work’ took a slight dip from 76% in 2020 to 74.5% but generally we have maintained our scores related to immediate manager support. The question ‘have you felt pressure from your manager to come to work’ has gradually reduced year on year and is now 19% with the sector average being 17%.

The results for the questions on the recognition and value demonstrated by the organisation are similar in CBU (64%) and SBU (63%) reporting close to the LCH overall score of 63% (comparator trusts average is 64%). However ABU shows 58% in this area requiring some focus and perhaps reflecting the pressure of work and how it can impact recognition being felt by colleagues.

3. We each have a voice that counts

This section of the People Promise includes questions on autonomy and control and raising concerns

The questions ‘I know my responsibilities’, ‘I am trusted to do my job’ and ‘there are frequent opportunities to show initiative in my role’ there were slight increases on 2020 scores demonstrating an upturn following a decline between the 2019 and 2020 surveys.

‘I would feel secure raising concerns about unsafe clinical practice’ has increased from 81% to 84% (Community Trust sector average 83%). Feeling safe to speak up has maintained its position alongside the sector average score of 71% (2020 72%)

4. We are safe and healthy

This category covers health and safety climate, burnout and negative experiences such as work-related stress, bullying and harassment

This section of the survey featured a number of new questions on burnout. as well as 'My organisation takes positive action on health and Well-being' where LCH scored 63% (comparator 65%)

There was a sharp decline in the views of colleagues on 'there are enough staff at this organisation to do my job properly' 25% agree - down from 34% in 2020. (comparator trust average 29%). This decline is shared with our comparator trusts, and no doubt the wider NHS given the context of staffing shortages, although LCH do sit 4% below the average score, which is of concern. Significant work is underway at LCH to address capacity challenges at LCH, and further analysis will be carried out linked to this indicator when whole-NHS comparator results are available.

Analysis of where the 'hotspots' are in relation to staffing are aligned in general with areas in the Trust which have been designated "C1" and as experiencing the highest Opel levels during the pandemic; and in areas with perpetually "hard to recruit" roles. For example, 81% of respondents from Neighbourhood teams disagreeing with the statement 'there are enough staff…'. In CBU CAMHS have the highest response- 79% disagree and in SBU it's Custody Services that have the highest negative response of 79% although the numbers of respondents are small (23)

In relation to health and safety culture the question 'the last time you experienced physical violence at work, did you or a colleague report it?' showed a large decrease to 68% from 79%. Similarly for the question 'the last time you experienced harassment, bullying or abuse at work did you or a colleague report it? ' declined to 52% from 58% (2020). This requires a sharp focus on reporting of negative incidents experienced by staff to ensure an improvement before the next survey. It links to the ongoing Trust work on Zero Tolerance and Freedom to Speak Up. It should be noted though that this element does require further analysis as colleagues could be referring to non-reporting of negative incidents that happened several years ago as the question is not specific to a date period.

The responses to the questions on burnout are concerning. In six out of the seven questions on burnout LCH scores are comparable to the worst in the Community Trust sector.

Analysis of responses to the question 'how often do you feel worn out at the end of your day/shift' shows the areas of focus as Neighbourhood Teams: 64% (345 responses), and custody teams in West Yorkshire 73% (12 responses) and South Yorkshire 91% (11 responses). There are other high responses in CAMHS (57%) and MSK services (58%)

Whilst this result should be seen in the context that the Community Trust Sector in previous years has overall performed better than other sectors of the NHS, the message it sends is being heeded at LCH, where we must seek to ensure staff recovery is prioritised alongside workforce recovery; and continue to bolster staff wellbeing and capacity with a broad range of support and interventions. Now that we have the data on burnout detailed in this report we need a strong emphasis on reducing workplace stress

and the risk of overwork, to help staff recover from the enormous pressures the pandemic brought and to lighten their load. There is much work to do to ensure we retain the staff we have, given the level of morale- staff thinking of leaving the Trust has increased to 32% (27% in 2020) .

All the responses to questions on physical violence from patients, manager and colleagues have improved slightly although, as described in the previous section, we know that reporting is an issue here. The same can be said for bullying and harassment either from colleagues or managers where improvement has been seen,

However harassment has increased from patients/service users/ members of the public to 26% which is the highest it has been since 2017. The sector average is the lowest it has been since 2017 at 21%. The data here provides additional opportunities for elements of LCH's Zero Tolerance work to focus on those services whose results are of greatest concern.

5. We are always learning

This section of the People Promise includes questions on development and appraisals. The development questions are new and 'this organisation offers me challenging work' is a high score of 78% which is the best in the comparator sector. 'There are opportunities to develop my career..' is also a high score of 55% (comparator average is 54%)

Appraisal rates have taken a downturn, this question wasn't asked in the 2020 survey and our 2021 score is 83% (sector average is 88%). There has been intense work to support areas of the Trust with the lowest appraisal compliance since the survey was carried out; and gradual improvement is now being seen.

6. We work flexibly

These are new questions apart from 'the opportunities for flexible working…' which has gradually improved year on year since 2017 bar a slight dip in 2019. This year we scored 63% which compares favourably to the community trust sector average of 64%.

Improving Flexible Working opportunities is an objective within the LCH Workforce Strategy. With recent changes to LCH's Flexible Working policy and all LCH roles now advertised as having the potential for flexible working arrangements, we hope to achieve continued improvement in this area.

7. We are a team

This section covers team working and line management. Answers within it may be seen to correlate with the overall culture and behaviours within the organisation; deriving from the colleague behaviours that individual employees experience every day in their working environment.

Team LCH can be proud of the response to the question 'I receive the respect I deserve from my colleagues at work' which is 78% this year, up 2% on last year and equal to the

comparator trust average. I enjoy working with the colleagues in my team' produces another result to be proud of-85% agree which is also comparable to the community trust sector average and is a new question for 2021.

The scores in the line management section of the survey on the whole stayed at the same level or slightly increased on the 2020 survey scores and are around the average for the community trust sector. This may be viewed as a positive result in the context of the pandemic situation and its associated pressures.

The question 'my immediate manager asks for my opinion before making decisions that affect my work' showed a good increase this year of 3% to 60%. A related question 'my immediate manager takes a positive interest in my health and wellbeing' increased to 73 % (sector average 74%). Both of these may be indicative of LCH's "People Before Process" focus on individuals; its attention to compassionate health and wellbeing conversations; and its overall organisational behaviours of listening, working together and caring for one another.

Equality Diversity and Inclusion

The Workforce Race Equality Standard data

This year there is a reduction in Black and Minority Ethnic (BME) staff experiencing bullying harassment or abuse from colleagues, 19% say they have experienced this as opposed to 25% in 2020, this is the lowest number since 2017.

There has been a 2% increase in staff from a BME background experiencing bullying and harassment or abuse from patients/service users/members of the public since last year (21-23%), and this is also reflected in the responses from our white colleagues who have seen a 2% increase (from 24-26%). As described previously, action on this links well to the live Zero Tolerance work within LCH.

'Does your organisation act fairly on career progression regardless of ethnic background, gender, religion, sexual orientation, disability or age' has declined by 1% to 88% but is in line with the comparator average

Additionally, there is a 6% increase in the number of BME colleagues who report believing the organisation provides equal opportunities for career progression and promotion 47% and this is the highest figure since pre-2017. This question was answered positively by 66% of white colleagues, so whilst the improvement in BME experience is positive there remains clear disparity in experience here, which we continue to address through our range of Equality, Diversity & Inclusion work.

The Workforce Disability Equality Standard data

Staff experiencing bullying, harassment from patients/service users – this has increased by 1% over the last 12 months to 34% (staff without a Long-Term Condition or illness is 24%), however staff experiencing the same from managers has reduced from 15% in

2020 to 12% this year. This is comparable to our the experience of our staff who do not have a LTC or illness (also 12%).

Staff who experience bullying or harassment from their colleagues has stayed the same at 20% however the disparity between those with a LTC or illness and those who do not is growing as those who don't are reporting at 10% this year. We also know that this group of staff are reporting bullying and harassment less- a drop of 9% this year to 49%. (comparator trust average is 56%). This is new information which has been passed to the LCH Health & Wellbeing Group for consideration in the first instance.

Feeling pressure to come to work from managers has decreased again this year following an increase of 7% to 29% last year and is now 26%. Feeling the organisation values respondents' work has dropped to 44% from 50% last year (comparator trust sector 43%, a drop from 47% in 2020). This decrease is also reflected in the staff group who do not report having a Long Term Condition or illness (56% this year and 53% in 2020) and correlates with the results in the 'We are Recognised and Rewarded' element of the people promise. This requires us to concentrate further on ensuring LCH recognise and value the work undertaken by our colleagues who have a disability. Overall staff engagement for this group of staff is 6.6 compared to the wider organisation score of 6.9.

Next Steps:

Information from the National Survey (information due to be released 30/03/2021) will provide the information on the themed areas to make direct comparisons with other trusts and share learning. Once this information is available in the public domain there will be further analysis and an update available for the May Board, including "deep dives" into selected questions representing areas of greatest concern or achievement.

Staff Survey results are currently being shared with SMT, Leaders Network, Race Equality Network, Senior Operational Strategy Group and with Staff-side colleagues through both the JNC and JNCF. A discussion with the 50 Voices group will also be scheduled.

Analysis of service level survey results has been completed and compiled into reports for all business units, services and teams within which there have been 11 or more respondents.

There is variation across teams, services and professions, in terms of the range of results, and much to learn from each other. Reports are currently being disseminated and considered. The Business Units hold events to enable the opportunity to share and learn, and also to discuss the offer of support to those teams in need of intervention and in respect of staff engagement. This includes triangulation of other cultural intelligence information to fully understand the overall situation, as well as the potential to 'buddy up' with services performing really well on engagement.

There is a real momentum and commitment across the organisation to understanding and using the data from the staff survey, whilst recognising the views are captured at a point in time- the helpful touch point of the Quarterly Staff Survey will support regular review.

Conclusion:

This report pulls together the vast data from the 2021 Staff Survey into helpful categories in the People Promise and will enable even better comparison going forward, as we receive further data once the embargo is lifted on 30 March 2022, and in future years.

The analysis provides the Trust with areas to consider for further interrogation into the data, areas for 'deep dive' which with additional concentration should improve the 'We are safe and healthy' experience for LCH staff. Work is ongoing, particularly in those services where it is an even greater challenge to recruit staff into, e.g. adult nursing and specialist services, and there are unprecedented pressures, such as children's mental health services. Likewise, we will identify an area to celebrate from 'We are a team' where we can further improve and build on our 'Team LCH' ethos and culture of respect – we know for example that questions relating to immediate manager support retained good scores for the trust as a whole and in the services where there are areas of concern as highlighted.

Finally, we have set out in this report, our approach to disseminating understanding and acting on our data at all levels in the organisation from team to Board.

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Recommendations:

- Note the release of 2021 Staff Survey results and findings to date; and endorse the proposed approach to the dissemination and use of the above.

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (136)

Title: Patient Safety Strategy Implementation Update Report

Category of paper: for assurance
History: N/A

Responsible director: Executive Director for Nursing and Allied Health Professionals

Report author: Assistant Director for Nursing and Clinical Governance and Head of Clinical Governance

Executive summary

The purpose of the paper is to provide Board with a six-monthly update of progress against the nationally published Patient Safety Strategy.

Leeds Community Healthcare NHS Trust (LCH) is making progress against the short and medium term aims published by NHS England. Due to the impact of the pandemic, there are national delays in piloting the Strategy and sharing guidance for wider implementation.

LCH has continued with our implementation plan to complete as much work as possible pending national guidance. A full update is provided in Appendix A.

Recommendations

The Board is recommended to:

- discuss the content
- agree the level of assurance provided

1 Introduction

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. It is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience.

The Patient Safety Strategy was published in 2019 and described how the NHS will continuously improve patient safety over the following five to ten years and recognised that the greatest opportunity to improve patient safety is at the point of care.

It is human to make mistakes so to continuously reduce the potential for error, we must learn and effectively act when things go wrong.

2 Background

A journey of continuous improvement is the key vision of the Patient Safety Strategy. Its success will be determined by the impact from improved incident reporting, more appropriate investigation of incidents, greater understanding of our areas of risk, and better-quality learning. This will result in a reduction in patient harm and an increase in our ability to deliver high quality care.

The Strategy suggests that through the following improvement areas 928 lives could be saved nationally, and there would be £98.5 million more available for care per year.

- **improved incident reporting and response** could save 160 lives and £13.5 million.
- If **boosting patient safety understanding and capability** reduces harm by a modest 2%, an extra 200 lives and £20 million could be saved.
- **focusing improvement programmes** on those areas where most harm is seen could save 568 lives and £65 million.

3 Key Priorities Current Position

A presentation was completed to Board in November 2021 that included an initial update of the national short- and medium-term key priority areas detailed in Appendix A, below.

Although the national piloting programme in the early adopter sites has been delayed due to the pandemic, LCH continues to make progress against the priorities where possible.

Good progress is being made in the involvement of Patient Safety Partners, the implementation of level one of the Patient Safety Syllabus and Just Culture. We have initiated improvements in our Incident Reporting and are working more in line with the Strategies approach to investigation methodology within the Patient Safety Incident Response Framework.

LCH has developed and led a Leeds Place forum who meet monthly to share understanding and progress against the Strategy. This includes the Clinical Commissioning Group, South West Yorkshire Partnership Trust, Leeds and York

Partnership Foundation Trust and Leeds Teaching Hospitals Trust (LTHT). The group aims to bring some standardisation across the Leeds Place in order to support our patients though joined up approaches to safety culture and systems.

A copy of the LCH Implementation Plan can be provided by email for Board members if required.

4 Conclusion

As an organisation, LCH is working towards implementation of the Patient Safety Strategy wherever possible. There have been national constraints due to the COVID pandemic that have slowed progress in some areas, but LCH is working with partners across the Leeds Place to gain insight into moving our Strategy response forward as quickly and robustly as possible.

5 Recommendations

The Board is recommended to:

- discuss the content
- agree the level of assurance provided

Appendix A – Progress Position Statement

Priority	**Just Culture:** The NHS Patient Safety Strategy highlights the central importance of cultivating a just culture. There are many aspects to a just culture. Local systems should set out how the principles of a patient safety culture will be embedded on an ongoing basis. These should include monitoring and response to NHS staff survey results and any other safety culture assessments, [and] adoption of the NHS England and NHS Improvement 'A Just Culture Guide' or an equivalent.
Update	Just Culture is incorporated in to LCH investigation training. An initial meeting was arranged with the HR team to consider how LCH formally adopts the Just Culture Guide and builds it into our HR policies. This work was paused due to the pressures of COVID and will be restarted. The LCH Patient Safety Specialists and the Trust Lead for Clinical Outcome Measures, who has completed previous work on Just Culture and the impact of second victim, will be involved. The Clinical Governance Team delivered training on Just Culture, Systems Approaches and Human Factors to the colleagues who lead and provide expert opinion to our Rapid Review process, these colleagues included our Tissue Viability, Falls, Safeguarding, Patient Safety colleagues in addition to the Patient Safety Specialists. We have introduced an introductory section to the Rapid Reviews to ensure Just Culture is the basis and focus of our panel discussions.
Priority	**National Patient Safety Alerts (NatPSAs) advice:** A key feature of National Patient Safety Alerts (NatPSAs) is the need for leaders in each organisation to manage the implementation of all relevant actions for each alert. This means ensuring the right systems and processes are in place to ensure alert implementation is centrally managed, the required actions are embedded into practice and compliance sign off has executive oversight.

Update	We continue to advise Board of any relevant NatPSAs through the Governance reports, these are included in the Quality Lead Business Unit report and the Patient Safety Performance Brief. In addition, any that are open and relevant to LCH are included in the Clinical Governance Report. Our Medical Device Safety Officer is now fully trained on the requirement of the NatPSAs and manages any device related alerts. We have re structured the role of the Governance Systems Manager who commenced in post on 28 February 2022 and will be trained in the alert process. This will provide some resilience to cover any absence in the team that may affect the alerts being processed.
Priority	**Improving quality of incident recording:** Improving the quality of incident reporting as one of the principles of improving safety culture. The objective of incident reporting is to highlight opportunities for patient safety to be improved both locally and nationally and to enable that information to be shared with those who need to see it. It is critical for that information to be acted upon effectively and sustainably. The quality rather than quantity of information submitted is vital to support this.
Update	Project management support has been approved by the Business Development Team to support an organisation wide remodel of our Datix system. The aim is to reduce the complexity of our current system and ensure staff feel equipped and confident to use Datix to its maximum potential. An ergonomic focus will be used to develop the system to meet the needs of the user rather than our staff having to navigate a needlessly complicated system. All staff will require further training once the new model is developed. We are awaiting approval from the education team to train six colleagues in Datix to a greater depth, this will include an IT/SystmOne colleague to provide support if required, but to also support wider application of Datix through to the Performance Portal. Online resources are being developed to support colleagues to use Datix in the interim and training will be revised with the Governance Systems Manager.
Priority	**Support transition from NRLS and StEIS to the new Learn from patient safety events (LFPSE) service:**

	In Spring 2021, the new national Patient Safety Incident Management System (PSIMS) entered its public beta stage, marking the start of the transition away from the current National and Reporting Learning System (NRLS).
Update	The LFPSE service is now live and providers can start to use the system once it has been rolled out by their Local Risk Management System (Datix). All organisations must continue to provide information to the National Reporting and Learning System (NRLS), LCH continues to provide information weekly. RLDatix will manage and oversee the transition. Discussions will be initiated with Datix to understand the planned timescales.
Priority	**Preparation for implementing the new Patient Safety Incident Response Framework (PSIRF) when it is launched in 2022:** The Patient Safety Incident Response Framework (PSIRF) outlines a new approach to responding to patient safety incidents and how and when a patient safety investigation should be conducted. An introductory version of the framework was published in March 2020 and is currently being tested with nationally identified early adopters who will inform the creation of the final version. We anticipate publishing the final version in Spring 2022 when roll out across the NHS will commence.
Update	Delays in the national early adopter scheme continue that have impacted local teams from implementing the PSIRF, including for LCH. LCH attend a monthly city-wide working group where Leeds Teaching Hospitals Trust provide insight and updates as one of the national early adopter sites. They are providing a full update at the March 2022 meeting in relation to PSIRF. Work will commence on the LCH PSIRF as soon as we receive the national guidance. In the interim, we are working towards the principles of the Strategy and have included additional methodologies to our Serious Incident investigation reports. This has included incident walkthroughs with summary reports to date, a meeting is planned for 22 March 22 to initiate a suite of methodologies to support an appropriately proportionate response to incident reviews.

	Benchmarks for who can complete the various stages of an incident's management investigation have been published. However, the supporting Patient Safety Syllabus is required for full review, levels 1 and 2 are available, levels 3 to 5 remain in national development. LCH is concordant with the known elements of the benchmarks.
Priority	**Implementation of the Framework for involving patients in patient safety (published June 2021):** The Framework for Involving Patients in Patient Safety is currently planned for publication in April 2021. Organisations who haven't previously started involving patients in organisational safety are recommended to undertake a safety culture assessment to assess their readiness for working with patient safety partners (PSPs). Local systems and regions aim to include two PSPs on their safety related clinical governance committees (or equivalent) by April 2022 and elsewhere as appropriate.
Update	Following national guidance, the implementation date is now July 2022. However, LCH has prioritised this piece of work and has developed and shared the Patient Safety Partner Policy week commencing 7 March 2022 for wider comments. A recruitment pack has been developed that includes induction information, role description, interview documents and a visual road map of the process that will be shared with prospective Partners. A dedicated implementation plan has been developed to support the process and is attached for reference (Appendix B). It includes the following key topic areas: 1. Commitment to involving PSPs in patient safety: The organisation should express a commitment to the involvement of PSPs and promote their recognition throughout the organisation. 2. Creating a framework to develop and support PSP involvement: There is no contract of employment between PSPs and the organisation. Instead, the relationship is based on mutually agreed expectations about the role 3. Inclusive approaches to attracting PSPs: The organisation works to involve PSPs who reflect the diversity of the local community 4. Developing PSP roles and task profiles: The organisation develops appropriate roles for PSPs in line with its aims and objectives, which are consistent with this guidance and which are valued by the PSPs in those roles

	5. Safeguarding PSPs, staff and patients: The organisation is committed to ensuring that, as far as possible, PSPs are protected from any emotional and financial harm arising from their role. 6. Recruiting PSPs: The organisation is committed to using fair, efficient and consistent recruitment procedures for all potential PSPs. 7. Induction and training for PSPs: Clear procedures are followed when inducting new PSPs to their role, the organisation and relevant policies. 8. Supporting PSPs: The organisation takes account of the varying support needs of PSPs and provides for them. 9. Valuing and recognising PSP contributions: The whole organisation is aware PSPs need to be given recognition.
Priority	**Patient safety education and training including the first two levels of the Patient safety syllabus launched in October 2021:** The National Patient Safety Syllabus is due to be published shortly and we will let you know when this happens. The initial requirement in the strategy is for training in the 'essentials' of patient safety to be available for all NHS staff by July 2021 with a view to all staff being trained by April 2023. PSSs will be key to supporting their colleagues to engage with and understand the new 'essentials' training. They can also provide additional advice and help translate the principles of the training into real world activity. Support all staff to receive training in the foundations of patient safety by April 2023
Update	Levels one and two of the national syllabus have been released in the format of elearning. LCH has made level one part of the mandatory training offer for all to complete. Due to winter pressures, this became mandated on 1 March 2022 and will be monitored from Quarter Two 2022/2023. Discussions are ongoing in relation to the staff group for level two and ESR is being reviewed to support inclusion of staff groups. Initial considerations are for all Band 6 clinical colleagues. Work is being completed for a detailed staff list from ESR to enable further review.

	As levels three to five are developed and released updates will be provided in future papers.
Priority	**Supporting involvement in the National Patient Safety Improvement Programmes, working with local AHSNs and Patient Safety Collaboratives:** There are currently five National Patient Safety Improvement Programmes: • Managing deterioration • Maternity and neonatal • Adoption and spread • Medicines safety • Mental health These programmes are supported by the Patient Safety Collaboratives (PSCs), who develop Local Improvement Plans collaboratively with relevant local stakeholders.
Update	LCH has established and led a citywide Patient Safety Specialist Forum that meets monthly and involves local partners. The group discusses and shares progress with the Strategy implementation with an aim for a citywide approach that is standardised wherever possible. LCH continues to establish contacts with AHSNs and PSCs and a presentation on work so far on the above areas was shared at our November 2021 meeting by the Patient Safety Collaborative Programme Manager. Our Patient Safety Specialist's include our Medicines Safety Officer and our Medical Device Safety Officer to ensure their expertise is captured as we move forward in our implementation. As this workstream develops additional updates will be provided, national forums tend to relate to secondary services currently.
Priority	**COVID-19 recovery support:** As organisations start to develop plans for recovering from this phase of COVID-19 it is important that they are appropriately driven by their potential impact on patient safety.

	We will be offering support to the relevant national leads for COVID-19 recovery-related work to ensure patient safety is appropriately considered. If you have any views or ideas, please share with us by emailing patientsafety.enquiries@nhs.net
Update	We have now registered seven Patient Safety Specialists, they are our Assistant Director of Nursing and Clinical Governance, Head of Clinical Governance, three Quality Leads, Medicines Safety Officer and Medical Device Safety Officer. They are involved in the organisations reset and recovery from COVID and are able to share safety information as required. This is not currently a formalised process from a Patient Safety Strategy perspective, but they are involved in recovery elements such as service EQIA's for service improvement in reset, business planning, and Trust Priority development.

Appendix B – Patient Safety Partner Implementation Plan

Principle	Areas for consideration	
Commitment to involving PSPs in patient safety: The organisation should express a commitment to the involvement of PSPs and promote their recognition throughout the organisation.	❖ Board level sponsor ❖ Executive Director & Operational lead ❖ LCH Patient Safety Partner policy ❖ Consider how PSP role can contribute to Trust & Quality priorities ❖ Consider who we measure the impact of the PSP role and how we celebrate this	❖ Helen Thomson ❖ Steph Lawrence ❖ Draft developed and then PSP input to finalise / evolve – in recruitment pack folder ❖ Referenced in table of engagement / involvement events in PSP ❖ In PSP policy
Creating a framework to develop and support PSP involvement: There is no contract of employment between PSPs and the organisation. Instead, the relationship is based on mutually agreed expectations about the role	❖ PSP agreement ❖ PSP role profile – how we support them and they support improving pt safety	❖ Agreement being developed by Hannah based on honorary contract. Input from Capstick's ❖ Applied national template with tweaks. In recruitment pack folder

	❖ Define clear management structure for PSP ❖ Develop recruitment process ❖ Declaration of interest ❖ Renumeration policy aligned with framework. Including, defining and scoping potential financial costs to cover out of pocket expenses and 'involvement' payment (suggested at £75 per half day, £150 per full day) ❖ Renumeration arrangements across PBP to ensure consistency and equity	❖ Role description describes Head of Clinical Governance as report to & ADoN as responsible to. ❖ Follow normal process, recruitment pack in development ❖ Required for each relevant activity. Adopted national template as LCH version refers to Trust policy which won't apply to these roles. Required for Quality Committee. In recruitment pack folder ❖ Included in PSP policy. Agreed will limit activities of partners in 1st 18m so as not to develop employment relationship / rights and review future requirement – number of roles etc. Currently exploring local and national arrangements in relation to payment of non-employees. Continuing conversations at city wide forum
Inclusive approaches to attracting PSPs: The organisation works to involve PSPs who reflect the diversity of the local community	❖ Recruitment plan to address how people with protected characteristics and from diverse backgrounds will be supported to become PSP –	❖ Will launch through midday brief, social media, flyers, specifically target Leeds City Council as well as GIPSIL, Leeds Mind and different charities – to develop based on Youth Board

	reasonable adjustments, accessible information, ❖ Learn from good practice already in LCH e.g. Youth Board. ❖ Liaison with partner organisations across the place of Leeds / PSPs for their thoughts and ideas	❖ Conversations taken place, Youth Board more volunteer role than this, but good practice been considered into this plan ❖ As above, will ensure PSP involvement in evolution once in post. Included co-production section in policy.
Developing PSP roles and task profiles: The organisation develops appropriate roles for PSPs in line with its aims and objectives, which are consistent with this guidance and which are valued by the PSPs in those roles	❖ National templates available to build on ❖ Board sponsor, Executive Director and Operational Lead to support the development of how we want the PSP role to support us in LCH and therefore what benefit this offers to individuals	❖ Role description and policy both in recruitment pack
Safeguarding PSPs, staff and patients: The organisation is committed to ensuring that, as far as possible, PSPs are protected from any emotional and financial harm arising from their role.	❖ Need employer's liability insurance to cover if PSP harmed by organisation and public liability insurance to cover both org & PSP if 3rd party harmed by PSP ❖ Policy for reimbursing and renumeration ❖ OH / employee assistance access, ❖ Duty of care and safeguarding,	❖ Both included in LTPS by NHS Resolution of which LCH is a member. Included in PSP policy ❖ Will be included in PSP policy once LCH position confirmed. ❖ Problem solving process in PSP policy, would be expected to be signposted to GP or relevant other ❖ Safeguarding included in training requirements. Problem solving process and support structure within PSP policy. ❖ Covered in induction checklist and within role profile. In recruitment pack

	❖ Induction to cover safeguarding / FTSU awareness, ❖ ID badges	❖ Agreed not needed. Unlikely to be attending office space unaccompanied or without a named point of contact. May consider a 'visitors' badge when back to face to face meetings
Recruiting PSPs: The organisation is committed to using fair, efficient and consistent recruitment procedures for all potential PSPs.	❖ Clear role description and PSP agreement ❖ Consider term of each role in implementation plan / policy development e.g.3-5-year term and can re-apply, ❖ 2-way recruitment process to ensure mutual fit and continue values-based recruitment ❖ Keep application and interview process as simple as possible and consider national templates for this	❖ Adopted national role description with some tweaks. PSP agreement in development based on honorary contract ❖ Agreed 18 month term in 1st instance, to minimise risk of challenge for employment relationship ❖ Application form in recruitment pack – Suite of interview questions adopted from partner organisation. In recruitment pack folder
Induction and training for PSPs: Clear procedures are followed when inducting new PSPs to their role, the organisation and relevant policies.	❖ Develop Trust induction for PSP ❖ Consider all relevant policies and procedures and ensure inclusive of PSP role, ❖ Define line management within policy / implementation plan to ensure personal development supported	❖ Induction checklist in recruitment pack folder. ❖ Hannah developing honorary contract based on feedback from Capsticks ❖ In PSP policy and report to / responsible to in role description. In recruitment pack folder
Supporting PSPs: The organisation takes account of the varying support needs of PSPs and provides for them.	❖ Requirement for annual appraisal, regular 1:1s, NED/ED support as mentor / buddy, peer support, exit	❖ Included in PSP policy and on PSP road map. In recruitment pack folder.

	interviews, which need defining within implementation plan and policy	
Valuing and recognising PSP contributions: The whole organisation is aware PSPs need to be given recognition	❖ Case studies to showcase the role, ❖ QI project description document for activities that would benefit from PSP ❖ Training and education needs for all staff	❖ In PSP policy and will evolve with co-production from PSPs ❖ LCH 'Our Eleven' in recruitment pack ❖ Need to develop launch / communications

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 31 March 2022

Agenda item number: 2121-22 (139)

Title: Digital Strategy Update Report

Category of paper: Assurance

History: Business Committee February 2022

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 and provide the Business Committee and the Board with the opportunity to review proposed plans for 2022/23 and the developing relationship between the Trusts Digital priorities, the Leeds “place” digital priorities and the wider ICS digital priorities.

The current digital plan for 2022/23 is presented in both road map and in a plan on a page form but are subject to resource planning to validate the plan. Recent experience has highlighted the impact of operational capacity to engage with digital workstreams caused by winter pressures and how unexpected hardware issues can divert technical resource, suggesting we won’t be able to complete as much as we plan for.

The requirement to “test” LCH digital plans against national criteria and to submit these plans to support the Leeds / ICS brings added workload and complexity. Should areas of the LCH digital plans be found to be not compliant, or within required timescales or are missing completely, further work will be required which may require new projects and programmes to be established, which will have an impact on other areas of the Digital plan

Recommendations

The Committee and Board are recommended to note and comment on the Digital the strategy and plans and the emerging relationships and complexities with the Leeds Place and ICS based digital priorities

1. Purpose of the Report

This report has two purposes. Firstly, to present the plan and priorities for 2022/23 and secondly, to signal the emerging relationships between the LCH, Leeds "place" and ICS digital priorities and the complexities this presents through a requirement to ensure the digital priorities throughout remain aligned.

2. LCH Digital Strategy 2020-23 Plan

Appendix one provides an illustration of the Digital Strategy for LCH, with the major schemes and their purpose identified. This remains largely the same as previously presented to the Business Committee.

Appendix two presents the latest version of the digital plans for 2022/23. A process of resource planning is constantly occurring to ensure there are adequate resources in place to allow the project to proceed. A barrier to progress in the last quarter has been a lack of service capacity to engage as they have responded to Winter Pressures, which has slowed down progress of ABU optimisation work in particular.

Resource planning exercises will be repeated throughout the year to ensure projects are only started or continued where there are adequate resources in pace.

3. Leeds Placed Based Digital and ICS Digital Priorities

Through the Leeds Office of the ICS, it is expected that the LCH digital plan will demonstrate how it fits within and contributes to the Leeds Place and ICS digital plans and priorities.

There is also a national mandate to provide a response as to how the Trust will "Transform and build community services capacity to deliver more care at home and improve hospital discharge which specifically requires LCH to provide digital plans which demonstrate and respond to the following:

Identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
Ensure providers of community health services, including ICS-commissioned independent providers, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards
Deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK)

The Trust will also be expected to contribute to the following broader digital planning requirements:

By March 2022, systems should develop plans that set out their first year's priorities for achieving a core level of digitisation across all acute, mental health, community and ambulance settings	
Acute, community, mental health and ambulance providers are required to meet a core level of digitisation by March 2025, in line with the NHS Long Term Plan commitment. By March 2022, systems should develop plans that set out their first year's priorities for achieving a core level of digitisation across all these settings (as set out by the Frontline Digitisation minimum viable product, which published 31 December)	
Costed three-year digital investment plans should be finalised by June 2022 in line with What Good Looks Like (WGLL)	Include provisions for robust cyber security across the system. We will continue to provide and further enhance centralised cyber security capabilities systems; however, local organisations are responsible for managing their own cyber risk
	Reflect ambitions to consolidate purchasing and deployment of digital capabilities, such as electronic patient records and workforce management systems, at system level where possible
	Set out the steps being taken locally to support digital inclusion
	Consider how digital services can support the NHS Net Zero Agenda
A digitised, interoperable and connected health and care system is a key enabler of delivering more effective, integrated care. Systems are asked to ensure that:	By March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024. Standards will be published to support this
	Local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system
	Suppliers comply with interoperability standards as these are finalised by April 2022
	General practice promotes the NHS App and NHS.UK to reach 60% adult registration by March 2023
	Plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions

Whilst each of the planning requirements are helpful in establishing the validity of the LCH Digital Strategy, the mechanisms for achieving these are not yet established and with a draft submission due by the 1st March (and a final submission due in April) it adds pressure and complexity.

4. Next Steps

Complete resource planning exercises, to ensure the projects identified in 2022/23 are viable and achievable.

To validate the LCH digital plans by testing their content against the key Minimum Viable Product and other requirements as specified in national planning guidance.

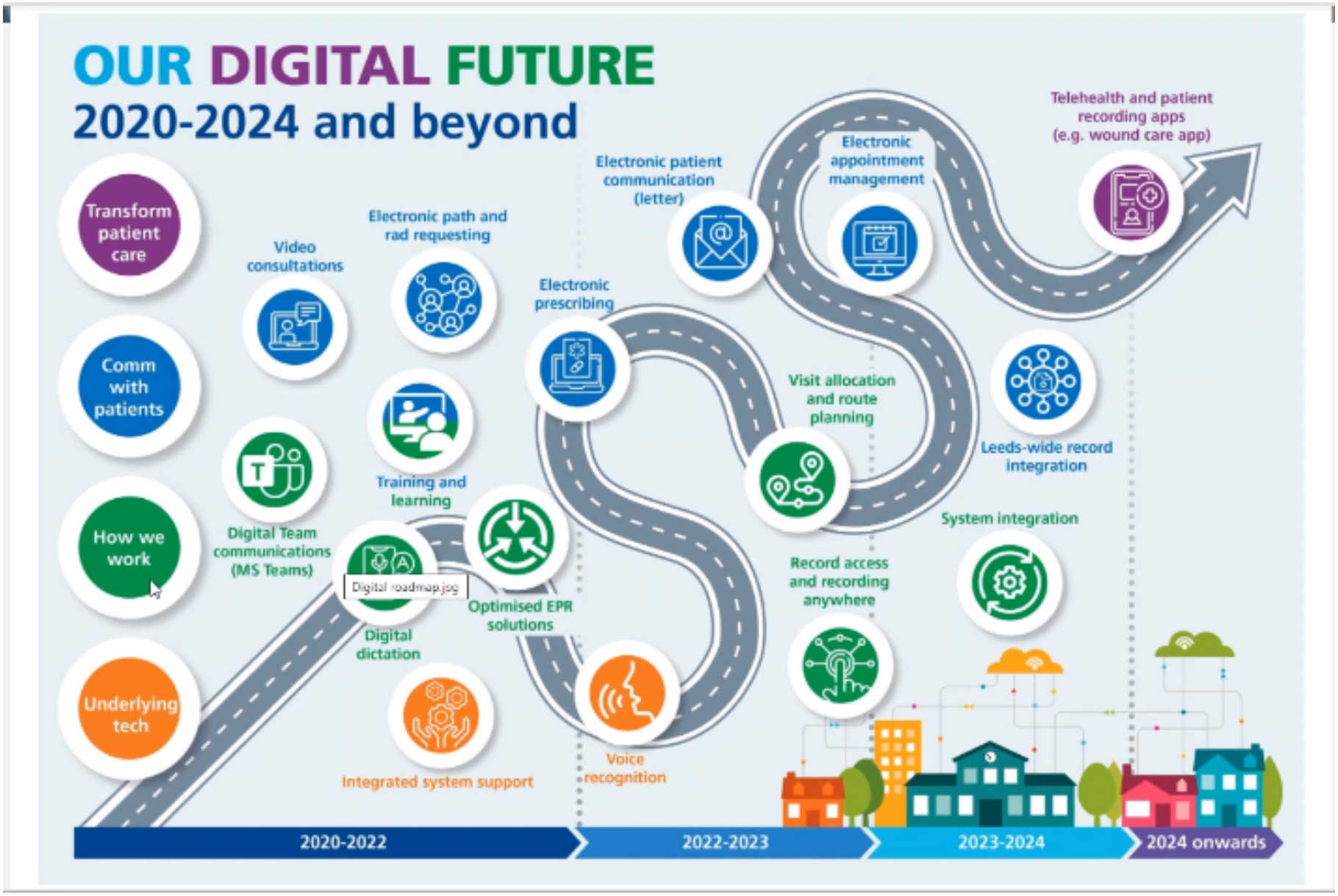
To develop 3 year costed digital implementation plans

To establish the mechanisms and provide LCH approved content to the Leeds Place / ICS plan

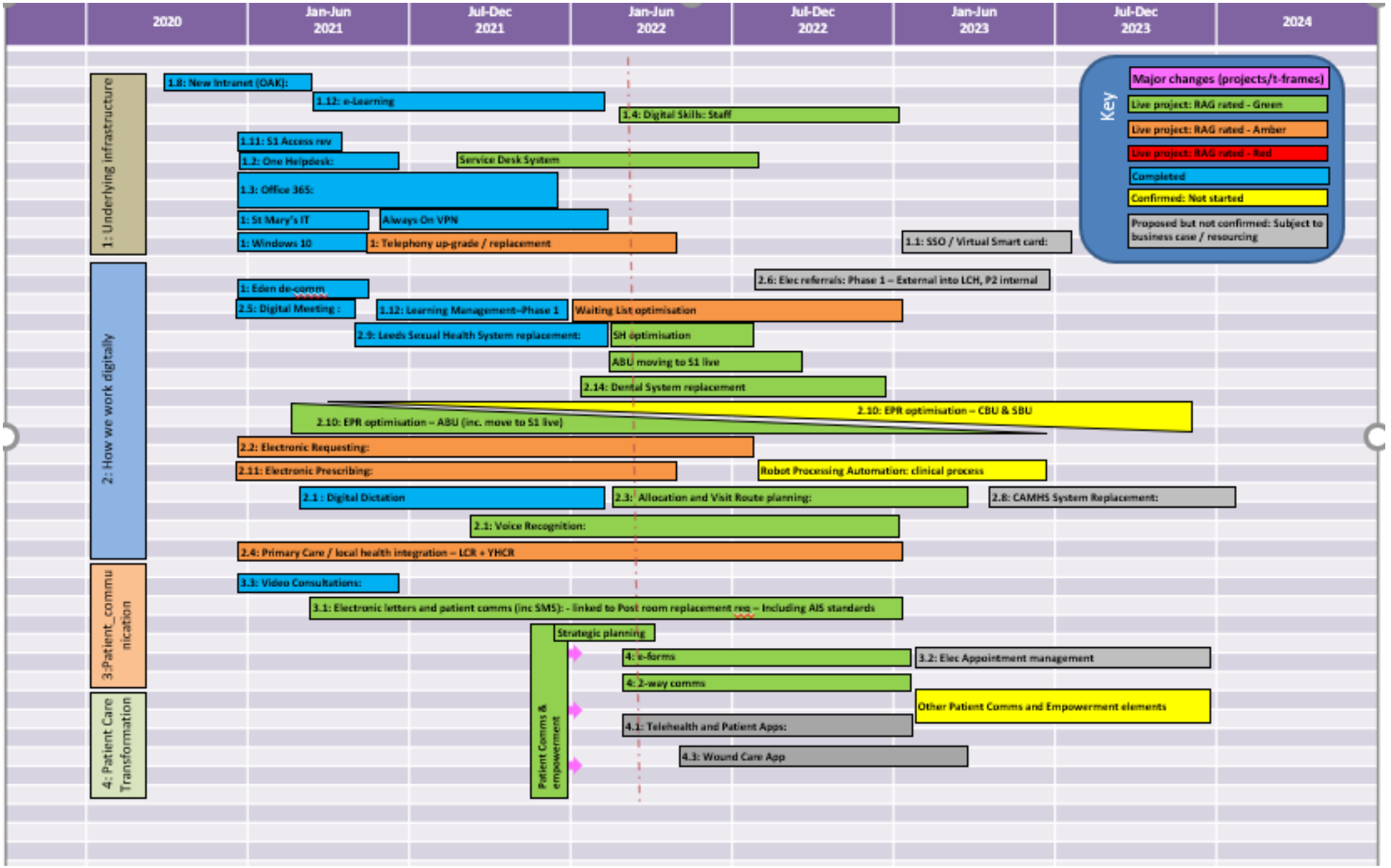
5. Recommendation

The Business Committee and the Board are asked to note the current plans for progressing the Digital Strategy Implementation plans and the complexities and uncertainties introduced by the linking of the Trust Digital plans to those of the Leeds “place and also the ICS.

Appendix One – Draft Digital Roadmap



Appendix Two – Digital Plan on a Page for 2022/23



Trust Board meeting held in public: 31 March 2022

Agenda item number: 2021-22 (140)

Title: Engagement Strategy Six Monthly Update Report

Category of paper: For information and assurance
History: Quality Committee 21 March 2022

Responsible director: Executive Director of Nursing and Allied Health Professionals
Report author: Specialist Quality Lead

Executive summary

Purpose of the report

The purpose of this report is to provide an update to the Trust Board 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 6 monthly updates on progress of the Operational Plan requested.

This paper provides an update on the work to date as part of the Year 2 Operational Plan.

Main points

Progress has been maintained on implementing the Engagement Strategy Operation Plan despite difficulties presented throughout the Covid-19 pandemic.

The report provides an update against three of the six priority areas, these being:

- Culture of Engagement
- Working with others
- Leadership

All actions have been completed 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 implementation plan against the three priority areas of the Engagement Strategy discussed.

- Support the Engagement Strategy review process beginning April 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 three of the six priority areas, these being:

- Culture of Engagement
- Working with others
- Leadership

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 September 2021 Quality Committee received an update on the following three areas:

- Listening to everyone's voice
- We are ALL experts
- How we do what we do

3 Current position

3.1 Detail of achievements against each of the 3 areas identified above is given in Appendix 1. Below is a summary of progress.

3.2 CULTURE OF ENGAGEMENT: Engagement will be embedded within our culture and underpins everything that we do

3.2.1 Always Events is a co-production quality improvement methodology which seeks to understand what really matters to patients, people who use services, their families, and carers and then co-design changes to improve experience of care.

3.2.2 The Always Event workstream continued in Year 2, with the establishment of a new steering group and business unit action groups in Q2. The revised structure providing an opportunity to keep actions local while sharing progress with colleagues across the Trust. The new approach has been supported with additional service specific development sessions led by the Patient Experience Officer with the support of NHS Improvement resources.

Attendance has been variable over the last 6 months as a direct result of the increased demand on services.

3.2.3 The Children's Business Unit have continued to work on their Always Event project exploring what matters when transitioning from children's to adult services and what should "always happen" as part of this journey. The work is led by a Consultant Paediatrician, with a special interest in this area with representatives from a variety of services and professional backgrounds. In Quarter 3 a telephone structured survey with parent/carer and young people having gone through transition or about to go through transition to adult services was completed. The findings were shared with staff in the Children's Business Unit in December 2021. The next step is to co-produce and test with parents and young people some of the suggested improvements in the transition pathway.

3.2.4 Following a national pause on the Friends and Family questions, services reintroduced the test in Quarter 2. Additional resources have been provided to support the use of the Friends and Family question, including translated materials, the introduction of an online survey and QR (Quick Read) codes, alongside the continued use of paper forms.

3.2.5 The Membership Engagement Systems (MES) platform used for Friends and Family question reporting is also being used for specific service change or improvement feedback questionnaires, as well as collecting responses for the Friends and Family questions. This has included feedback on the experience of digital consultations in MSK and Community Dietetics.

3.3 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

3.3.1 The Trust continues to work with Healthwatch with the Trust actively represented at the Peoples Voices Partnership and other programmes led by Healthwatch.

3.3.2 The How Does It Feel For Me programme of hearing and sharing the experience of users with long term conditions through video has continued. The value of services such as Podiatry and Community Matrons have been cited by users, along with services listening to them and working together. These videos have been shared at team/service meetings, Quality Committee and Trust Board.

3.3.3 The Patient Experience Officer, is part of the Big Leeds Chat Working Group. This year it went to a variety of user groups across the city to listen to what their health concerns were and consider possible solutions. A report is due in April 2022 and will help inform our Patient Engagement Strategy.

3.3.4 In a complementary piece of work to the citywide network, the CCG is leading on the development of a city-wide insight repository and grey literature library, LCH is contributing to its development. This new resource will provide a central place for the findings from previous public engagement events and reports by partners to help inform decision makers and reduce duplication when working with our users. The library will be easy to use and accessible

to all partners. The resource will support our Health Equity workstream within the Trust.

3.4 LEADERSHIP: There will be leadership from every voice, we are accountable to our citizens as well as the Trust board.

3.4.1 The Trust's Patient Engagement Champions Network with over 60 members has continued to meet virtually throughout Year 2 and is led by the Patient Experience Officer.

3.4.2 The network continues to meet monthly, alternating with development and support sessions. The development sessions have focused on a variety of subjects, based on needs identified by Champions and services through appraisal and development reviews. Subjects include various how-to sessions, for example facilitating a focus group, developing patient surveys, and developing easy read resources. There have also been sessions led by Trust leads on health equity, health outcomes and users with learning disabilities, demonstrating the importance of user engagement and feedback when considering improvements in service delivery. Support sessions provide a space for one to one or small group support in specific engagement ideas or proposals with the Patient Engagement Officer.

3.4.3 Staff continue to feed back that the forum is helpful in supporting engagement in services, sharing and listening to good practice and improving knowledge and skills. Additionally, the Patient Engagement Officer delivers bespoke development sessions to services based on identified need

3.4.4 There continues to be inconsistency in how user feedback is shared in team, service and business unit meetings. This will be a priority for Year 3 and will include the new LCH Learns page on MyLCH and the Quality Challenge Plus submissions where teams are asked to demonstrate how user feedback is shared. Business Unit Quality Leads include user feedback in their discussions at local clinical forums and include in reports to the Quality Assurance and Improvement Group, which is shared with service managers and clinical leaders.

4.0 Progress update for Year 2 of the Engagement Strategy

4.1 Progress has been made during Year 2 in all six priority areas, however due to changes put in place as a response to Covid-19, capacity within business units and the Patient Experience and Engagement Team not all actions in relation to training and development for staff in management of complaints and concerns have been achieved (Appendix 1).

4.2 Actions that have not been achieved will be reviewed and carried over to year three of the strategy implementation.

5.0 Priorities for Year 3 of the Engagement Strategy

5.1 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. The review process will begin with a planned workshop co-produced and led by Healthwatch on 27 April 2022. Health inequalities will be a key underpinning thread for the Engagement Strategy and for year 3

actions for the 6 priority areas. A key area of focus will be learning from patients/users and their carers how we increase access to services. As part of our strategy review process, we will ensure that the Year 3 Operational Plan links to other actions within the Trust around equity, working with partners, including the 3rd sector, and supporting our staff in "ALL being experts".

5.2 Building on the achievements delivered in Year 2, the current Priority Areas objectives will be reviewed and influence Year 3's plan. This will include;

- the establishment of a complaints and concerns training programme in Quarter 1
- the development of improvements in how complaints are managed based on feedback
- the sharing of learning from complaints across all services, as appropriate.
- developing a Trust wide approach to compliance with Accessible Information Standards (AIS).

6.0 Conclusion

6.1 Progress has been maintained on implementing the Engagement Strategy Operational Plan according to agreed timescales in the plan, with the acceptation of training and development on management of complaints and concerns.

6.2 It continues to be important 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.

7.0 Recommendations

The Board is recommended to:

- Note the actions of the year two implementation plan against the three priority areas of the Engagement Strategy, these being
    - Culture of Engagement
    - Working with others
    - Leadership

- Support the engagement Strategy review process beginning April 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 *Note: Always Events paused December 2021 – March 2022 due to Covid 19 Pandemic* - Every service to have a plan in place to obtain FFT feedback and to review comments. Plan to include how to share improvements made as consequence. Demonstrated through Quality Challenge submission and Quality Walks - LCH Carers Group established and part of Leeds Carers Partnership. Workplan for the group established including training for all staff.	Patient Experience Team AE Oversight group Patient Experience Team Patient Experience Team with colleagues from HR and operational services	End of Q1 2021/22 End of Q1 2021/22 End of Q2 2021/22	- AE Oversight Group Meeting Workplan in place and reviewed with Business Unit workplans in place. - Process on Business Unit Always Events workstreams reported to QAIG (Quality Assurance and Improvement Group) via Clinical and Quality Lead Reports. - MES System used to develop additional service user questionnaires, building on FFT - Patient engagement built into service resetting and refocusing programmes (transformation)
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	- Development of learning from engagement and feedback posters. - Development of a system for learning from posters complimenting the process in place from learning from incidents Learning to be shared in Clinical and Quality Lead Reports and contribute to Quality Account	Patient Experience Team Quality Leads Wider Clinical Governance Team	End of Q4	- 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 We will work closely with existing networks in the city We will develop our offer for involvement	- Review Friends of LCH member's network - Review our approach to an LCH people's network; Aims and purpose	Patient Experience Team with colleagues from Communications and Operational Services		- Membership is reviewed and communication sent to all members - 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	- Participate in the Patient Voices [Healthwatch] programme and related programmes including How Does it Feel For Me - Participate in the Leeds Big Chat Steering Group, co-facilitate events, participate in the reports and other means of sharing learning - Support the development of a Partnership approach to the development of a "Grey Library" to share resources and learning	Patient Experience Team with colleagues involved in Health Equity and Third sector workstreams Patient Experience to support CCG with workstream	Commenced in Q1 and ongoing throughout year Commence Q3	- 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 every governance meeting - The people's voice will form part of the Quality Committee membership; through the Youth Board, PSEGG and the Engagement Staff Champion Network - 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	Q1 2021/22 Q1 2021/22 Q1 2021/22	- The People's voice is represented at Clinical Governance team meeting - Patient Safety Strategy embeds peoples voices in systems and processes - The Youth Board, PSEGG, Engagement Staff Champion Group have regular contact with Quality Committee - Healthwatch Leeds a member of the Quality Committee
Engagement will be role-modelled and embedded across the organisation	Dedicated staff roles; central Patient Experience Team and within Business Units	- Implement processes to ensure that engagement is a standing team meeting agenda item within all service team meetings - Have an active Patient Engagement (Staff) Champion Network, meeting a monthly. Sessions alternate between developmental workshops and opportunities to share and learn from each other	Team Leads/ Patient Engagement Champions	Q1 2021/22 Q2 2021/22	- The Engagement Staff Champion role defined in staff objectives within appraisals, and measured through performance reviews

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 - Review current managing complaints and concerns training for managers and clinical leads - establish patient experience feedback of the complaint process - Embed the Datix 'Action tab' function across all complaint investigators	Patient Experience Team; Complaint manager, Patient Experience and Engagement Lead	Q2 2021/22 Q3 2021/22: **Note this has not been achieved** Q4 2021/22 Q3 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. - 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 - Establish an Accessible Information Standards (Communication) Template for SystmOne, and compliance reporting systems. - To develop initial suite of resources for staff to access, including training e.g., digital intelligence. Priority group Patient Engagement Champions	Patient Experience Team supported by • SystmOne Team • IG • Business Intelligence • Quality Leads and Clinical Leads	Q1 2021/22 Q2 201/22 Q2 July 2021 Q3: 2021/22	- Completed audit of Accessible Information Standards for all services - Regular updates are provided to Healthwatch Inclusion for All - 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

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**
		- Link Accessible Information Standards into other internal and external workstreams e.g. Learning Disabilities, Health Equity, Healthwatch Inclusion for All Working Group - Develop systems to share learning from changes made following recognition of Accessible Information Standards - Review compliance against Accessible Information Standards and develop action plan (governance through DON)		Q4: 2021/22 Q4: 2021/22	- We promote inclusivity through our information sharing; this is accessible to everyone
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	In place by Q4 2020/21 and then continuous	- 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) Creation of development sessions for services based on specific need Support and leadership of the Patient Engagement Champions Network	Patient Experience Team with colleagues from operational services	To commence Q1 and continue through year	- Annual and six-monthly appraisals and review, monthly one-to-one meetings - Training and development to services following identification of need - Patient Engagement Champions Network with representation from all services - 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 - Key links established with Quality Improvement - 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 - To establish links with other workstreams including Health Equity, Clinical Outcomes and 3rd sector	Patient Experience Team/ Clinical Leads/ Quality Leads Patient Experience Team/ Quality Improvement Team	Q4: 2020/21 Q4: 2020/21 Q4: 2020/21	- Completed scoping exercise across Business Units - Plan is agreed with Quality Improvement Team - 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 tool kit at 6 months and 12 months post development Processes identified in each unit, which includes supporting FFT Development of Patient Engagement Dashboard by the Patient Experience Team to bring together the different projects being undertaken, ensure consistency, avoid duplication and share learning To develop a crib sheet for services when wanting Patient Experience Team support, to	Patient Experience Team With • Patient Champions • Quality and Clinical Leads • BU General Managers and Clinical Leads	Q4: 2020/21 Q2: 2021/22 Q4: 2021/22 Q3: 2021/22 Q2: 2021/22	- Increase in engagement activity across the Trust - Staff are confident and have what they need to lead engagement in services - There is consistency in how we engage with users - Experience and engagement activity has a clear rational and is meaningful to all involved

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**
		ensure fair allocation of resources based on resetting priorities			

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2020-21 (141i)

Title: 3rd Sector Strategy Progress Update

Category of paper: Assurance

History: Business Committee 23 March 2022

Responsible Director: Executive Director of Operations

Report author: Partnership Development Manager

Executive Summary (Purpose and main points)

The programme plan on a page provides an overview of progress across the 4 workstreams of the year 1 implementation plan.

In November ’21, because of service pressures, most work was paused, along with Steering Group meetings.

There has nevertheless been progress across nearly all priority focuses and some excellent partnership developments including:

- LCH providing £1m funding via Leeds Older People’s Forum for 3rd sector organisations (£25-100k funding available) to develop and test partnership working, principally with NTs, that supports discharge and reduces admissions. Funding decisions to be announced 31 March and funding made available 1 April.
- work with BASIS and BID (NHS Charities Together funded projects: LCH partnered) to make services / health centres more accessible and inclusive for people with sensory impairments and women sexworkers and /or women who are sexually exploited respectively

The Steering Group reconvened in March and work paused has re-started / will re-start in April.

The March Steering Group (co-chaired by LCH Director of Operations and Forum Central / Volition Director) recognised the need for the group to identify and respond to emerging priorities such as the very significant increase in demand for mental health services, by

- considering how we can work together better and deploy collective 3rd sector and LCH resource to better meet need
- advocate for additional resource, wider system partner collaboration and changes in commissioning

Recommendations

Trust Board to note progress in implementing the year 1 implementation plan.

LCH 3rd Sector Strategy Year 1 Implementation Plan on a Page – Progress Update

Date: **8/03/2022**

Workstream and Priority Focuses	Progress	Lead	RAG
1. DEVELOP INCLUSIVE, ACCESSIBLE SERVICES			
Support people with sensory impairment to 'bridge the last 3 metres' at health centres	Training: 6 sessions delivered to front of house and admin staff. Establishing Business Unit interest. Health centre access audits: 2 completed, identifying another site. Compliance review of Accessible Information Standard and other access standards to restart in April	Chris Jessop, BID	
Develop easy read information	Developing page for easy read resources on MyLCH: Patient information and accessibility. Connecting with 3rd sector networks & NHS partners to identify standard service user comms, additional images.	Lisa Smith, LD Lead	
Develop equality of representation in services	BASIS (NHS Charities Together funding) working with CUCS and Integrated Wound Clinics to enable access and good experience of care. EQIA review: engage with 3rd sector to identify learning - not started	Em Campbell, HE Lead	
2. CONNECT BETTER			
Optimise NT ability to connect service users & carers to local services & support	Establishing NMTP capacity to support NT Co-ordinator interviews. To explore with Burmantofts PCN hub how best to connect and optimise primary care & ABU, SBU resource. Asked LCP Development Team to produce info about PCN social prescribing and similar roles: due April, to cascade to services.	TBA	
Develop NT-Neighbourhood Network collaboration to meet local need	Enhance programme: £1m funding via Leeds Older People's Forum (LOPF) for 3rd sector (£25-100k funding) to develop and test partnership working mainly with NTs to support discharge and reduce admissions. 26 bids, funding decisions to be announced 31 March, go-live 1 April.	Gail Fort, LCH	
Ensure effective 2-way information flows with vulnerable communities	Forum Central (FC) evaluating the Community of Interest network. Engagement and Involvement web page redesigned for accessibility. Work planned to review accessibility for making complaints, concerns, issues	Helen Rowland, PE Lead	
3. ENABLE MORE EFFECTIVE SELF MANAGEMENT			
Develop self-management approaches to reduce pressures	Enhance programme: focus on supporting discharge and reducing admissions expected to alleviate pressures on NTs	Gail Fort, LCH	
Develop NT Self-Management Facilitator 3rd sector collaboration	Developing collaboration with Feel Good Factor, connecting with LCP 3rd sector initiatives: impacted by priority focus on developing NT Self-Management Facilitator hospital discharge in-reach	Steph Lowen NT SMF Lead	
4. CO-PRODUCE SERVICES			
Childrens services to engage more inclusively	Working with GATE to enable Gypsy and Traveller community involvement in the Youth Board. Initiated discussions with FC about widening 3rd sector links to enable more inclusive Involvement	Debra Gill, 0-19 service	
Co-produce elements of the new Neighbourhood Model	To explore scope for co-production in the Enhanced Community Response supported by LOPF co-production lead: impacted by NMTP focus on initiatives that reduce service pressures or support HWB	TBA	Not started
Co-produce Specialist Business Unit service delivery models with 3rd sector	3rd sector to lead co-production of Sexual Health service ahead of retendered (2024): await clarity about commissioner requirements	TBA	Not started

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (142)

Title: Infection Prevention and Control Board Assurance Framework (BAF) Covid-19

Category of paper: for noting

History: Quality Committee 21 March 2022

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

Purpose of the report

This report is to appraise the Committee and Board 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 UKHSA.

The BAF is an updated version and in line with the UKHSA Respiratory Guidance issued in December 2021. Changes to the document have been made to reflect the current position in relation to the Covid-19 pandemic as we navigate toward business-as-usual dependant on local surveillance of Covid-19 figures.

Main issues for consideration

- The updates around gaps in assurance that have been previously identified and additional points in line with the 'Respiratory Guidance'.
- BAF updated to reflect current guidance and changes in relation to returning to business as usual.
- Limited assurance around centrally held fit testing records for all staff requiring FFP3 for example of ESR as a competency based approach.
- Ongoing work in relation to the Implementation of the National Cleaning Standards which are due to be embedded by November 2022.

IPC Current Overview

- Quarter 3 saw an undulating period of time for IPC whilst support was provided to a high volume of outbreaks throughout the Leeds healthcare economy in relation to Omicron with specific reference to Care Homes.
- Successful delivery of 'Cooperation Partnership Agreement' continues to be in place with a review meeting held between LCH and Leeds City Council January 2022.
- 2021/2022 Annual Report to go to QC / Board May 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, CDI and MRSA blood stream infections.
- 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:

- Further exploration in relation to an 'Options Appraisal' for the ongoing monitoring of FFP3.
- to note the contents of this report.

Infection prevention and control board assurance framework

1. Systems 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 their environment and other users may pose to them

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
1.1	Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ○ plan for and manage increasing case numbers where they occur. ○ a multidisciplinary team approach is adopted with leadership, estates & facilities, IPC Teams and clinical staff.	• Review of operational capacity daily at Bronze / Silver meetings • Respiratory guidance is being followed by LCH with risk assessment in place and step-down measures within a specific time scale. • The guidance is available on the Oak and staff are continuing to triage patients and ask Covid screening questions. IPC sit on citywide Health Protection Board and other Public Health Led groups which monitor surveillance of cases identified. • The organisation has escalated to bronze and silver and the senior management team are fully aware of plan in place. There is one in patient areas which is Hannah House, all bedrooms are single use and therefore there is not a need to identify additional isolation plans. Information and guidance has been shared in Midday Brief and on the Oak IPC, PPE and Covid Testing pages. If a patient was identified in a domiciliary setting as a potential respiratory virus case as identified in the national guidance from UKHSA the patient would be tested, and plans are in place with the local lab at LTHT. Evidence includes: Minutes and updates from Silver Command Opel Levels Wider system surveillance communications – Global email to staff Changes to posters if required		
1.2	• Health and care settings continue to apply COVID-19 secure workplace requirements as far as	• LCH Safer Working Group in place to meet weekly and determine safe working environment requirements. This is supported and has representation by IPC Team however, is led by Estates and Facilities / Operations. Risk assessment		

	practicable, and that any workplace risk(s) are mitigated for everyone.	in place and in line with Hierarchy of Controls. Messaging communicated via Oak, Midday Brief and cascade through leader's network. Evidence includes: Minutes and action log from Safer Working Group Clear information on Midday Brief Oak		
1.3	• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. ○ Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance	• Employers risk assessments are undertaken. Due to community environment there are individual cases of respiratory cases however outbreaks are minimal. Risk assessment and documentation on EPR System One that a clinical staff member undertakes and this identifies if the patient is symptomatic for a potential respiratory infection. HOC Risk assessment undertaken. • Communication in place on the Oak, Midday Brief and cascaded through leader's network. Evidence includes: Risk assessments Midday Brief Leaders Network minutes		

	procedures, for example Integrated Care Systems.			
1.4	• Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	• A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; • That advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. Evidence includes: Employee risk assessments Appraisals Clear information and links on Oak Midday Brief		
1.5	• If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	• 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 (link on Oak IPC Page) and documents on ESR for re check, filter and valve change.		
1.6	• The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases there are check and challenge opportunities by the	• SMT including CEO, MD and DON have systems in place for daily local update in current surveillance figures. Attendance at Silver and Gold Command and escalation from Director of Public Health. Understanding and daily figures in relation to LTHT OPEL level and escalations of pressure in relation to flow within the system that may impact on community provision.		

	executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Evidence includes: Minutes of meetings Escalation of Opel levels BI Reports Covid-19		
1.7	• The application of IPC practices within this guidance is monitored, e.g.: ○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination.	• Hand hygiene and PPE audits are undertaken at service level. Documentation on EPR Sys One that staff members have applied correct PPE. Standard Precautions Policy in place and readily available on trust internet Oak on IPC, PPE and Testing pages. Infection Prevention and Control (IPC) (lch.oak.com) Evidence includes: Demonstration videos Posters Audit of clinical environments	Level of compliance across business unit for hand hygiene audits can be difficult to obtain. Inconsistencies of hand hygiene audits.	IPC Nurse support
1.8	• The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board and has oversight of ongoing outbreaks and action plans.	• BAF is reviewed by QC on a 6 monthly basis. Outbreaks and concerns raised and escalated through Bronze and Silver meetings. Action logs in place. BAF stored within IPC and discussed as part of IPCG. Evidence includes: Minutes Board Meeting / QC Minutes of IPCG		
1.9	• The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	• Through the PPE group a range of masks have been made available to staff members including reusable and disposable. Evidence includes: PPE usage report from Supplies team		

	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**
2.1	Systems and processes are in place to ensure that: • The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	• There is a working group in place to discuss and implement the National Cleaning Standards by **November 2022**. Representation from Estates, IPC and QPD. • Cleaning schedules are in place for all clinical and non-clinical environments. All areas are monitored through IPC Environmental MEG audits as well as Facilities cleaning audits to determine level of compliance. Noncompliance reported through the IPCG and escalations are made to QAIG. • Functional Risk assessments for entire estate continue to be discussed and a task and finish group are meeting monthly to action. • Link on IPC Oak for National Cleaning Standards Infection Prevention and Control (IPC) (lch.oak.com)	Cleaning Policy is due for renewal and will be updated once cleaning schedules are in place to reflect the new cleaning standards.	Identified on the risk. Environmental IPC and cleaning audit continue to be undertaken to identify areas of non-compliance.
2.2	• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	• 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 Cleaning Company • 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 • 'S' cleaning guide to using disinfectant wipes and contact times available on the Oak and product website • (contact time 60 seconds) • IPC online training HEE • 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. Evidence includes: RAG rated cleaning charts Cleaning records Monitoring records IPC Environmental audits Posters in cleaning cupboards Training records		
2.3	• Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	• 'S' cleaning guide to using disinfectant wipes and contact times available on the Oak 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. Evidence includes: Cleaning schedules Monitoring records IPC Environmental audits Posters in cleaning cupboards Training records	Are ad hoc inspections led by estates to determine correct manufacturers guidance is followed.	

2.4	• Reusable non-invasive care equipment is decontaminated: ○ between each use. ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	• PL331 Local Decontamination of Reusable Medical Equipment Policy (lch.oak.com) is in place and available on IPC Oak intranet page. This is evidenced through IPC environmental audits, 'I'm Clean' stickers are used. Clinell Disinfectant wipes are available widely, they can be ordered through supplies and are played in some areas in wall mounted dispensers. Evidence includes: Monitoring records IPC Environmental audits		
2.5	• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	• Compliance monitored through service use as well as IPC environmental audits. Evidence includes: Monitoring records IPC Environmental audits		
2.6	• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	• 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. Evidence includes: HOC Risk assessment Ventilation and AC monitoring and checks via Estates.		

2.7	• The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	Estates have provided an overview of the ventilation we have over the estate. The majority of rooms have a window to aid natural ventilation and we have air conditioning in some buildings which are monitored and maintained. Evidence includes: Maintenance records Risk assessments undertaken by Safer Working Group and Building Managers.		
2.8	• A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	There are no rooms with enhanced mechanical ventilation, for example 15 air changes per hour. As above.		
2.9	• Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• Posters and communications in place to remind staff to have windows open at all times. Evidence includes: Communications in Midday Brief Posters Clear communication cascaded from leaders network.		
2.10	• Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Rooms that have no natural ventilation or AC have been advised not to be used in a clinical capacity. Evidence includes: Safer working group risk assessments.	To be added to the Estates Group meeting as an agenda item.	
2.11	• When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Screens and partitions in place in reception areas. Evidence includes: Safer Working Group Minutes Buildings Risk assessments		

	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**
3.1	Systems and process are in place to ensure that: • Arrangements for antimicrobial stewardship are maintained	• This is led jointly between IIPC and medicines management. AMR link on IPC Oak page on intranet and awareness days are held to promote AMR> Citywide there is a AMR group as well as one led via ICS where prescribing rates are monitored. Citywide campaign called 'Seriously Resident' is in place. • 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. Evidence includes: IPC Page on Oak Relevant Policies and Guidelines Minutes from Citywide AMR Group Minutes from ICS AMR Group Medicines Management Data CCG Medicines Management Prescribing Data IPC Week		
3.2	• Previous antimicrobial history is considered			
3.3	• The use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing. ○ to ensure patients with infections are treated promptly with correct antibiotic.			
3.4	• Mandatory reporting requirements are adhered to, and boards continue to maintain oversight.			
3.5	• Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.			

	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**
4.1	• Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	• 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. Infection status communicated: • 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. Evidence includes: Clear Communications to visitors Posters and signage		
4.2	• There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face	• At entrances to LCH premises there is clear signage on current guidance and control measures in place. Floor stickers have been used as well as mobile units to place at entrances with mask dispensers and alcohol gel units. Evidence includes: Clear Communications to visitors Posters and signage		
4.3	• Covering and physical distancing.	• Signage to recommend • Risk assessment undertaken inline with hierarchy of controls to reduce mask wearing in office space when seated at desk and maintaining social distancing. Poster signage on key IPC measures and social distancing guidance. Floor stickers reminding patients and staff about social distancing. National guidance available on the Oak • 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. • De-escalation plan in place for March-April 2022 – dependant on Covid-19 cases and surveillance.		
4.4	• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted 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. Evidence includes: Oak IPC Page Posters and screen savers that have highlighted branding. Discuss as part of IPCG		
	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**
5.1	Systems and processes are in place to ensure that: • Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	• Signage to remind patients and visitors that masks are still required in a healthcare setting are in place. • 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. Evidence includes: Clear signage at entrances Floor stickers Display panels with masks and alcohol gel		

5.2	• Staff are aware of agreed template for screening questions to ask.	• Screening questions shared with front of house staff and business units. • Added to EPR S1 to undertake relevant screening questions. Evidence includes: Patient records audit		
5.3	• Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	• System One screening template in place for patients for clinic appointments and domiciliary visits. • Front of house advised to ask where possible if patients have symptoms of Covid-19 • Posters and clear messaging in letters inviting patients for clinic appointments. Evidence includes: EPR audit of records		
5.4	• Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in communal areas if this can be tolerated.	• There is stock of surgical masks across all sites. Patients if deemed to be suspected of a respiratory infection would be asked to wear a mask. Other control measures in place – ventilation, hand hygiene stations. • Appointment to be reorganised for a future date when appropriate for patient and clinically well. • Testing in place for domiciliary visits. Evidence includes: PPE delivery stock notes. EPR audit		
5.5	• Face masks/coverings are worn by staff and patients in all health and care facilities.	• 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. Evidence includes: Clear messaging to staff on requirements of what PPE to wear wen in a clinical and non-clinical setting.		

		Posters Screensavers Messaging on Oak Communications cascaded through Leaders Network.		
5.6	• Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	• Risk assessment undertaken by estates and facilities. • Staff messaging around social distancing. • Information on Oak		
5.7	• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	• If on entering the building or appointment an individual is symptomatic it is suggested that the practitioner asked the patients is clinically fit enough to return to their home and follow national guidance in relation to symptoms and for the appointment to be rescheduled at a later date. • Trigger reminder on EPR S1. If patient not well enough to go home i.e. difficulty breathing, clinician to support individual and contact 111.		
	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**
6.1	Systems and processes are in place to ensure that: • Appropriate infection prevention education is provided for staff, patients, and visitors.	IPC training provision is now online for both level 1 and 2. Average training compliance 90-92% across LCH. Evidence includes: ESR data / PIP data / BI Package reviewed annually by IPC. Package in line with national standards and Health and Social Care Act 2008.		

6.2	• Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	• Up to date UKHSA 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, Oak Covid/IPC 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.**		
6.3	• All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	• Vlogs available on the Oak • Donning and doffing guidance on intranet with videos available on how to • UKHSA 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.		
6.4	• Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE prompt of S1. Clear messaging to staff on correct donning and doffing procedures as well as level of PPE required for intervention. National guidance shared with staff members and made available through Midday Brief. • Evidence includes: Link to A-Z of pathogens on IPC Oak page Clear messaging to staff members. Leaders network cascade. Posters and screensavers. PPE Audit.	Lack of consistency with PPE Audit	Training and education Support from IPC with 7 day provision

6.5	• Gloves are 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.	• Appropriate glove use has been shared throughout LCH. PPE guidance on S1 records and prompts of what to wear. Evidence includes: Standard precautions policy S1 Audit Hand hygiene and PPE Audit Campaign weeks – IPC / Hand hygiene Day May 2021 Posters and signage IPC Training and education	Concerns around inappropriate glove use, and gloves worn unnecessarily when no risk of blood and body fluids.	Plans for Hands Matters Campaign
6.6	• The use of hand air dryers should be avoided in all clinical areas. 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.	• No hand dryers are in use within LCH estate. • Paper towels made available in all toilet and kitchen space. • Clinical facilities have absorbent paper towels for effective hand hygiene. Evidence includes: IPC environment audit Cleaning Schedule Stock data / ordering Hand hygiene posters Standard Precaution's Policy		
6.7	• Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	• Clear communication in Midday Brief in relation to social distancing. Cascade of information shared at leaders network. Evidence includes: Oak staff information on IPC page Posters Screen savers Floor stickers Signage Minutes from Silver Command		
6.8	• Staff understand the requirements for uniform laundering where this is not provided for onsite.	• Laundry Policy in place and advice on IPC page in relation to staff laundering of own uniform. • Staff are provided with adequate number of uniforms and can use alternative of scrubs. • Advised to leave coats and unnecessary items in car or by front door of home visit to reduce cross transmission.		

		Evidence includes: Policy on Oak Poster Communications to staff via Midday Brief.		
6.9	• All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	• Clear messaging and flow charts are in place to support staff with Covid-19 testing. • Twice weekly LFT testing in place and messaging around submission of results onto government portal. Evidence includes: BI Data Sickness records and data Occupational health Data Clear signage Posters / screensavers Information on Oak		
6.10	• To monitor compliance and reporting for asymptomatic staff testing	• Clear messaging around submission of LFT testing results onto government portal. Previously submitted onto LCH specific portal. This has now stood down. Evidence includes: Submission data BI Data		
6.11	• There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for organisation onset cases (staff and patients/individuals).	• Yes as part of ongoing systemwide surveillance with UKHSA and Public Health / Health Protection at Leeds City Council. Evidence includes: Weekly surveillance emails from Health Protection Escalation to Silver / Gold Command – minutes of meetings		

	7. Provide or secure adequate isolation facilities			
	Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
7.1	• Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	• Standard infection control policy available on Oak. Fundamental basics to IPC clearly communicated to staff through training and education. Evidence includes: Overarching Policy Standard Precautions Policy IPC Training Every Action Counts Toolkit IPC Surgery		
7.2	• The principles of SICPs and TBPs continued to be applied when caring for the deceased	Evidence includes: Deceased Patient Policy in place.		
	8. Secure adequate access to laboratory support as appropriate			
	Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
8.1	• Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance; and screening for other potential infections takes place. •	Evidence includes: • Clear communication and availability of Respiratory Guidance. • Flowchart is in place to outline testing requirements and PPE required e.g. FFP3 • Laboratory testing arrangements LTHT • Safe transportation of specimens policy		
8.2	• Staff testing protocols are in place	Evidence includes: • 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.		

		• 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.		
	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**
9.1	Systems and processes are in place to ensure that • The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Evidence includes: • Clear messaging to staff members • Posters, floor stickers, screen savers available to remind staff and patients. • Regular communications in Midday brief. • Line management and team meeting discussions • Cascade of information at Leaders Network • Minutes from Silver Command • Minutes from Safter Working Group and IPCG		
9.2	• Staff are supported in adhering to all IPC policies, including those for other alert organisms.	Evidence includes: • 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.	
9.3	• Safe spaces for staff break areas/changing facilities are provided.	Evidence includes: • Estates building risk assessments completed identifying number of people that can use kitchen staff areas for breaks • Social distancing measures in place and reduction strategy in relation to BAU • 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'.	
9.4	• Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Evidence includes: • Outbreak Policy in place and clear messaging in relation to contact IPC for support. Staff awareness in place as a result of IPC training and what constitutes an outbreak. Flow charts in place around escalation.	
9.5	• All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	Evidence includes: • Evidence of guidance in midday brief Evidence in meeting notes with CCBs re supporting appropriate waste management processes	
9.6	• 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	

		Evidence includes: 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**
10.1	Systems and processes are in place to ensure that: • Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	• An occupational referral system is in place. Telephone and online referrals can be made. All information outlined on Oak 'Health and Wellbeing' page. Evidence includes: Occupational health data Oak 'hits' on Health and Wellbeing page. Employer Risk Assessment Information and clear access / sign posting on Oak		
10.2	• Bank, agency, and locum staff follow the same deployment advice as permanent staff.	• Staff have access to the above resource.		
10.3	• Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	• Return to work guidelines have been communicated and are available on the Trust Oak intranet. Evidence of information cascade from Midday Brief and Leaders Network. Local risk assessment in place.		
10.4	• A fit testing programme is in place for those who may need to wear respiratory protection.	• Service level fit testers are in place. As part of staff induction programme staff are encouraged to identify level of protection required as outlined for their job role. Level of protection s outlined in the national respiratory guidance from UKHSA. EPR SysOne Record highlights level of protection as part of documentation.		

10.5	• Where there has been a breach in infection control procedures staff are reviewed by occupational health.	Clear documentation on identifying what a breach is. Occupational health will ○ lead on the implementation of systems to monitor for illness and absence. ○ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 encourage staff vaccine uptake Evidence includes: HR / BI data on sickness absence Policies / Guidelines Information and links on IPC Oak page.		
10.6	• Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	• Clear guidance outlining IPC control measures regardless of vaccination status.		
10.7	• Vaccination and testing policies are in place as advised by occupational health/public health.	• Policies are available on Oak.		
10.8	• Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	• All staff identified as requiring FFP3 masks due to delivering Aerosol Generating Procedures (AGP's) have been fit tested in line with national guidance.		
10.9	• Staff who carry out fit test training are trained and competent to do so.	• Fit testers have undergone appropriate training. A log of this is held by IPC and an external train the trainer is used.		

10.10	• All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	• PPE Data. • Local fit testers to undertake fit testing. Stability in stock and decision to use a reusable FFP3 to reduce models not being available or sent through pull stock.		
10.11	• All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	• Staff members are fit tested against two different options - a reusable and a non-reusable mask.	There should be a central recording system on ESR to enhance the accuracy of this data.	
10.12	• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	• Record obtained by IPC and local service. Staff member is provided with a certificate.		
10.13	• Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	• Alternative portcount fit test provided. • If staff members fails on this method of fit testing then alternative options are sourced. Evidence includes: Portacount data Staff records and completion of fit testing held by local fit tester within the service	Central record on ESR not held at present.	IPC hold record on excel document.
10.14	• That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	• Alternative portcount fit test provided. • If staff members fails on this method of fit testing then alternative options are sourced. Evidence includes: Portacount data Staff records and completion of fit testing held by local fit tester within the service	Central record on ESR not held at present.	IPC hold record on excel document.

10.15	• Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	• Staff Covid – 19 risk assessment undertaken and recommendation for referral to Occupational Health to be made.		
10.16	• A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	• Employee risk assessment is emailed to lcht.riskassessments@nhs.net • Record of this should be recorded on the staff members file from line manager.		
10.17	• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• Currently fit testing data is not held centrally and is stored on an excel document within IPC. • Current work with WFI to develop a competency coding around fit testing and enhanced assurance measures around valve and filter changes. Evidence includes: Information on IPC Oak page around HSE requirements for Fit testing / fit checking. Portacount qualitative data from testing – electronic recording of pass rate, however not aligned on ESR with staff members records. Staff member receives a certificate on completion of fit testing.	ESR recording assurance not in place. Record not reviewed by the Board routinely. Accurate deep dive into current number of staff that require fit testing per business unit.	Escalations have been made to QAIG and Clinical Leads of number of staff that require fit testing. Fit testers throughout business units work with IPC to record fit testing of staff members.
10.18	• Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	• Where known outbreaks / increased Covid-19 transmission is evidence staff will not work across specific sites for example: WYOI and Adel Beck. • Surveillance of outbreak setting in Care Homes is shared with leaders and where possible we try to avoid cross working. However control measures are in place to prevent cross transmission. Evidence includes: Care home outbreak data / email		

		Effective communication of outbreak settings EPR Audit		
10.19	• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• Risk assessments are undertaken as described earlier in BAF. Evidence includes: Safer working group minutes and action log Employer risk assessment IPC Environment audit Cleaning audit, increased touch point cleaning		
10.19	• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	Evidence Includes: BI and HR data		
10.20	• Staff who test positive have adequate information and support to aid their recovery and return to work.	Information on national guidance is available on Oak and staff are well supported in their return to work. Phased returns can be provided as well as support with general health and wellbeing. Covid -19 Risk assessment can be undertaken and changes to working pattern / conditions can be made. Evidence includes: Risk assessment Occupational Health Referral Data Health and Wellbeing Resources on Oak		

Leeds Community Healthcare NHS Trust

Agenda item 2021-22 (143)

Version 8: 08 02 2022

Topic	Frequency	Lead officer	3 December 2021	4 February 2022	31 March 2022	27 May 2022	17 June 2022	5 August 2022	7 October 2022	2 December 2022
Preliminary business										
Minutes of previous meeting	every meeting	CS	X	X	X	X		X	X	X
Action log	every meeting	CS	X	X	X	X		X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X		X	X	X
Patient story	every meeting	EDN&AHPS	Staff story X	X	X	X		X	X	X
Quality and delivery										
Chief Executive's report	every meeting	CE	X Inc system pressures update	X Inc system pressures update	X	X		X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X		X	X	X
Performance brief:Measures for inclusion in the performance brief	Annual	EDFR			X					
Perfomance Brief: annual report	Annual	EDFR				X				
Significant risks and risk assurance report	every meeting	CS	X	X	X	X		X	X	X
Care Quality Commission inspection reports	as required	EMD								
Quality account	annual	EDN&AHPS				X				
Mortality report	4 x Year	EMD	X -blue box	X -blue box		X plus annual report 2021-22		X -blue box		X -blue box
Staff survey	annual	DW			X					
Safe staffing report	2 x year	EDN&AHPS		X -blue box				X -blue box		
Seasonal resilience	annual	EDO							X	
Business Continuity Management Policy	As required	EDO								
Serious incidents report	2 x year (Feb and August)	EDN&AHPS		X -blue box				X -blue box		
Patient Safety Report	2 x year (Feb and August)	EDN&AHPS		X -blue box (Deferred)				X -blue box		
Patient experience: complaints and concerns report	2 x year (Feb and August Annual report)	EDN&AHPS		X Six monthly report - not taken as blue box this meeting				X Blue box Annual report		
Freedom to speak up report	2 x year (Feb and Aug)	CE		X				X Annual report		X
Guardian of safe working hours report	4 x year	EMD	X		X	X Quarterly report x Annual report 2021-22		X		X
Strategy and planning										
Organisational (Trust) priorities position paper	Annual	EDFR			X 2022-23 new					
Trust priorities update	4x year	EDFR/EDN&AHPS	XQ2 blue box	XQ3- blue box (Deferred)		x end of year report		X -Q1 blue box		XQ2 blue box
Third Sector Strategy	2x year (Feb and Aug)	EDO		X -blue box (Deferred)	X -blue box			X -blue box		
Estate Strategy	2xyear (March and October)	EDFR			X deferred May	X Blue box item			X	
Digital Strategy	2x year	EDFR			X -blue box				X -blue box	
Business Intelligence Strategy	First presented Feb 2022			X						
Engagement Strategy	2xyear (March and October)	EDN&AHPS			X -blue box update existing strategy				X -blue box update existing strategy	X revised strategy not Blue Box
Patient Safety Strategy	March/Ocotber	EDN&AHPS			X				X	
Health Equity Strategy	3 x year(March, August and December in 2022)	EMD	X		X Board workshop			X		X
Quality Strategy	2xyear	EDN&AHPS				X				X
Children's Strategy	As required					X				
Workforce Strategy	2x year May and December	DW				X				X
Research and Development Strategy	annual (August)	EMD						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 Defer June	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					
Procurement report	2xyear	EDFR				X				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 framework	2x year(October and March)				X -blue box				X -blue box	
Infection prevention control annual report	annual	EDN&AHPS				X 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

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (144a)

Title: Approved Audit Committee minutes: 10 December 2021

Category of paper: for noting
History: N/A

Attendance

Present:	Khalil Rehman (KR)	Chair of the Committee, Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Richard Gladman (RG)	Non-Executive Director
In Attendance:	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Company Secretary
	David Robinson	Internal Audit Manager (TIAA Limited)
	Mark Dalton	Director Public and Social Sector (Mazars)
Apologies:	Peter Harrison	Head of Internal Audit (TIAA Limited)
Minutes:	Liz Thornton	Minutes

Item: 2021-22 (36)

Discussion points:
Welcome, introductions, apologies and preliminary business

The Chair of the Committee, Non-Executive Director (KR) welcomed everyone to the meeting.

a) Apologies

Peter Harrison, Head of Internal Audit (TIAA Limited).

b) Declarations of interest

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

There were no new declarations of interest made in relation to any items on the agenda.

c) Minutes of the meeting held on 15 October 2021

The minutes of the meeting were agreed as a correct record subject to the addition of the Assistant Director of Business Intelligence as an attendee.

d) Matters arising and review of the action log

Meeting held on 15 October 2021

Item 2021-22 (26a) –SICA report contract management audit: the Executive Director of Finance and Resources explained that this action specifically referred to the Infection Prevention and Control Annual Report. He said that he would discuss this with the Executive Director of Nursing and Allied Health Professionals and the Head of Infection Prevention and Control and suggest that future annual reports include an explicit reference to contractual performance. **Action closed.**

There were no further actions or matters arising from the minutes.

Item 2021-22 (37)

Discussion points:
Internal Audit

a) Summary internal controls assurance report

The Internal Audit Manager introduced the report. The Committee reviewed the completed audits and progress against the annual audit plan for 2021-22.

Completed audits

The Committee discussed the executive summary and strategic findings for the three audits completed since the last meeting of the Committee on 15 October 2021.

Professional assurance

This audit had been determined as **reasonable assurance** with three important and three routine recommendations to note.

It was noted the audit had been reviewed by the Quality Committee on 27 September 2021 and approved for presentation to this Committee.

Non-Executive (IL) felt that overall, the report was a fair reflection of the situation during the pandemic. He added that the management comments and implementation timetable for each of the recommendations appeared to be reasonable.

The Committee discussed the audit findings and expressed concern about the risks associated with the weaknesses identified in the audit on the quality assurance processes in the Trust on appraisal, job planning and revalidation for medical and dental staff. There were also concerns raised around the checks and balances in place for staff who were not directly employed by the Trust.

The Committee suggested that it was for the Quality Committee to consider whether the current systems in place were effective and provided the required level of assurance.

The Chair of the Committee agreed to discuss the outcome of the Audit with the Executive Medical Director including how the implementation of the recommendation could be effectively monitored by the relevant committees including the nature and timing of the assurance that was required.

Action: A discussion with the Executive Medical Director about the outcome from the audit on professional assurance, the implementation and monitoring of the recommendations and the nature and timing of the assurance that was required.

Responsible Officer: Chair of the Committee.

The Committee noted the outcome of the Audit and the **reasonable** assurance provided.

Quality Account – data quality
This audit had been determined **reasonable** assurance with one important recommendation about the accuracy of the data reported within the year-end performance brief and subsequently incorporated into the Quality Account report.

The Internal Audit Manager explained that as part of the audit a review had been undertaken of a sample of 22 Key Performance Indicators to establish whether the data reported was accurate and four errors were found within the Quality Account.

The Chair of the Committee felt that the outcome of the audit raised wider concerns about the overall quality of the data presented to the committees and the Board in the performance brief and consequently the level of assurance which could be taken.

The Executive Director of Finance and Resources acknowledged the level of concern raised by the audit and expressed disappointment that the current checking process had failed to identify the errors. He said that steps were being taken to review and revise the systems in place and evidence would be presented to the committees to provide assurance that this had been done.

The Committee discussed the value of adding an audit on data in the performance brief to the 2022-23 internal audit plan to provide an additional level of assurance on the overall quality of data. It was agreed that the Executive Director of Finance and Resources would discuss this further with the new Internal Audit Provider.

The Committee noted the outcome of the Audit and the **Reasonable** assurance provided.

Risk Management
This audit had been determined **reasonable** assurance with one important recommendation related to the training and support provided to members of staff in terms of Datix recording and two routine recommendations related to effective monitoring of the risk register and the review of risks through service performance reports.

It was noted that this audit report came direct to the Audit Committee for review.

The Committee noted the management comments against each of the recommendations and accepted that the timescales for implementation were reasonable.

No questions were raised.
The Committee noted the outcome of the Audit and the **Reasonable** assurance provided.

<u>Internal audit plan 2021-22</u>
The Committee reviewed and noted progress against the 2021-22 Plan.

The Committee reviewed the list of the remaining audits which were planned to commence in quarter four. Two of those were service related (Wetherby Young Offenders' Institute and Police Custody Suites). The Committee discussed the feasibility of undertaking these two audits given the challenges on service pressures and because of changes to Government guidance (currently 'Plan B') during the pandemic. Members were concerned about service audits not being completed and agreed that a contingency plan was required to include meaningful alternative audits which could include further work on data quality in the performance brief.

The Executive Director of Finance and Resources agreed to discuss this further with members of the Senior Management Team (SMT).

Action: Internal audit plan for 2021-22 – remaining audits to be reviewed by SMT.

Responsible Officer: Executive Director of Finance and Resources

The Committee noted that any changes to the remaining audit plan could impact on the ability of the internal auditors to provide an audit opinion. The Internal Audit Manager said that so far good progress had been made but recognised that as services faced increased pressures some audits may not be able to go ahead.

Outcome: the Committee:

- noted the contents of the summary internal controls assurance report, including the completion and outcome of three audits, and progress against the 2021-22 plan.

b) Internal audit recommendations update

The Committee reviewed the recommendations update paper and noted that there were 11 recommendations due for completion by 30 November 2021 including two that had been deferred and five of which had been completed. Of the six that remained outstanding two had yet to reach the revised due date agreed by the Committee.

The Committee reviewed the six overdue recommendations. In particular those relating to estates noting that there were challenges to completing some of the audit actions, particularly those involving external organisations, including contractors, but agreed that sufficient progress was being made.

No questions were raised.

Outcome: the Committee:

- noted the update report.

Item 2020-21 (38)

Discussion points:
External Audit

The Director for the Public Sector presented the report. He said that there were no formal matters to report to the Committee at this meeting. Communication between the auditors and management in the Trust was good. He drew attention to the indicative timetable for the 2021-22 audit year. Completion was anticipated to be June 2022 in line with draft year-end proposals. It was noted that Board and Audit Committee meetings that were planned for May 2022 may need to be revised.

Outcome: the Committee

- noted the report.

Item 2021-22 (39)

Discussion points:
Risk Management

a) Risk Management Update Report

The Company Secretary presented the report which provided an update to the Committee on the ongoing development of the Trust's risk management processes. Particularly focussing on actions completed since the last report to the Committee in January 2021.

The Committee noted that the recent internal audit gave risk management reasonable assurance, face to face risk management courses had resumed and risk review meetings were being trialled within each business unit.

Non-Executive Director (IL) queried why the SMT only saw risks scored at 12 or more.

The Company Secretary explained that individual directors saw all risks that were placed on the register that were within their portfolio of responsibilities. On a monthly basis, SMT received an extract from the risk register (15+ risks) and a summary of the risks scored at 12 (very high) so that SMT were sighted on the wider risk profile across the Trust.

The Executive Director of Finance and Resources confirmed that new risks scoring 12 or more were presented to the SMT with greater detail of the control measures and planned actions and were scrutinised carefully.

Outcome: The Committee:

- noted the actions undertaken since the previous report in January 2021

b) Risk Appetite Statement

The Company Secretary presented the report which provided details of the Trust's current risk appetite statement.

The Risk Appetite Statement had been reviewed by the SMT prior to being presented to this Committee for review and SMT had concluded that the risk levels remained appropriate.

Members discussed the risk appetite target scores and had a mixed view on the 'minimum' risk appetite applied to risks that could compromise the delivery of high quality, safe services, and questioned whether the organisation should accept any level of risk in that regard. It was agreed that an opinion should be sought from SMT and Trust Board.

The Executive Director of Finance and Resources agreed that in light of the Committee's comments he would discuss the target scores with the SMT.

Action: The Committee's views on the risk appetite target scores to be considered by the SMT.

Responsible Officer: Executive Director of Finance and Resources.

Outcome: the Committee

- noted the risk levels agreed by the SMT and requested further input from the Board following further consideration by the SMT.

Item 2021-22 (40)

Discussion points:
Information Governance (IG) – six monthly update report

The Executive Director of Finance and Resources presented the report which updated the Committee on progress on the Information Governance agenda and the responsibilities for the Data Protection Officer. He highlighted the following key issues:

Data Security & Protection Toolkit (DSPT)
The DSPT work programme had commenced for2021-22. The baseline assessment is due 28 February 2022 and the final assessment 30 June 2022, this remained in line with last years' reporting timeline. There are no initial concerns raised regarding the Trusts ability to meet compliance with the 33 mandatory assertions by 30 June 2022. The Trust will declare compliance with 8 assertions on 28 February 2022 a plan is in place to meet compliance by the June deadline.

Microsoft Office 365 Implementation
The deployment of multi-factor authentication (MFA) for all Trust staff is being supported as a self-enrolment exercise and with a pilot group to identify risks and benefits. Recommendations have been suggested and implemented to support a more security conscious culture with agile working.

IG Incident Update 1 July 2021 – 1 December 2021
An incident relating to the disclosure of personal sensitive data of a patient to an internal staff member via NHSmail. The potential risk that the disclosure could cause significant harm and distress to the patient met the threshold for reporting to the Information Commissioner's Office (ICO). A full internal investigated had been completed, actions to address implemented and the ICO confirmed no further action.

Outcome: the Committee

- noted the work undertaken during this period including the progress being made on the Data Security and Protection Toolkit.

Item 2021-22 (41)

Discussion points:
Financial Controls

a) Changes for standing financial instructions

The Executive Director of Finance and Resources presented a paper which asked the Committee to consider endorsing a recommendation that the Board amended its Standing Financial Instructions. He advised that many services now wished to plan their recruitment to avoid long gaps between staff leaving and new staff joining. At present only the Chief Executive could approve the appointment of one or more staff members that may result in the funded establishment being exceeded, even if only for a short and planned period and even if affordable within the financial position of the budget in question and/or the Trust.

It was proposed that this responsibility is delegated to the Chief Executive or Executive Director of Finance and Resources plus the responsible Director and the Standing Financial Instructions should reflect this.

Outcome: the Committee

- recommended that the Board approves this amendment at its meeting on 4 February 2022

b) Revaluation of non-current assets

The Executive Director of Finance and Resources reminded the Committee that one of the main areas of audit focus when reviewing the Trust's accounts was the valuation of property plant and equipment. In preparing the annual accounts the Trust must ensure that the carrying value of the non-current assets disclosed in the Statement of Financial Position is consistent with current market values.

He presented the report which set out the rationale for not undertaking a formal revaluation for the 2021/22 accounts. In March 2021 the Committee agreed that a 5% movement in the Building Costs Information Service (BCIS) issued by the Royal Institution of Chartered Surveyors would trigger a formal revaluation exercise. He advised that there was potential for movement to be 5.9%, however this was less than the threshold applied by the External Auditor and he confirmed that he had consulted with Mazars before taking the decision not to undertake a revaluation exercise.

The Committee agreed that a watching brief should be maintained on this and the Trust should continue to liaise with the District Valuer's Office.

Outcome: the Committee

- noted the rationale for not undertaking a formal revaluation for the 2021/22 accounts.

c) Tender quotations and waiver report

The report provided the Committee with details on the procurement of goods and services where the procedures on seeking tenders and quotations for items of material expenditure had been waived, including an extract from the 2021-22 register of waivers completed since the last Committee meeting.

There had been twelve waivers approved in the period; all of these are commercial suppliers. Details of all the waivers were contained in the report.

The total number of waivers for 2021/22 was 20.

The Executive Director of Finance and Resources said that he was mindful that the list was increasing and whilst this was in part due to circumstances connected with the pandemic, he said that there would be greater scrutiny of the requests in future to ensure that value for money was being addressed.

Outcome: the Committee:

- received and noted the report and the extract from the 2021-22 register.

d) Contracts register

The terms of reference for Audit Committee include the requirement for the Committee to formally review the Trust's contracts register.

This report presented included details of all the Trust's contracts awarded over the tender threshold of £30,000. These were separated into new contracts agreed in the last 12 months, existing contracts and contracts which had terminated during the last 12 months.

Using the National Audit Office – Good Practice Contract Management Framework the contracts have been assessed by the Procurement Manager and were RAG rated to rank the contract management activity and highlight the key contracts; this in turn is used to prioritise where procurement resources are focussed.

Outcome: the Committee

- received and noted the report.

Item 2021-22 (42)

Discussion points:
Minutes for noting

Information Governance Group

The minutes of a meeting held on 14 October 2021 were presented.

Outcome: the Committee

- received and noted the minutes.

Item 2021-22 (43)

Discussion points:
Committee's work plan

There were no items removed or changes made to the workplan.

It was noted that the dates for the submission of the end of year accounts had not been confirmed so the meeting dates scheduled for May 2022 may be subject to change.

Item 2021-22 (44)

Discussion points:
Matters for the Board and other committees and review of the meeting

The Chair noted the following items to be referred to Board colleagues:

- Internal audit and progress against plan
- External Auditor's Update
- Risk Appetite Statement
- Proposed change to Standing Financial Instructions
- Revaluation of non-recurrent assets
- Information Governance Update
- Assurance on BAF risk 2.4
  '*If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber-attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage'.*

  As the Committee had received very few sources of assurance on this meeting's agenda, an assurance conclusion was not required.

Item 2021-22 (45)

Discussion points:
Any other business

No matters were raised.

Item 2021-22 (46)
Discussion points:
Close

The Chair closed the meeting at 12.15pm.

Date and time of next meeting

Friday 11 March 2022 10.00am – 12.30pm
Friday 22 April 2022 10.00am-12.30pm
Wednesday 11 May 2022 10.00am-12.30pm (page turner)
Friday 20 May 2022 10.00am-12.30pm (end of year business)
Friday 15 July 2022 10.00am-12.30
Friday 14 October 2022 10.00am-12.30pm
Friday 16 December 2022 10.00am-12.30pm

Leeds Community Healthcare NHS Trust

Trust Board Meeting: 31 March 2022

Agenda item number: 2021-22 (144bi)

Title: Quality Committee minutes 24 January 2022

Category of paper: For noting

Attendance

Present:	Helen Thomson (HT)	Non-Executive Director (Chair)
	Alison Lowe (AL)	Non-Executive Director
	Steph Lawrence	Executive Director of Nursing and AHPs
	Sam Prince	Executive Director of Operations
	Ian Lewis (IL)	Non-Executive Director
	Rachel Booth (RBo)	Non-Executive Director
	Ruth Burnett	Executive Medical Director
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
In Attendance:	Thea Stein	Chief Executive
	Brodie Clark	Trust Chair
	Stuart Murdoch	Deputy Medical Director
	Diane Allison	Company Secretary
Observing:	Adam Freeman	Complaints and Claims Officer
	Lucy Jackson	Consultant for Public Health
Apologies:		
Minutes:	Lisa Rollitt	PA to Executive Medical Director

Item: 2021-22 (71)

Discussion points:

(a) Welcome and introductions

The Chair welcomed members and attendees. There were no apologies noted.

(b) Declarations of interest

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

(c) Minutes of the previous meeting 22 November 2021

The minutes of the meeting held on 22 November 2021 were reviewed and agreed as an accurate record.

(d) Matters arising and review of action log

It was noted that the actions due at this meeting were included on the agenda and agreed that these were complete.

i. E-allocation software paper

The Executive Director of Operations stated that the Transformation Group had prioritised E-allocation to release more clinical time to be re-invested in care delivery. The preferred option was E-Community, run by Allocate which matched with some existing Trust systems. The total cost is approximately £1m and this will be put through as revenue in the next financial year. A business case would be presented at a future Quality Committee meeting.

The Chief Executive asked if there was any way to improve the allocation system whilst awaiting the implementation of E-Community. The Executive Director of Operations stated that implementation of the electronic system would begin rolling out as soon as the business case had been approved, beginning with a pilot site. It was hoped that the implementation would gain traction as the Neighbourhood Teams realised its benefits.

ii. QAIG key issues for escalation

The Executive Director of Nursing and AHPs presented the assurance report from the QAIG business meeting which took place on 18 January 2022, highlighting the escalated positions in the business units and the work ongoing to support them.

2021-22 (72)

Key issues

a) Covid-19 update: current pressures

The Executive Director of Nursing and AHPs referred to the Government decision to lift Plan B from 27 January 2022, stating that the Trust would not be changing anything at the moment and was awaiting further guidance from the NHS.

The Committee heard that there were currently 90 Care Homes with Covid-19 outbreaks reported, predominantly in staff, and a small number of residents. Where the outbreaks were in staff only, system-wide work was ongoing to keep the Care Homes open. The Infection Prevention and Control (IPC) team continued to support all Care Homes with outbreaks.

The Executive Director of Operations stated that the Trust was currently at OPEL Level 3 following a long period of escalation at OPEL Level 3e and at Silver Command from 14 December 2021. The main drivers were the pressures at the Young Offenders Institute (YOI) and in the Neighbourhood Teams. It was noted that the YOI level had since de-escalated, however the Neighbourhood Teams remained at OPEL Level 3e. On review, it had been identified that the multiple reasons for the position was due to the underlying staffing issues, with higher than average non-Covid-19 related sickness, plus a spike in Covid-19 related sickness, and the general winter pressures. It was noted that other Trusts in Leeds were also in an escalated position. The Committee heard that the Covid-19 rates had begun to stabilise in the last week, and the data suggested that the peak had passed.

The Committee Chair spoke about the Covid-19 rate stabilising at 1k per 100k people and asked what this would mean for the Trust's services. The Executive Director of Operations stated that depending on further mutations, it was hoped that this would be more manageable however there were a number of variables that could affect this.

A Non-Executive Director (IL) asked about evidence of any other respiratory or winter viruses which could be adding to the winter pressures. It was noted that there was a very small number of Influenza cases in the City.

The Chief Executive stated that if the isolation rules were ended, the staffing pressures would be reduced, however the issue of vaccinations as a condition of employment was causing psychological and practical pressures and it was uncertain what the quality impact of this would be if moving staff to redeployment or dismissal, as the detail was currently unknown, however this was being scoped.

The Trust Chair asked about the Long Covid work. The Executive Director of Nursing and AHPs stated that the Long Covid Team continued to be busy and whilst there was not as much Long Covid coming through from the Omicron variant, there would still be some patients who were unvaccinated and/or had co-morbidities resulting in Long Covid.

The Trust Chair also asked about pressures within general practice. The Executive Medical Director stated that GPs were likely to be at OPEL Level 3e given the ongoing balance of clinical pressures and unmet winter needs.

b) Long Covid update – research priorities feedback

The Executive Medical Director stated that the NIHR Locomotion study was looking at patient pathways and outcomes in different service models in four different units, both within and without long Covid-19 services. It was hoped these results would be obtained in 12 months' time.

It was noted that although there were increased rates of infection for healthcare professionals, there was no data to evidence that healthcare professionals were more likely to suffer with Long Covid. It was acknowledged however that more healthcare professionals with Long Covid were likely to access the service due to greater awareness of the condition.

In terms of research priorities, the Executive Medical Director stated that the main priorities were:

- Capture appropriate outcomes and understand the nature of the new condition and whether this was a long term condition
- Evaluate the effect of interventions and cost-effectiveness of the service
- Work with other LC services nationally and develop best practice guidance for implementation
- Also incorporate work with the LCH research strategy by driving investment in service research fellows and research outputs and grants.

It was noted that the three specific ongoing projects were, Locomotion, Heartloc and the Fatigue and Immune Response and MSK pain studies which were all HRA and Ethics approved.

Action: Research projects slides to be circulated

Actionee: Executive Medical Director

c) Neighbourhood model transformation project update

The Executive Director of Operations presented a flash report and highlighted the good progress with the Neighbourhood model and digital allocation work despite the escalated position. However, it was acknowledged that there were some areas which had delays and some which had not been started.

The following areas of work were specifically highlighted:

- The way GP referrals are received has been changed and was no longer through the Single Point of Urgent Referral (SPUR), making the process more efficient and reflects positive progress.
- The ongoing work to align the Podiatry service with the Neighbourhood Teams leading to better outcomes for patients was noted as positive progress.
- Progress on the Digital EPR work, particularly the transformation of the clinical templates had slowed down due to the current pressures, however work continued on some elements.
- There were plans to have a Health and Wellbeing Champion in some Neighbourhood Teams to add some capacity, ensuring good conversations were taking place.
- Capacity and demand work continued, looking at what was a fair day's work would look like in practice and consideration around consolidating the Twilight hubs into one area.

The Trust Chair stated that it felt like a new staffing model across the organisation was happening and asked if this was the intention. The Executive Director of Operations stated that the review of roles and responsibilities was a part of the paused elements. A workshop was planned in April 2022 with key partners to look at this in more detail. The Executive Director of Nursing and AHPs stated that work was also ongoing to look at the development of the clinicians' roles.

The need for a performance dashboard was acknowledged and it was agreed that the Executive Director of Operations would present further performance data at a future Quality Committee meeting.

Action: Performance data to be presented at a future Quality Committee meeting

Actionee: Executive Director of Operations

2021-22 (73)

For discussion: Quality governance and safety

a) Performance Brief

The Executive Director of Nursing and AHPs highlighted the slight increase in Pressure Ulcers reported, however it was noted that these were not as a result of lapses in care on the Trust's part.

The Committee Chair asked about the reduction in incident reporting as noted in the QAIG assurance report. The Executive Director of Nursing and AHPs stated that the slight decrease was not an unusual finding over the Christmas and New Year period related to seasonal reduction in services, but this continued to be monitored closely.

A Non-Executive Director (RBo) spoke about the themes of learning not embedded, particularly around risk assessments tools and asked about the approaches to address this. The Executive Director of Nursing and AHPs stated that work was ongoing to eradicate recurring themes from serious incidents, including the importance of ensuring that learning was communicated and embedded. It was acknowledged that the Patient Safety Summits continued to take place across the Trust with that remit. It was agreed that it would be useful to provide an update on how recurring themes from serious incidents were being addressed to improve safety at future Quality Committee meetings.

Action: Updates on improvement work to eradicate recurring themes from incidents to be presented at future Quality Committee meetings within 6 monthly Serious Incident reports

Actionee: Executive Director of Nursing and AHPs

A Non-Executive Director (IL) commented that he was pleased to see the maintenance of clinical effectiveness activity and asked how this had been achieved. The Executive Medical Director spoke about the centralisation of work to keep the assurance progressing in the background of an escalated operational position.

b) Clinical Governance report

The Executive Director of Nursing and AHPs presented the paper and asked the Committee to acknowledge that the Clinical Governance team continued to support clinical services and whilst a little behind, due to sickness within corporate teams, this was progressing.

It was highlighted that the report provided an update on work around Learning Disabilities.

The Committee were updated regarding a challenging situation with a complainant who had been discharged from services as a result of behaviour towards staff, acknowledging the individuals clinical needs were able to be managed by the General Practitioner.

c) Risk Register

The Chief Executive presented the report.

The Committee Chair asked about the risk regarding the unsupported software across the estate, and the Trust plan to move away from these systems was discussed. It was agreed that the risk would benefit from a more explicit description of the mitigation.

A Non-Executive Director (AL) referred to Risk 1084: *Occupational Health Provider declared Opel Level 4* and asked about the assumed lack of control to monitor accreditation. It was noted that a further update would be provided to Board by the Director of Workforce in relation to the Occupational Health provision and the monitoring of a partner organisation's accreditation.

A Non-Executive Director (IL) referred to Risk 792: *Change in prison regime is reducing young people's access to healthcare and increasing waiting lists* and asked about the clinical impact of this for the patients. The Executive Director of Nursing and AHPs stated that this risk was linked to staff sickness and the lockdown due to Covid-19 and was being closely monitored. It was acknowledged that there had been no rise in incidents reported.

The Non-Executive Director (IL) also asked about Risk 1043: *Service delivery risk for CAMHS Transitions Service.* The Executive Director of Operations stated that this would be a short-term issue until additional posts were recruited to, as detailed in the business case previously presented at the Quality Committee meeting in November 2021. It was agreed that the timescale would be reviewed.

Action: Timescale for resolution to be reviewed

Actionee: Executive Director of Operations

The Deputy Medical Director referred to Risk 1085: *Resuscitation training skill and compliance* and asked if this was a real risk. The Executive Director of Nursing and AHPs stated that as staff travelled around the City, there could be a number of situations where they would need to be fully trained in resuscitation e.g. a road traffic accident. The Executive Director of Nursing and AHPs also stated that the risk would be removed in the near future, however it was felt to be appropriate to note it on the Risk Register at this time.

d) Mortality report (Quarter 3)

The report was presented by the Executive Medical Director, highlighting that work that continued with the Clinical Commissioning Group (CCG) to extract Trust data from the Electronic Palliative Care Co-ordination System (EPaCCS) to be able to identify and understand reasons behind excess hospital bed days related to people on a LCH caseload.

The Committee heard that mortality continued to be monitored despite the formal mortality meetings in the Adult Business Unit (ABU) having been paused in response to the current escalated circumstances. It was also noted that Statistical Process Control data continued to be monitored at Neighbourhood team level and level 1 and 2 mortality reviews continued.

It was noted that this was the second quarter where there had been no formal chair for the Trust Children's Business Unit (CBU) mortality review meetings, however a plan was in place to resolve this, and the meetings continued with support from the Executive Medical Director and Deputy Medical Directors. In response to a query from a Non-Executive Director (IL), the Committee was assured that the citywide meetings were appropriately chaired and contributed to from the Trust.

A Non-Executive Director (IL) spoke about excess deaths in under 65's and asked if the mortality review process had explored this. The Executive Medical Director stated that the data set did not record cause of death, which is provided by Primary Care, however this would continue to be monitored and any themes identified would be reviewed.

Action: Deaths in under 65's reported to be reviewed to identify any themes

Actionee: Executive Medical Director

e) Safe Staffing report

The Executive Director of Nursing and AHPs presented the bi-annual report. It was noted that this was no longer a statutory report, however it was important to keep sight of this in terms of what it means for our community services. It was acknowledged that no national safe staffing tool existed for community services at present, however the Trust was involved in the ongoing development of a tool.

The Executive Director of Nursing and AHPs stated that there had been an impact on staffing from the Omicron variant however when triangulated with patient safety data, there was no suggestion of any significant issues being identified.

A Non-Executive Director (AL) asked if there was an opportunity to overlay the safe staffing report with areas of deprivation / health inequality. It was agreed that this would be explored. The Non-Executive Director also asked if the 0-19 Public Health Integrated Nursing Service (PHINS) contract was at risk. The Executive Director of Nursing and AHPs stated that the service changes within the 0-19 PHINS had been made in close partnership with commissioners.

The Non-Executive Director also spoke about the slight increasing trend of leavers and asked if exit interviews were taking place. The Committee heard that this was the case, and work was taking place to strengthen the mechanism.

The Trust Chair made a request to connect future reports with subsequent risk if risks were not at a level to be reported within the Risk Register. It was agreed that this would be actioned in future reports.

f) Serious Incidents report

The Executive Director of Nursing and AHPs presented the report, highlighting that learning was being embedded, evidenced by the lack of some recurring themes. It was noted that the Care Quality Commission (CQC) had positively commented within relationship meetings on the Trust's approach to Serious Incidents.

g) NHS asymptomatic staff testing: Lateral flow device distribution and assuring compliance to testing regimes

The Executive Medical Director presented the paper and highlighted the imminent move to logging test results on the Government system, stating that the Trust would still be possible to access its specific data.

h) Quality Strategy 6 month update

The Executive Director of Nursing and AHPs presented the paper, and it was acknowledged that despite the escalated position, positive progress had been made.

2021-22 (74)

For discussion: Clinical Effectiveness

a) Patient Group Directions

The Committee received and ratified the Patient Group Directions.

b) Internal audit reports: Quality Challenge

The Executive Director of Nurses & AHPs presented the report related to internal audit of the Trusts Quality Challenge+ process. It was noted that there was one recommendation made which was being progressed.

A Non-Executive Director (IL) spoke about what was identified as being done better and asked about the centrally held spreadsheet, questioning the need for central control. The Executive Director of Nursing and AHPs stated that the teams did hold responsibility for this locally, but that the information was also held centrally to assist quality walkers to appropriately prepare for walks in order to monitor and gather assurance around expected improvements.

2021-22 (75)

Patient Experience

a) Patient experience and engagement: complaints, concerns and feedback

The Executive Director of Nursing and AHPs presented the report which provided data around the Trust's statutory requirements in relation to complaints.

The Chief Executive referred to a conversation from the QAIG meeting to ensure we work harder to hear all voices about our services. The Executive Director of Nursing and AHPs confirmed that there was a plan for a workshop with external partners and service users to hear people's voices more widely in addition to the work undertaken by service level patient engagement champions.

The Trust Chair spoke about complaints related to staff and asked about the process to evidence change in behaviours, particularly relating to staff attitude. The Executive Director of Nursing and AHPs spoke about the complexity of complaints about staff attitudes where there could be some element of patient interpretation based on their expectations of how services should be run, and work on this would be ongoing. It was noted that the Executive Director of Nursing and AHPs was in regular contact with other trusts to ensure LCH was benchmarking with these.

2021-22 (76)

Sub-Group minutes

a) Safeguarding Children's and Adult's Group: minutes 8 December 2021

The Executive Director of Nursing and AHPs highlighted the delay in completing Integrated Health Needs Assessments and it was noted that this was being added to the Risk Register.

The Committee was pleased to learn that the Trust had been awarded the West Yorkshire Domestic Violence and Abuse Quality Mark Level 2, which promotes consistent and high-quality service provision to women, children, and men affected by domestic violence and abuse and suggested this was celebrated more widely.

b) Integrated Care Steering Group: Action log: 16 November 2021

It was noted that the January meeting had been paused because of the escalated system position however work was continuing with the reinstating the integrated work, including integrated wound clinics.

2021-22 (77)

For noting:

a) Workplan

The Committee received the workplan.

b) Items from the workplan not on agenda

The deferred items were noted.

Matters for the Board

2021-22 (78)

Committee's assurance levels and additional comments

The Committee agreed that the overall level of assurance was reasonable.

It was noted that Risk 1.2 related to care pathways and there were no items on this agenda that specifically covered the risk. It was agreed that future agenda setting would consider this risk.

The following comments were made against the strategic risks:

Risk 1.1
This was agreed acknowledging the challenging circumstances and escalated position across the Trust and the wider health and care system.

Risk 1.3
This was agreed acknowledging the challenging circumstances and escalated position across the Trust and the wider health and care system.

Risk 1.4
It was agreed this could be further enhanced by expanding engagement with people to ensure all voices about our services are heard.

Risk 1.5
This was agreed, considering the circumstances the Trust continues to operate under, whilst acknowledging the actions being taken to address the increasing risks around WYOI and CAMHS to reduce any impact on patients.

2021-22 (79)

Reflections on Committee meeting

There were no reflections discussed at the meeting.

2021-22 (80)

Any other business

The Chief Executive informed the Committee that the Trust's Thank You Awards would be taking place this week and asked all to follow this on social media.

Date and time of next meeting

Monday 21 February 2022 9.30am – 12.30pm (Via MS Teams)

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 31 March 2022

Agenda item number: 2021-22 (144bii)

Title: Quality Committee minutes 21 February 2022

Category of paper: For noting

Attendance

Present:	Helen Thomson (HT)	Non-Executive Director (Chair)
	Steph Lawrence	Executive Director of Nursing and AHPs
	Sam Prince	Executive Director of Operations
	Ian Lewis (IL)	Non-Executive Director
	Rachel Booth (RBo)	Non-Executive Director
In Attendance:	Brodie Clark	Trust Chair
	Diane Allison	Company Secretary
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Victoria Douglas-McTurk	Head of Business Intelligence (Items 82d & 84a)
	Dan Barnett	SRO for Performance and Outcomes (Item 82d)
	Sharron Blackburn	Audit Manager, Yorkshire Audit (Item 85a)
	Claudia Poynton	Senior Nurse/ Clinical Coordinator, Community Intravenous Administration Service (CIVAS) (Item 83a)
Apologies:	Ruth Burnett	Executive Medical Director
	Alison Lowe (AL)	Non-Executive Director
	Thea Stein	Chief Executive
	Stuart Murdoch	Deputy Medical Director
Minutes:	Lisa Rollitt	PA to Executive Medical Director

Item: 2021-22 (81)

Discussion points:

(a) Welcome and introductions

The Chair welcomed members and attendees. Apologies were received from the Executive Medical Director, a Non-Executive Director (AL), Chief Executive and Deputy Medical Director.

(b) Declarations of interest

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

(c) Minutes of the previous meeting 24 January 2022

The minutes of the meeting held on 24 January 2022 were reviewed and agreed as an accurate record.

(d) Matters arising and review of action log

It was noted that the actions due at this meeting were included on the agenda or were complete.

i. QAIG key issues for escalation: Deep dive 15 February 2022

The Executive Director of Nursing and AHPs stated that the group had met on 15 February 2022 to complete a deep dive into patient safety incident data: 2019 – 2021 comparison. It was noted that the patient incident data across all business units over the previous 12 months had been reviewed. A trend of low reporting of falls incidences in the Meanwood Neighbourhood Team had been identified and a further deep dive into this was underway.

Action: Quality Committee members to receive a copy of the QAIG paper from 15 February 2022

Actionee: Executive Director of Nursing and AHPs

2021-22 (82)

Key issues

a) Covid-19 update: current pressures

The Executive Director of Operations informed the Committee that Covid-19 rates across Leeds were decreasing, with reducing numbers of people requiring hospital admission and therefore there was some limited recovery of elective surgery procedures. Outbreaks in Care Homes were noted to have reduced significantly and positive feedback from Healthwatch regarding IPC input to Care Homes throughout the pandemic was acknowledged.

It was noted that the Trust remained at OPEL level 3, and it was recognised that a system wide impact remained, with Covid-19 related absences across health and social care workforce, an increased demand through the hospital and in Primary Care.

The Executive Director of Operations spoke about the mid-winter review which had taken place and had been very useful.

In response to a query from a Non-Executive Director (IL) regarding the number of people awaiting hospital discharge, the Executive Director of Operations stated that a system visit had taken place in the previous week from the national team, concluding that a comprehensive community offer was available. National recommendations were expected to come from this work in due course.

The Executive Director of Nursing and AHPs informed the Committee that she had attended the Transfer of Care hub in the previous week and made some suggestions on her observations. Conversations had taken place since the visit around the list of people waiting for reablement, with the feeling that there was more the Trust could do and work was underway to review this.

A Non-Executive Director (RBo) spoke about national changes in mass testing and isolation and asked if there was any local intelligence on what the impact could be. The Executive Director of Nursing and AHPs stated that this was being monitored however it was not expected that significant changes would take place across the IPC requirements for NHS providers. Likewise, it was noted that national guidance was still awaited in relation to the vaccination of children.

b) Closed culture

The Executive Director of Nursing and AHPs presented the paper which highlighted the ongoing work to identify and prevent closed cultures within the Trust. The Committee heard that whilst there have been very few Quality walks in the last quarter, leaderships visits had continued, and senior clinical staff had been more visible in services. As a result, there were currently 3 services within the Trust that were being monitored more closely and specific visits or attendance at team meetings were being arranged to monitor this further. A conversation was due to take place to co-ordinate the re-commencement of the Quality walks.

In response to a suggestion from a Non-Executive Director (IL), it was agreed that the Trust should consider how closed cultures are considered and monitored along a spectrum.

A Non-Executive Director (RBo) asked about the list of risk factors, commenting that they were all very reactive and asked if there was any proactive auditing to prevent generic poor practice. The Executive Director of Nursing and AHPs stated that this was the case and further audits would be considered.

It was noted that specific questions had been incorporated into the Quality Walk template to explore potential triggers for closed cultures which received positive acknowledgement from the Committee.

The Committee also heard about the work progressing across the Trust with the Foundation of Nursing Studies, and specifically their support in ‘Creating Caring Cultures’.

It was agreed that feedback to the Committee should continue through the Quality Walk updates.

c) Cancelled and rescheduled visits

The Executive Director of Nursing and Allied Health Professionals gave an update regarding the daily activity data reviewed and local escalation process where clinical visits were unable to be undertaken. The Executive Director of Nursing and AHPs stated that there was no significant variation across neighbourhoods, with the number of cancelled visits being minimal.

A further update was agreed to return to the Committee in May 2022 when it was hoped that the position in terms of pressures would be more stable.

Action: Update to be provided at Committee meeting in May 2022

Actionee: Executive Director of Nursing and AHPs

d) Neighbourhood transformation project update

The Executive Director of Operations introduced the SRO for Performance and Outcomes workstream as part of the Neighbourhood Team transformation project and the Head of Business Intelligence who presented the paper. The progress against the overall aim of developing a simple and accessible performance / operational management dashboard, based on existing data, was noted.

In response to a query from the Trust Chair, the SRO for Performance and Outcomes confirmed that one of the functions of the dashboard would be to measure performance and use learning between services.

There was a discussion around the structure of the dashboard including links to KPIs and the NHS Operational framework. It was requested that further consideration of themes / categories to ensure an effective and user friendly system for all staff be given.

The Head of Business Intelligence stated that there had been good engagement so far, acknowledging that the work had provided an opportunity to ensure that the data would be easily understandable for all clinical colleagues.

The Trust Chair referred to the health inequalities information, suggesting that all elements of inequality should be included.

e) Risk register update: CAMHS transition timescale

A verbal update was provided by the Executive Director of Operations regarding the current challenges with recruitment at Red Kite View. It was noted that the lack of progress with recruitment to these posts had resulted in the unit being unable to open all beds including the PICU beds. This had resulted in some Young People having to move out of area. It was also noted however that the Section 136 suite was working well.

In regard to the transitions business case, the Executive Director of Operations gave an update on the Trust's recruitment challenges to the posts, specifically the Psychiatrist and Psychologist posts.

It was agreed that the Quality Committee would continue to be appraised of the situation.

f) Mortality report: themes in deaths in under 65s

The Executive Director of Nursing and AHPs gave an update stating that a review of the increasing number of deaths in the under 65's did not identify any themes or trends, and that the cause of death had predominantly been related to long term conditions. It was felt that the increase was due to an increase in the number of people choosing to die at home.

A Non-Executive Director (IL) stated that there was a concern that as a consequence of the Covid-19 pandemic, more patients were presenting and dying due to inadequate treatment and that it was important to look at it in this context. It was noted that further analysis may be possible following the publication of the national excess death data.

Action: Further details (email) to be circulated to Committee members
Actionee: Executive Director of Nursing and AHPs

2021-22 (83)

Spotlight

a) CIVAS: DVT incident trend and improvement actions

The Executive Director of Nursing and AHPs introduced Claudia Poynton, Senior Nurse/ Clinical Coordinator, Community Intravenous Administration Service (CIVAS) who gave a presentation regarding a cluster of separate incidents of upper arm Deep Vein Thrombosis (DVT) in patients with a Central Venous Access Device receiving care within the service.

The Committee heard the data around the incidence of upper arm DVTs and the exploration that took place in relation to different practices across the Integrated Care System footprint. The Committee also heard how the team became curious after one incident and commenced partnership working after the second incident. This resulted in quality improvement work and the service developing a Standard Operating Procedure (SOP), in partnership with LTHT, to ensure patients were seen as soon as possible when a DVT is suspected. This had been demonstrated through early diagnosis and treatment of subsequent cases.

It was noted that there was still work to do, given the incidence and level of clinical risk, and potential collaborative research opportunities to understand the significance of the cluster of incidents. It was agreed that the Committee would receive a further update given the quality and safety implications.

Action: Presentation to be circulated to Committee members
Actionee: Executive Director of Nursing and AHPs

Action: Update on progress to be presented at a future Quality Committee meeting
Actionee: Executive Director of Nursing and AHPs

2021-22 (84)

For discussion: Quality governance and safety

a) Schedule of KPIs

The Head of Business Intelligence presented the proposed KPI schedule for 2022/23 and it was acknowledged that work was ongoing in the performance and outcomes dashboard to have a framework of indicators from KPIs to service level data.

The Trust Chair referred to the Safe domain and asked about the potential under reporting of patient safety incidents. The Executive Director of Nursing and AHPs stated that this was the topic of the QAIG deep dive on 15 February 2022.

There was a lengthy discussion about the balance of measures within each domain and the requirement for the Committee to hear about successes as well as challenges. The Committee requested to see the breadth of data within the context of specific escalations from the QAIG. An agreement was made to undertake a further review of the indicators with Business Units giving consideration of system measures / indicators and how to incorporate a health equity lens before returning to Committee for approval.

b) Quality Account (1st draft)

The Executive Director of Nursing and AHPs presented the first draft of the 2021/22 Quality Account with a clear emphasis on the intended inclusion of stories and video clips. It was noted that the submission date was June 2022.

A Non-Executive Director (RBo) stated that the Staff Health and Wellbeing Engagement Group was recommencing this week and she would be in attendance and able to feed in headlines from this.

The Non-Executive Director (RBo) also felt that the Trust's leadership role on the vaccination programme should be highlighted more. It was agreed that the Executive Director of Nursing and AHPs would feed the comments back to the author.

The draft was positively received, and Committee members felt this was progressing in the right direction, welcoming the further iteration back to Committee in April 2022.

c) Risk Register

The Company Secretary presented the paper, noting two escalated risks, two de-escalated risks and two closed risks since the last Committee meeting. The Executive Director of Nursing & AHPs confirmed that the increased risk relating to constant supervision of young people at WYOI (Risk 981) had reduced and would be reflected within the next report.

The Committee was pleased to hear that the previous telephony system risk in Sexual Health (Risk 961) was reported to have progressed with movement to an LTHT operator system which informs callers they are in a call queue. It was noted that three additional reception staff had also been recruited in order to understand the subsequent demand as it was expected callers would be placed on hold, to be answered and resource would be aligned once the regular demand was better understood.

The Committee Chair referred to the Cyber security risk (Risk 1050), stating that the Committee's concern should be noted, and the risk monitored.

***Post meeting note**: After the Committee meeting it was agreed that the Audit Committee was best placed to monitor Risk 1050 on the risk register, as the Audit*

Committee is responsible for monitoring BAF Risk 2.4 'If the Trust does not maintain the security of its IT infrastructure, then there is a risk of being increasingly vulnerable to cyber-attacks causing disruption to services, patient safety risks, financial loss and reputational damage'. A request has therefore been made to the Audit Committee to review this risk as part of its assurance processes.

d) Safeguarding strategy update

The Executive Director of Nursing & AHPs presented the update, stating that good progress had been made despite some impact from the pandemic. The Committee were pleased to see the progress.

2021-22 (85)

For discussion: Clinical Effectiveness

a) Internal audit annual plan

The Company Secretary introduced Sharron Blackburn, Audit Manager, Yorkshire Audit. It was noted that Audit Yorkshire would be taking over completion of internal audits for the Trust from 1 April 2022 and Sharron would be the designated audit manager.

The Audit Manager presented the Internal audit annual plan, which had been approved by Executive Directors on 11 March 2022.

There was a discussion about flexibility in the plan to enable any additional internal audit requirements to be addressed in a timely manner. The Committee were happy to support the proposed plan with the caveat of the need for flexibility as quality issues arose. It was agreed that internal audits would be added to the Committee's assurance levels template and to the Committee work plan for December/January going forward.

b) Learning and Development Strategy update

The update was presented by the Executive Director of Nursing & AHPs.

The Trust Chair asked if there was any confusion between the Trust's and City's agendas. The Executive Director of Nursing and AHPs stated that the academy would work to ensure the strategies were aligned.

2021-22 (86)

For noting

a) Integrated Care Steering Group: update on progress

The Executive Director of Nursing and AHPs gave a verbal update to confirm that integration work had continued through various projects, ahead of the group reconvening in March 2022. The projects included work in relation to Care Home populations with jointly funded posts; management of people living with frailty; advanced clinical practitioner and ARRs roles across PCNs and the expansion of integrated wound care clinics.

Matters for the Board

2021-22 (87)

Committee's assurance levels and additional comments

The Committee agreed that the overall level of assurance was reasonable.

The following comments were made against the strategic risks:

Risk 1.1
Limited assurance was agreed in relation to CIVAS spotlight. Whilst this showed positive partnership working in response to an incident trend, further work is required in relation to the clinical risk – potential future audit or research opportunity.

Draft KPI schedule received, and lengthy discussion took place. Acknowledged comments have been taken to re-shape and reform the schedule.

Risk 1.2
Limited assurance was agreed in relation to the CAMHS pathway given the quality impact on recruitment challenges.

Risk 1.3
See above re CIVAS limited assurance.

2021-22 (88)

Reflections on Committee meeting
There were no reflections discussed at the meeting.

2021-22 (89)

Any other business
The Executive Director of Nursing and AHPs informed the Committee of the planned Patient Engagement and Experience workshop on 27 April 2022. The Committee Chair asked that Young People be included in the workshop.

Date and time of next meeting
Monday 21 March 2022 9.30am – 12.30pm (Via MS Teams)

Leeds Community Healthcare NHS Trust

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 26 January 2022 (9.00 to 10.30 am)

Present:	Richard Gladman (Chair)	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Helen Thomson	Non-Executive Director (HT)
	Khalil Rehman	Non-Executive Director (KR)
Attendance:	Laura Smith	Director of Workforce
	Victoria Douglas-McTurk	Head of Business Intelligence and Performance (in attendance for item 72b only)
Apologies:	Diane Allison	Company Secretary
Note Taker:	Ranjit Lall	PA to the Exec Director of Finance & Resources

Item 2021/22 (70): Welcome and introductions

Discussion points:
The Committee Chair welcomed everyone to the meeting.

a) Apology: Please see above.

b) Declarations of interest
Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda to ensure there was no known conflict of interest prior to papers being distributed to Committee members. No additional potential conflicts of interest regarding the meeting's agenda were raised.

c) Minutes of meeting dated 24 November 2021
The private and public minutes of meeting dated 24 November 2021 were noted for accuracy and approved by the Committee.

d) Matters arising and review of action log
The Committee reviewed the action log and noted updates as follows.

Item 40b: Development of Team LCH Dashboard
It was noted that there was a further delay in production of the Team LCH Dashboard. The Business Intelligence Team had not had the capacity to be able to prioritise this piece of work whilst supporting Covid responses. The Executive Director of Finance and Resources said he would consult with the Head of Business Intelligence and Performance and provide an update to the Committee in February 2022 in terms of resetting pieces of work that were paused over the past few months. (**Action BM)**

Item 51b: Reducing Covid-created backlogs
This action was to establish ways of harmonising scrutiny of backlog information between the Quality Committee and Business Committee. The Committee was advised that there were still further discussions to be had on how all the backlogs and waiting lists in the coming year are presented consistently. A Non-Executive Director (HT) added that further work was needed on how to present the backlog information without seeing duplication at both Committees and a desire to standardise the production of some of those measures.

Item 64b: Neighbourhood team digital allocation tool
The Committee was advised that a brief paper on the financial plan was being presented to the Trust Board meeting on 4 February 2022. **(Action closed)**

Item 2021/22 (71): Covid and system pressures

Discussion point:
The Committee received an update on the Covid infection rate in Leeds. The Executive Director of Operations said that the position this morning showed a decrease in the infection rate for Leeds. The current rate had reduced to 1190 per one hundred thousand. In terms of the over 60 years of age that had also come down to 450 per one hundred thousand.

Further update was noted as follows:
- Currently 83 care homes were affected by Covid infection
- 212 people were in hospital with Covid positive
- 12 people in critical care (either non-vaccinated or partially vaccinated)
- 76.7% of the population had now been vaccinated
- 78.9% of eligible patients had come forward to have their booster vaccinations.

In terms of the schools programme around 40% of children had been vaccinated and this week the vaccination programme was continuing to offer either a second dose or first dose. The Executive Director of Operations said that because of increased infections in schools she was concerned about the numbers that she was expecting to vaccinate. A temporary vaccination unit was being opened in the Trinity Shopping Centre throughout the half-term holiday for drop-ins for schools for all age school children including their family members.

System pressures
The Executive Director of Operations said that in terms of impacting on the system, there was significant pressure across the system and through to community services, particularly in the neighbourhood teams. She said this week the Trust had reported at OPEL 3 level including pressures at Young Offenders Institute. Daily Silver Command meetings were continuing to assess system pressures in the three business units. Shorter to medium term actions were being reviewed to improve the situation going forward.

In terms of Covid related absences there was a downward trend and capacity had slightly improved as a result of that. The Director of Workforce (LS) said that in the first week of January 2022 there was a steadier rate of absence. 60-65 members of the workforce had been absent, down from early 70s last week and during the peak it was up to 100.

The Committee Chair asked about the flow around the system and hospital discharges. The Executive Director of Operations explained that there were around 300 people in hospital who had no reason to reside. She said there were still issues around waiting for care home placements and homecare. The Trust was looking at ways to ensure that people being discharged without a need for any service are moved through the system as rapidly as possible.

The Chief Executive advised the Committee that the Nightingale Hub in Leeds was not going to be utilised. She then explained that she was waiting on detailed information about

circa 200 people in the Trust who had not been vaccinated. These included first dose only or not had any and some individuals have come forward with exception legal letters and statements. Vaccination conditions of employment had been discussed at the Quality Committee on 24 January 2022. She said there was some success with people coming forward for asking individual conversations which had helped to convert. The offer of support and other ways of working was being continued to help staff.

The Director of Workforce (LS) assured the Committee that a vaccination working group had been established looking after vaccinations and conditions of deployment within the organisation. She said it was an important point to note that the Trust would prefer not to lose any member of staff or any talent as a consequence of the implementation of this regulation from 1 April 2022. The vaccination working group were doing everything to understand the opportunities for people who chose to be unvaccinated for a broad range of reasons to retain their skills and knowledge.

The Committee Chair thanked both the Executive Director of Operations and the Director of Workforce (LS) for the updates.

Item 2021/22 (72): Strategy and planning

Discussion point:

a) Third Sector Strategy update

The Committee was advised that the strategy update expected today was still being worked through. The Executive Director of Operations said that a piece of work was underway with the Third Sector partners across Leeds to develop a support service for patients served by the neighbourhood teams on the concept of proxy family to help with some elements of care.

Over 60 people from different organisations recently attended the Leeds Older People's forum. The Executive Director of Operations said that there was lots of interest in supporting neighbourhood teams in doing this work. The expressions of interest were now coming through and hoped to be operational by end of February 2022. She continued to say that this phase one of the programme, is be evaluated throughout the course of next year with a view to making it permanent arrangements. The Committee considered plans for the evaluation of this approach during 2022/23 and the financial issues were considered.

The Committee was also advised that discussions were underway with colleagues in social care about accessing capacity in homecare to support neighbourhood teams.

The Trust Chair was pleased to hear about the important connectivity of relationship with the Third Sector and asked about any further set plans or opportunities. The Executive Director of Operations said that at the moment she was cautious until there was confidence in the model and worked through all governance issues associated with that and see what difference it makes and then build from there, like a programme of work with a clear governance structure and a desired model. She said she would be able to bring an early initiative of the Third Sector strategy in March 2022.

Action:

The planned progress on the action plan and a full report on the Third Sector would be available for reviewing in the March 2022.

Outcome:

The Committee welcomed the example of working with the Third Sector Partners and how the Trust was working with Social Care colleagues to make the best possible use of the staffing resources available from all sectors.

b) Business Intelligence Strategy

The Head of Business Intelligence and Performance was welcomed to the meeting.

The Head of Business Intelligence and Performance said that the strategy had been updated following discussions and consideration of the previous draft at this Committee and Senior Management Team and with other colleagues during November/December 2021. She said today she was asking the Committee's approval prior to sign off at the Trust Board meeting. The improvements and changes to the strategy were listed in the cover paper.

The Committee welcomed the changes that had been made to reflect comments at the November 2021 Committee meeting. The Committee also welcomed the assurance from executive colleagues about the level of engagement there had been across the Trust in the development of the Strategy.

A Non-Executive Director (KR) felt that the timelines of 2 to 3 years seemed long for a critical function to deliver key improvements highlighted by the strategy which could be delivered as quickly as possible. The Head of Business Intelligence and Performance said that the strategy was quite conservative in the first year and having a greater focus in the second and third year. The Committee was keen that the improvements highlighted by the Strategy were delivered quickly.

The Trust Chair asked about affordability of the proposed work associated with this Strategy and the need to invest early to improve technical infrastructure and solutions.

The Head of Business Intelligence and Performance said that the efficiency savings of the Trust would efficiently manage services and help highlight and tackle health inequalities. She said it was a saving about freeing up resources to be able to deliver more and better.

The Committee Chair summarised the discussions to say that there was clearly a lot of consideration around affordability and timing of things and prioritisation against other improvements in the Trust. He said in order to get a step change in business intelligence he supported standardisation and self-service. The Committee was pleased with the improvements and the direction of travel subject to a few caveats around the pace linked to affordability and the balance of this as a priority.

Outcome:

The Committee consider the changes and approved the strategy for approval to the Board for sign off subject to caveats concerning pace, affordability, and balance with other Trust priorities.

c) Premises Assurance Model action plan

The Committee had previously been advised that the Facilities Management Team from another NHS Trust had been engaged to provide support with the action plan. It was noted that this engagement had now ceased. An expert Facilities Team and a national leader from the North Tees and Hartlepool NHS Foundation Trust had been approached to guide and review significant gaps in the facilities management model across the Trust. A full report was expected by end of February 2022.

The Committee was advised that the progress on immediate actions around risk assessments and the review of soft facilities management which would underpin work on the PAM had been delayed. An internal resource identified as a NEBOSH qualified and supported by the Risk Safety team would be carrying out the right risk assessments on those immediate actions. The Committee was also advised that it was hoped to secure the advisory services of an expert Waste Management advisor to support the Trust's response to a recently commissioned Waste Management audit.

The Committee Chair said that the Trust had now engaged with the right kind of skills and expertise. The Committee was looking forward to receiving reports and recommendations for those two different elements following consideration by the Senior Management Team. The Committee Chair said that the key was to begin the work as soon as receiving the reports on those recommendations and to seek out assurance.

The Trust now expected a report by the end of February and that recommendation and proposed management actions would be brought to the Business Committee as soon as possible after that.

Outcome:
The Committee noted the update and expressed a desire to consider the outcome of the work commissioned as soon as possible following scrutiny by the executive colleagues. The Committee also stressed the need to tackle urgent actions highlighted in the Waste Management audit.

Item 2021/22 (73): Change Management

Discussion point:

Change Management Board update
The Committee received an update on the progress of the Change Management Board Programme. The Executive Director of Operations said that the governance arrangements were in place and that the Board was meeting on monthly basis to oversee the whole portfolio of changed projects. To support the update the Committee received minutes of meeting dated 13 December 2021, exception reports and a PowerPoint presentation on the 'Point of Care Testing Trial'. The Executive Director of Operations said that she hopes this would be embedded by next winter months before the expansion of the Virtual Wards. She was hopeful that the tests would demonstrate confidence in the trial.

The Committee was asked to confirm what information it required in terms of an update going forward. This time the Committee received the minutes and two associated presentations particularly for that month. It was noted that the Leeds Sexual Health services was experiencing some delay in terms of the critical pathway due to the telephony system in place.

There was detailed discussion about the point of care testing trial. The Executive Director of Operations said that this would reduce risk of result delay and speed up assessment and treatment for patients in the Leeds Virtual Ward (Frailty). The reliable point of care testing equipment on site would give results at the time when clinicians would be able to make a more rapid decision.

The Committee Chair said that in terms of future reporting normally the Committee would receive quarterly updates. He said for the new financial year starting April 2022 he would like to agree priority programmes or projects for that year and that the. The challenge was to agree what was to be included in that priority portfolio. The Committee Chair was happy to support the Executive Director of Operations in preparing a draft list and to decide on the format by the end of March 2022.

Action:
The Executive Director of Operations to agree a priority projects list going forward and the Committee receiving assurance for each of those projects being on track and or overview by exception.

Outcome:
The Committee received a verbal update and noted the minutes and two associated presentations.

Item 2021/22 (74): Performance Management

Discussion points:

a) Performance Brief and domain reports

The Executive Director of Finance and Resources introduced the Performance Brief and Domain reports. In the light of the current Silver Command response to the Omicron wave, the report concentrated its escalations on the safe and caring domains only which the Quality Committee considered in detail at its meeting on 24 January 2022.

The Committee was advised that whilst a number of the well-led KPIs remained red there was evidence of some stabilisation, and it was expected that the Trust would begin to see improvements.

The Executive Director of Operations provided a brief update on the backlogs and waits. The area of concern at the moment was the paediatric and neuro disability having 18 weeks waits due to some elements of the service being paused. The Committee Chair referred to previous updates alternating between general update and more detailed backlog and service pressure information. He was keen to have an in-depth discussion on backlogs and wait lists in the near future.

In her update, the Director of Workforce (LS) said that clearly it was not good to see red indicators across all the well-led indicators. She said previously the Committee was advised about the work in place to support the health and wellbeing, which was continuing. She expected to see a high staff absence in January given the recent surge and may take a while to get back into green. The Committee was also advised about work around retention linked to turnover figures and analysing in preparation for work with business units and directorates and making improvements to appraisals and statutory and mandatory training.

FINANCE

The Executive Director of Finance and Resources shared a PowerPoint slide to provide a finance summary of the latest position and year-end update. The Committee received an update on how it planned to utilise financial resources across the Trust, and across Leeds, over the remainder of the financial year.

The Committee was advised of some changes to the information presented at the last Trust Board meeting about the plans to manage resources and the potential to more changes as resources were managed across the ICS and all its partner organisations. The potential for a small surplus to remain in LCH at the year-end was noted.

b) Safe staffing report

The report covered progress in relation to maintaining safe staffing over the last six months. Noting that the report had been received and discussed at the Quality Committee. The Business Committee agreed that in the future the report would be considered as part of a wider workforce issues.

Outcome:

The Committee thanked the report's authors for the helpful and comprehensive commentary and looked forward to future discussions on ensuring each service had the right numbers and mix of staff.

c) Operational and non-clinical risks register

The summary report showed changes to non-clinical risks on the risk register. There was one new non-clinical risk, two risks had been escalated and two risk had been de-escalated.

Outcome:
The Committee discussed risk 1050, use of unsupported software across the IT network estate. The Chief Executive said that this risk had been discussed at the Quality Committee and a more comprehensive written response would be circulated to members of both Committees. The Committee Chair said that the risk was owned by the Audit Committee.

Outcome:
The Business Committee noted the contents of the risk register to assure the Board that non-clinical risks were being appropriately managed.

d) Health and Safety compliance report
The Committee was provided with information on the current level of compliance with health and safety legislation and policies as well as an update on the developments and effectiveness of the Trust's health and safety management system.

A new Security and Safety Lead was in post and a review of the security management arrangements was currently underway. Static roles within buildings for security, fire and first aid required review to ensure that there were adequate numbers of trained staff available to respond in an emergency.

The Committee noted some concerning aspects of lack of response to fire safety risk assessments. The Committee welcomed the current significant investment in fire safety work from an estate's perspective, but this now needed to be followed with an enhanced fire safety culture and day to day actions in the Trust. The need to continue to develop the organisational culture in all aspects of health and safety was recommended by Committee members. The potential under-reporting of incidents, particularly aggression towards staff was noted and this would be picked up by the new Security and Safety Lead.

The Trust Chair was pleased to note a comprehensive and a thorough report on matters of urgency and wished to receive updates sooner particularly around fire safety and failure to meet systems across a number of parts of the business and further consideration given to the culture across the organisation.

The Executive Director of Finance and Resources agreed with the Trust Chair and said that from a fire safety perspective an external fire safety firm had been engaged in the last six months to work on the remedial estates work on fire safety. He continued to say that part of overall maintenance a process was in place to identify and rectify work so that it did not occur again.

The Committee Chair suggested that when a more regular cycle of business planning was in place the Committee would welcome seeing a list of priorities and timescales associated with remedial actions or key activities of health and safety documented a year ahead, for example, the key areas of priorities for 2022/23.

Action:
The Committee Chair and the Executive Director of Finance and Resources to agree and schedule a comeback in future meetings to invite the Health & Safety team members to the Committee for a more in-depth discussion including a list of key areas of priorities for 2022/23.

Outcome:
Overall, the Committee welcomed the comprehensive 'position statement' report but agreed that it highlighted the need for continued improvements across a range of areas and could only provide limited assurance. It was agreed that when the Committee returned to its full time duration, a longer discussion on the plans of Health and Safety work for FY22/23 would be held and key personnel from the team would be invited to attend.

Item 2021/22 (75): Minutes to note

Discussion point:

Health and Safety Group minutes (16/12/21)

The Committee noted the H&S group minutes.

Item 2021/22 (76): Matters for the Board and other Committee

Discussion point:

Assurance levels
The Committee reviewed and discussed the levels of assurance for the strategic risks related to the following agenda items:

- Performance Brief and Domain Reports
- Business Intelligence Strategy
- Finance update
- Safe staffing
- Health and Safety update

The Committee agreed a reasonable level of assurance on all the papers and topics discussed in today's meeting.

Item 2021/22 (77): Business Committee Governance

Discussion point:

Future work plan
The Committee reviewed and noted the work plan and rescheduled deferred items.

Item 2021/22 (78): Any other business

None discussed.

Leeds Community Healthcare NHS Trust

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 23 February 2022 (9.00 to 10.45 am)

Present:	Richard Gladman (Chair)	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Helen Thomson	Non-Executive Director (HT)
	Khalil Rehman	Non-Executive Director (KR)
Attendance:	Jenny Allen	Director of Workforce
	Richard Slough	Assistance Director of Business Intelligence (in attendance for item 81 only)
	Victoria Douglas-McTurk	Head of Business Intelligence and Performance (in attendance for item 82a only)
	Ann Hobson	Assistance Director of Workforce (for item 83 only)
	Sharron Blackburn	Deputy Head of Internal Audit (Audit Yorkshire) (in attendance for item 84a only)
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to the Exec Director of Finance & Resources

Item 2021/22 (79): Welcome and introductions

Discussion points:
The Committee Chair welcomed everyone to the meeting.

a) Apology: None recorded.

b) Declarations of interest
Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda to ensure there was no known conflict of interest prior to papers being distributed to Committee members. No additional potential conflicts of interest regarding the meeting's agenda were raised.

c) Minutes of meeting dated 26 January 2022
The minutes of meeting dated 26 January 2022 were noted for accuracy and approved by the Committee.

d) Matters arising and review of action log
The Committee reviewed the action log and noted updates as follows.

Item 2021/22 (49d0: Operational and non-clinical risk report
This outstanding action was related to the possibility of joining up future IT arrangements in the City. The Committee was advised that there was no such forum set up in the city to actively discuss IT issues. The Committee Chair said that any further details or progress about the long-term strategy around partnering with others should be considered within the LCH Digital Strategy. **Action closed.**

Item 21/22 (39b): Premises Assurance Model

The Committee was advised that there was a lack of engagement from the independent source who had been engaged to support the review of Trust's facilities management. The Executive Director of Finance and Resources said that the current lack of feedback meant that the report due in March 2022 may be delayed. **Deferred action.**

Item 21/22 (40b): Development of Team LCH Dashboard
The Executive Director of Finance and Resources said that in terms of development of the Performance Brief, the aim was to continue to develop by the increased use of Statistical Process Control Charts (SPC) and to have a narrative which concentrated more on trends to support data sets.

Item 2021/22 (73): Change Management Board
The Committee was to receive a list of priority projects and the schedule of progress reports in March 2022. The Executive Director of Operations said that this was being considered by the Senior Management Team (SMT) later that day to agree the priority order.

Covid and system pressures

Discussion point:

Covid update / system pressures including backlogs and hot spots
The Executive Director of Operations was pleased to advise the Committee that the citywide infection rate had considerably reduced and was much better than anticipated.

Pressures on the health system continued and A&E had been very busy that week. The bed occupancy rate was high and there were still many people in hospital awaiting discharge due to delays in home care and care home placements. The Neighbourhood teams continued to work with systems to try and improve the situation.

Backlog / waiting lists
The Committee received a paper on key themes from a recent stocktake of waiting times. The paper also highlighted several services where additional focus was required to tackle the backlog. Reports can now be generated that split the patients waiting for care into populations by ethnicity and deprivation, and these reports will be used alongside backlog modelling to ensure that at risk groups are not further disadvantaged by recovery approaches.

The Executive Director of Operations said that the pressures over the winter period meant that mutual aid was necessary, and services had to reduce their offer to support neighbourhood teams. It was agreed back in autumn that some investment should be put into clearing backlogs, a non-recurrent money to end on 31 March 2022. The Executive Director of Operations said that the services were now concerned about that coming to an end. The SMT had agreed to making any fixed term contracts associated with backlog support permanent or by extending them. Some concern was expressed about the available estate to support this, but it was confirmed that estates capacity should not be an issue that prevented waiting lists decreasing.

The Executive Director of Operations said that a discussion took place at the Quality Committee on 21 February 2022 about patients on waiting lists that were not being prioritised. She said clinical priority will always take precedence. She was concerned about the group of patients who could therefore remain on the waiting lists for a prolonged period. A further Quality Committee discussion was planned.

The Executive Director of Operations said that she was concerned about the Trust having less control over wait lists because of shared pathways with Leeds Teaching Hospitals NHS Trust (LTHT). She said a number of patients referred had already passed the 18 weeks point and automatically a breach was adopted. The Community Gynaecology service was working with LTHT colleagues to gain transparency on referral processes and understanding demand patterns.

The Executive Director of Operations drew the Committee's attention to the significant waiting list in MSK service. She said there had been reduced activity as a result of moving to a digital environment during the pandemic and this is being explored further.

The Director of Workforce (JA) commented that it was important to acknowledge the recovery of staff in terms of their wellbeing when planning the reduction of the waiting lists.

The Chief Executive said that the stress of waiting list was overwhelming for staff and that the wellbeing of staff was also important to help people not to overwork. She said waiting list and staff recovery was further being considered by SMT later today, looking to create innovation or something to motivate people.

The Committee Chair said he was concerned about the waiting lists increasing when the population becomes more confident at going out again. He asked about the trends in each service and how the Committee would be assured that the work was happening or having a standard set of matrices to scrutinise the backlogs. The Executive Director of Operations said that there was a number of reports available to look at from an individual service basis, and to produce a report at a summary level would be a challenge. The PIP system produces reports show the increase in referrals and face to face activity, which is more useful at service level than a summary level. She asked for views on the information the Committee was seeking.

The Committee Chair said that he would like further discussion outside the meeting to agree whether reporting on waiting lists and backlogs becomes quarterly or a six-monthly update and works for both the Business Committee and the Quality Committee.

The Committee Chair asked about the affordability of some of the schemes in the report to reduce waiting lists and about the sustainability of funding rolling into new financial year and the scope to be able to keep some of those schemes going. The Executive Director of Finance and Resources responded to say that work was continuing to identify resources to reduce the waiting lists as well as to maintain the level of business-as-usual services. It was noted that the affordability of schemes and what it actually means in practice for capacity and wait lists would be detailed in the budget paper presented at next month's Committee meeting.

A Non-Executive Director (KR) said it would be good to articulate in future reports the journey to recovery from the base line and to see a figure or a percentage on catch up.

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

Outcome:
Discussions continued with each service to agree a recovery plan and realistic timescales for improvement. The current waiting lists were being validated both from a service and business intelligence perspective with a view to a comprehensive report being presented to Business Committee in March 2022.

Item 2021/22 (81): Strategy and planning

Discussion point:

Digital Strategy update
The Assistant Director of Business Intelligence was welcomed to the meeting.

In his introduction, the Assistant Director of Business Intelligence said that the key points of the strategy were much the same as seen before by the Business Committee in September 2021. The changes to note were to bring out the requirement to test the Digital Strategy against the City; the Leeds Place Based Partnership and wider Integrated Care System (ICS) based on their digital aspirations. The Assistant Director of Business Intelligence said that this brought a level of uncertainty and complexity to work with. He said the next stage was to have a conversation with

the Clinical Commissioning Group's Leeds Place Digital Lead on working in partnership. In terms of community space and digital development, some regional ICS workshops had been organised. The Trust had not yet had the opportunity to share its voice and he was not aware of what other community partners had in mind. There was a risk that larger trusts would benefit more from the time, energy and resource that comes through the ICS.

A Non-Executive Director (KR) referred to the Gantt charts and said that the challenge would be to fucus attention to what's within the organisation's control and needs over the next two to three years and focus on matters of IT infrastructure and perhaps this would help with some of the waiting lists and improve what could be achieved for patients and communities.

Concerns were raised about the interoperability of systems across organisations. The Director of Workforce (JA) said she had experienced some difficulties with interoperating systems within partnership arrangements, for example the vaccination centre was a huge challenge when putting rosters in place that worked. It was suggested that there should be a greater emphasis in the digital roadmap on transforming patient care and a recognition of digital exclusion.

The Committee Chair agreed with a Non-Executive Director's (KR) comments in terms of the aims on things that are citywide and about access to funding to help accelerate some of the innovation within the Trust. The Committee Chair was keen to explore further and to invite the West Yorkshire CIO or Leeds Place Lead, either to the Trust Board or Business Committee meeting to learn about their support to help with integrating solutions for patient and or kind of infrastructure across the city. The most important element would be the population health data analytics.

The Committee Chair suggested a review of the NHS framework which was increasingly judged in terms of performance. The other area was the interaction with patients and to start to streamline letters and consider different types of communications and to find ways of patients feeling they are part of their care plan, and they can see things and influence things and their needs are taken into account.

The Chief Executive said that in terms of service transformation and digital exclusion, a digital journey was something many of the residents are struggling with and the strategy must always be aware of that. She said that as the community provider, it's important to have that as the essential part of work. Another piece of work was underway looking at challenges with virtual coverage within the Neighbourhood Teams.

The Committee Chair drew the conversation to a close and thanked the Assistant Director of Business Intelligence for a helpful discussion. Further feedback was noted for the next iteration of the roadmap and some of the information considered were the key areas to influence the priority areas for the next financial year.

Action:
The Executive Director of Finance and Resources to explore inviting partners in the City to one of the Trust's governance meetings.

Outcome:
The Committee noted and commented on the Digital strategy and plans and the emerging relationships and complexities with the Leeds Place and ICS based digital priorities.

Item 2021/22 (82): Performance Management

Discussion points:

a) Key Performance Indicators (KPI) annual review
The Head of Business Intelligence and Performance was welcomed to the meeting.

The KPI paper had also been considered at the Quality Committee meeting on 21 February 2022.

The paper provided a list of indicators that would be examined within the Performance Brief for 2022/23. The Head of Business Intelligence and Performance said that this list had been brought in line with the System Oversight Framework, reported on before, and additional indicators from local performance processes and national planning requirements had also been considered for inclusion that had been developed over time.

The high-level indicators were listed in a format for quick reference to the LCH dashboard. It was proposed that the non-operational indicators listed at the end of the paper were not for monitoring by the Performance Brief. The Head of Business Intelligence and Performance said in the discussion at the Quality Committee, these indicators were service specific and monitored at service level. The Quality Committee requested to receive updates on a regular basis to ensure things were on track. The Business Committee's views on those indicators were welcomed.

The Committee discussed the purpose of the Performance Brief and its measures. The Executive Director of Finance and Resources said that the KPIs were organisational overview, and the Trust must get the reporting right to make sure there was appropriate escalations of issues. It was suggested that evidence should be collated of where service level indicators were discussed with a view to either removing some of the indicators from the performance brief or reporting them less frequently.

A Non-Executive Director (HT) added that the discussion at Quality Committee was about understanding the purpose of the Performance Brief and a further debate and discussion was suggested as a future Board Workshop. There had also been discussion about identifying any closed cultures.

A Non-Executive Director (KR) said that it was also about assurance and trajectory supporting more equity and linking to KPIs, as not everything is a key performance. He was more interested in seeing the layers of performance data available and where these would be interrogated, building up to the strategic objectives. He would also expect that there would be further reviews of KPIs throughout the year and that these may be amended if priorities changed.

The Committee Chair commented that the measures in the Performance Brief should be as high level as can be, but there should also be assurance that granular information was being reviewed against standard set of standards per service. This could be a report that gives more information and more detail on a quarterly or six-monthly basis.

The Committee Chair queried the one-off measures in the Performance Brief, for example the staff survey. The Director of Workforce (JA) said that she was awaiting further clarity nationally on precisely what those engagement scores were and how they would be constructed and utilised. She said that previously there was just an annual staff survey but now there was the quarterly staff surveys and some of the information could benchmarked quarterly.

The Head of Business Intelligence and Performance was content with the feedback received to update the reporting of the Performance Brief for the new financial year. She said she would write a paper on development of those indicators that are service specific and where they would be discussed and embedded in the performance management processes. This would provide the assurance needed to take them out of high-level indicators further on in the year.

The Committee Chair said that the feedback should help make any minor changes for the year ahead. A broader conversation was needed about levels of details and assurance at different levels in the Trust as a whole. The Committee Chair agreed to discuss this with the Trust Chair in terms of scheduling a Board development discussion.

Outcome:
The Committee broadly agreed to recommend the KPIs for Trust Board approval subject to the document providing assurance on those indicators that are service specific and where they would

be discussed and embedded in the performance management processes in order to remove them from the Performance Brief.

b) Operational and non-clinical risks register
The summary report showed changes to non-clinical risks on the risk register. No risks had been added to the Trust's risk register since the last report in January 2022 and two risks had been de-escalated.

Outcome:
The Business Committee noted the contents of the risk register to assure the Board that non-clinical risks were being appropriately managed.

c) Estate Management report
The Management report covered the period 1 October to 31 December 2021. There was a long-standing issue of compliance within the leased estate and landlords' responsibilities to the Trust. Since this paper was written, progress had been made with Leeds Teaching Hospitals NHS Trust and the City Council. It was also highlighted that majority of tasks in the report were rated 'green'.

The Executive Director of Finance and Resources said that this was a management report, essentially on Community Venture's performance as estates management contractors and does not necessarily report on performance of the estate. He said over the next few months he would like to consider what the Trust was seeking from an assurance perspective on whether the estate was fit for purpose.

The Risk and Safety Team were invited to the Committee meeting in March 2022 to hold discussions around health and safety and fire risks and compliance with legislation. The Executive Director of Finance and Resources said that this was a small part of estates performance and bringing everything together would provide that overview.

Outcome:
The Business Committee received the management report and concluded a reasonable assurance on contractual management of the estate.

Item 2021/22 (83): Workforce focused topic

Discussion point:

Workforce Strategy – inclusion
(Please see private minutes)

Item 2021/22 (84): Internal Audit

Discussion points:

a) Strategic Internal Audit Plan 2022/23
The Committee welcomed the representative from the Trust's new internal auditors, Audit Yorkshire, who presented the strategic internal audit plan for 2022/23.

The Committee was advised that there had been engagement with the SMT members in the production of the draft plan. The Committee was assured that whilst it was a three-year plan, the plan could flex as required if additional or alternative internal audits were needed.

The Deputy Head of Internal Audit said it was a plan based on current assessment to meet its assurance needs for the Trust Board and was aligned with the strategic risks on the Board Assurance Framework. The scope of the audit was to look at previous years' audits and Directors views on the risk to the organisation and crucially where internal audit could help to address some

of those risks and issues. The plan was designed to cover 3 to 4 years and would continue to focus on those areas where there were high risks.

The Committee was asked whether the plan, as it stands, addresses some of the risks that the Business Committee was aware of or any other areas from Committee's deliberations that the internal audit be able to provide a greater assurance to the risk to the organisation.

A Non-Executive Director (KR) asked about the possibility of aligning the review of recruitment and appraisals and sickness. He said recruitment process, sickness absence, managing resource and wellbeing were a concern. The Workforce Director (JA) also reflected on reviewing the recruitment process, reviewing sickness absence and then the resourcing and health and wellbeing of staff. She said the audits were usually traditionally focused on the processes around managing those things and whether enough is done for the health and wellbeing of staff. It was noted that the discussion with the Director of Workforce (LS) resulted in the audit focusing on sickness and health and wellbeing of staff. The plan would be renamed to reflect this minor change.

The Committee Chair said that there was a good broad mix of audits proposed for the year ahead backed by the Senior Management Team. The plan would be presented at the Audit Committee in March 2022 for final discussion and approval.

Outcome:
The Committee agreed that it was a logical and comprehensive plan. The plan was to be presented at Audit Committee in March 2022 for final discussion and validation of the schedule for the year ahead.

b) Internal Audit report – Emergency Response Planning
The internal audit report covered the completed audit from the 2021/22 plan and the audit opinion related to Emergency Planning and obtained a reasonable assurance opinion. There were three routine recommendations and some good practice identified.

The Executive Director of Operations agreed to the outcome and remained confident about the work being undertaken for emergency planning.

Outcome:
The Committee noted the audit completed as part of the approved 2021/22 plan and discussed the findings, recommendations, and associated managers' actions.

Item 2021/22 (85): Matters for the Board and other Committee

Discussion point:

Assurance levels
The Committee reviewed and discussed the levels of assurance for the strategic risks related to the following agenda items:

- Key Performance Indicators
- Digital Strategy
- Covid update: waiting lists and backlogs
- Workforce focused topic
- Internal Audit Plan for next year

The Committee agreed a reasonable level of assurance on all the papers and topics discussed in today's meeting.

Item 2021/22 (86): Business Committee Governance
Discussion point: **Future work plan** The Committee reviewed and noted the work plan and rescheduled deferred items.
Item 2021/22 (87): Any other business
None discussed.