Bundle Public Board Meeting 5 August 2022

	Agenda
	Final Agenda Public_Board_Meeting_5 August 2022.docx
34	09:00 - Welcome, introductions and apologies:
35	Declarations of interest
36	Questions from members of the public
37	09:05 - Minutes of previous meeting and matters arising:
37.a	Minutes of the meetings held on 27 May 2022
	Item 37a Draft Public Board minutes 27 May 2022.docx
37.b	Minutes of the meeting held on 17 June 2022
	Item 37b Draft Public Board minutes 17 June 2022.docx
37.c	Actions log: 27 May 2022 and 17 June 2022
	Item 37c Public Board Actions log 5 August 2022.doc
38	09:10 - Chief Executive's report: including update on system pressures
	Item 38 CEO report for Board August 2022.docx
39	09:20 - System Flow Developments and Issues
	Item 39 - System Flow - August 2022.docx
40	09:30 - Committee Chairs' Assurance Reports:
40.a	Nominations and Remuneration Committee: 17 June 2022
	Item 40a Nom and Rem Committee June 2022 - Chair Assurance report.docx
40.b	Charitable Funds Committee: 22 June 2022
	Item 40b Charitable funds Committee Chair Assurance Report June 2022.docx
40.c	Quality Committee: 27 June 2022 and 25 July 2022
	Item 40ci QC Chairs assurance report June 2022.docx
	Item 40cii QC Chairs assurance report July 2022.docx
40.d	Business Committee: 29 June 2022 and 27 July 2022
	Item 40d BC Chairs assurance report June 2022.docx
	Item 40dii Business Committee assurrance report July 2022.docx
40.e	Audit Committee: 3 August 2022 (Verbal update)
41	09:55 - Performance brief: June 2022
	Item 41i Performance brief cover paper Aug 2022.docx
	Item 41ii Performance Brief - June 2022.docx
42	10:00 - Significant Risks and Board Assurance Framework (BAF) Summary Report
	Item 42 Significant risks and risk assurance report August 2022 Board.docx
43	10:05 - Freedom to Speak Up Guardian Report (John Walsh presenting)
	Item 43 FTSUG Board report August 2022.docx
44	10:15 - Guardian of Safe Working Hours Quarter 1 2022-23 - (Dr Nagashree Nallapeta presenting)
	Item 44 GoSWH Quaterly report August 2022_.docx
45	10:25 - Safe Staffing Report – seen by Business and Quality committees July 2022
	Item 45 Safe staffing report JULY 2022.docx
	Item 45i Additional page for Safe Staffing report (after page 5).docx
46	10:30 - Nursing and Allied Health Professionals re-validation and registration
	Item 46 Professional registration Trust Board August 2022.docx
47	10:45 - Health Equity Strategy update
	Item 47 Health equity Board update Aug 2022 final.docx
48	10:55 - Medical Director's Annual Report 2021-22 (reviewed by Quality Committee July 2022 – for approval of compliance statement for submission and Health Education England Self Assessment Return

Item 48i Annual Medical Directors report - Board - 21-22 FINAL.docx

Item 48ii Annual Medical Directors report Annex A - Annual Board Report and Statement of Compliance 21-22.docx

49 11:05 - Safeguarding Annual Report (reviewed by Quality Committee June 2022 - to approve publication)

Item 49i Safeguarding Annual Report July 2022 cover paper.docx

Item 49ii Safeguarding Combined Annual Report 2022 V2 draft submitted to board.docx

50 11:15 - Risk management policy and procedure

Item 50i Cover paper - Risk Management Policy and Procedure (Aug 2022).docx

Item 50ii PL354 Risk Management Policy and Procedure V5 - August 2022.docx

51 11:20 - Registers of seals – to ratify

Item 51 Use of Seal June-July 2022.docx

52 11:25 - Any other business and questions on Blue Box items

53 11:30 - Close of the public section of the Board

54 Blue Box Item - Mortality Reports – 2022-23 Quarter 1 update – reviewed by Quality Committee July 2022

Item 54i Mortality Q1 22 (1).docx

Item 54ii Mortality Q1 22 Appendix 1.docx

Item 54ii Mortality Q1 22 Appendix 2.docx

55 Blue Box Item - Patient Experience (complaints and concerns): 6 monthly /Annual Report – reviewed by Quality Committee July 2022

Item 55 2022 07 14 Final QC Patient Experience Six Month report.docx

56 Blue Box Item - Patient Safety Report:- reviewed by Quality Committee July 2022

Item 56 Patient safety 6 monthly report July 22 approved.docx

57 Blue Box Item - Serious Incidents Report (this is the twice yearly thematic/learning report) – reviewed by Quality Committee July 2022

Item 57 Bi-annual SI report Jan to June 22 August 22 Board (002).docx

58 Blue Box Item - Health and Safety Compliance Report – reviewed by Business Committee July 2022

Item 58 Health and Safety Compliance Report August 2022.docx

59 Blue Box Item - Third Sector Strategy – reviewed by Business Committee July 2022

Item 59i 3rd Sector Strategy Update Cover Paper - July 2022.docx

Item 59ii Plan on a page - July 22 Bus Comm.pptx

60 Blue Box Item - Board workplan to note

Item 60 Public Board workplan 2022-23 v4 27 07 22.pdf

61 Blue Box Item - Approved minutes and briefing notes for noting:

61.a Quality Committee: 23 May 2022 and 27 June 2022

Item 61ai Approved QC minutes 23 May 2022.docx

Item 61aii Approved QC minutes 27 June 2022.docx

61.b Business Committee: 25 May 2022 and 29 June 2022

Item 61bi Approved BC Minutes May 2022.docx

Item 61bii Approved BC Minutes June 2022.docx

Leeds Community Healthcare NHS Trust

Agenda Trust Board Meeting Held In Public

Virtual meeting on Microsoft Teams

Date 5 August 2022
Time 9:00am – 11.30am
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
2022-23 34	9.00	**Welcome, introductions and apologies:** *(Trust Chair)* Apologies: *Dr Ruth Burnett, Richard Gladman*	**N**
2022-23 35		**Declarations of interest** *(Trust Chair)*	**N**
2022-23 36		**Questions from members of the public**	**N**
2022-23 37	9.05	**Minutes of previous meeting and matters arising** *(Trust Chair)* *For approval*	
37a		Minutes of the meeting held on: 27 May 2022	**Y**
37b		Minutes of the meeting held on 17 June 2022	**Y**
37c		Actions' log 27 May and 17 June 2022	**Y**
QUALITY AND DELIVERY			
2022-23 38	9.10	**Chief Executive's report – including update on system pressures** *(Thea Stein*	**Y**
2022-23 39	9.20	**System Flow Developments and Issues** *(Sam Prince)*	**Y**
2022-23 40	9:30	**Committee Chairs' Assurance Reports:**	
40a		Nominations and Remuneration Committee: 17 June 2022 (Trust Chair)	**Y**
40b		Charitable Funds Committee: 22 June 2022 (Alison Lowe)	**Y**
40c		Quality Committee: 27 June 2022 and 25 July 2022 *(Helen Thomson)*	**Y**
40d		Business Committee: 29 June 2022 and 27 July 2022 *(Khalil Rehman)*	**Y**
40e		Audit Committee: 3 August 2022 (Verbal update) (Khalil Rehman)	**N**
2022-23 41	9.55	**Performance Brief: June 2022** *(Bryan Machin)*	**Y**
2022-23 42	10.00	**Significant Risks and Board Assurance Framework (BAF) Summary Report** *(Thea Stein)*	**Y**
2022-23 43	10.05	**Freedom to Speak Up Guardian Annual Report 2021-22** *(John Walsh presenting)*	**Y**
2022-23 44	10.15	**Guardian of Safe Working Hours Quarter 1 2022-23** *(Dr Nagashree Nallapeta presenting)*	**Y**

2022-23 45	10.25	**Safe Staffing Report – seen by Business and Quality committees July 2022** *(Steph Lawrence)*	**Y**
2022-23 46	10.30	**Nursing and Allied Health Professionals re-validation and registration** *(Steph Lawrence)*	**Y**
BREAK			
STRATEGY			
2022-23 47	10.45	**Health Equity Strategy update** (Dr Ruth Burnett)	**Y**
SIGN OFF/APPROVAL			
2022-23 48	10.55	**Medical Director's Annual Report 2021-22** (reviewed by Quality Committee July 2022 – for approval of compliance statement for submission and Health Education England Self Assessment Return *(Dr Ruth Burnett)*	**Y**
2022-23 49	11.05	**Safeguarding Annual Report** (reviewed by Quality Committee June 2022 - to approve publication) *(Steph Lawrence)*	**Y**
2022-23 50	11.15	**Risk management policy and procedure** (Thea Stein)	**Y**
2022-23 51	11.20	**Registers of seals – to ratify** *(Diane Allison)*	**Y**
CLOSE			
2022-23 52	11.25	**Any other business and questions on Blue Box items** (Trust Chair)	**N**
2022-23 53	11.30	**Close of the public section of the Board** *(Trust Chair)*	**N**

Additional items (Blue Box)		
2022-23 54	**Mortality Reports – 2022-23 Quarter 1 update – reviewed by Quality Committee July 2022** *(Dr Ruth Burnett)*	**Y**
2022-23 55	**Patient Experience (complaints and concerns): 6 monthly /Annual Report – reviewed by Quality Committee July 2022** *(Steph Lawrence)*	**Y**
2022-23 56	**Patient Safety Report:- reviewed by Quality Committee July 2022** *(Steph Lawrence)*	**Y**
2022-23 57	**Serious Incidents Report (this is the twice yearly thematic/learning report) – reviewed by Quality Committee July 2022** *(Steph Lawrence)*	**Y**
2022-23 58	**Health and Safety Compliance Report – reviewed by Business Committee July 2022** *(Bryan Machin) –*	**Y**
2022-23 59	**Third Sector Strategy – reviewed by Business Committee July 2022**	**Y**
2022-23 60	**Board workplan – to note**	**Y**
2022-23 61	**Approved minutes and briefing notes for noting – all approved by the respective committees :** *(Brodie Clark)*	**Y**
61a	Quality Committee: 23 May 2022 and 27 June 2022	**Y**
61b	Business Committee: 25 May 2022 and 29 June 2022	**Y**

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 5 August 2022

Agenda item number: 2022-23 (37a)

Title: Draft Trust Board meeting minutes 27 May 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
	Alison Lowe (AL) OBE	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Executive Medical Director
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	Diane Allison	Company Secretary
	Dr Sheila Puri	Consultant Paediatrician, Community Paediatrics, Leeds Community Healthcare for Item 5
	Dr Nagashree Nallapeta	Consultant Paediatrician- Guardian of Safe working Hours for Item 10 (virtual link).
Minutes:	Liz Thornton	Board Administrator
Observers:	Julie Hickton	Gatenby Sanderson
Members of the public:	None	

Item 2022-23 (1)
Discussion points
Welcome introduction, apologies and preliminary business
The Chair of Leeds Community Healthcare opened the Trust Board meeting held in public.

He welcomed Board members, attendees and observers to the meeting.

Apologies
Apologies were received and accepted from Jenny Allen, Director of Workforce, Organisational Development and System Development (JA).

Trust Chair's introductory remarks
Before turning to the business on the agenda, the Trust Chair provided some introductory comments to add context to the meeting discussions.

He said that the Trust was still facing unrelenting pressure and must continue to do all it could to protect; support its staff and reward and recognise their outstanding commitment and work.

The Integrated Care System (ICS) would become a reality in the next few months which meant that the Leeds Health and Care (Place based) Partnership would become an arm and a committee of the Integrated Care Board (ICB) but more importantly, the Trust's key partnership delivery focus.

He said that for the Trust:

- It was not 'Business as Usual' there was a new and changing agenda to drive, create and demonstrate the left shift in action.
- There was a need to clarify our strategic intent – for partners, but, more importantly, for staff and for the community.
- A need to support the development of a coordinated *Place* effort – as the Chief Executive Officer (CEO and her colleague CEOs are doing and the need to do everything possible to ensure the very best of, and for the ICS over these early days.
- A need to build, grow, drive and strengthen those important strategies that have been launched during difficult times – health inequities; the engagement strategy; the great work with third sector colleagues, digital, estates and the Children's Strategy and the Workforce strategy which were both on the agenda for the meeting today.
- The need to find time for reflection, as a Board.

In conclusion he said that the Trust had performed brilliantly and there was much positive, opportunity ahead. No opportunity must be missed in progressing a powerful agenda that was designed and dedicated to the health and wellbeing of the communities the Trust serves.

Item 2022-23 (2)
Discussion points:
Declarations of interest
Prior to the Trust Board meeting, the Trust Chair had considered the Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest before the papers were distributed to Board members. The Trust Chair asked the Board for any additional interests that required declaration and he noted that the draft revised register of declarations of interest formed part of the meeting papers pack. There were no new declarations of interest made at the meeting.

Item 2022-23 (3)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2022-23 (4)

Discussion points:

Minutes of the last meeting, matters arising and action log

a) Minutes of the previous meeting held on 31 March 2022

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

b) Actions' log 31 March 2022

None to note.

Item 2022-23 (5)

Discussion points:

Patient story: Harry's story.

The Executive Director of Nursing and AHPs introduced the story and welcomed Harry's parents to the meeting supported by Dr Sheila Puri, Community Paediatrics, Leeds Community Healthcare.

Harry sadly passed away last year aged 12. He had neo natal seizures and global developmental delay and spent his first five weeks in hospital where he started the family's journey with the NHS. Many tests and procedures later the family partnered with multi-disciplinary teams and Leeds Community Healthcare paediatric services to give Harry the best life possible. Harry was generally a very happy boy supported by caring parents who loved him and a team of experts who supported him to have a good life and achieve his potential. They shared a portfolio of photographs of Harry with Board members.

Harry's parents described the positive relationship and partnership they had built up with healthcare professionals in the Trust in a variety of services but particularly Dr. Puri. For the majority of the time, they felt fully involved in decisions about his care but on some occasions, particularly when a gastrostomy was proposed they felt that their views and intimate knowledge of how Harry felt should have been acknowledged as advocates for their son. During this time, they had felt that their views were disregarded to some extent.

The Trust Chair invited questions and observations from Board members.

The Executive Director of Operations said that she felt that it was important for a wider group of staff to hear more detailed feedback on this story and the family agreed to participate in a session if this could be organised.

The Executive Medical Director said that it was important that healthcare professionals recognised the critical role of parents and asked what Harry's parents though might help with this.

They suggested that the team of staff should spend some time living with the family, share their experiences, gain a more balanced view and a deeper understanding of the patient. They had found it particularly helpful for healthcare professionals to be support Harry at his specialist education provision.

The Trust Chair thanked Harry's parents for sharing such a positive and thought provoking story. He also thanked them for agreeing to participate in a longer session with staff who provided direct care to children and supported families in similar situations.

2022-23 Item (6)

Discussion points:

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

The Chief Executive presented her report and highlighted some of the key points:

- Integrated Primary and Community Care Conference
- Healthcare Support Workers recruitment event
- Relocation from Stockdale House
- Awards and recognition including the Unicef Gold Award 0-19 Service

She also updated the Board on time the Trust Chair and members of the Senior Management Team had spent with teams in the Adult Business Unit as part of the recent 'connect and reflect week'.

System pressures
The Board noted that the only information available on infection rates was data provided by the Office for National Statistics (ONS) due to the decline in mass testing, current data indicated that 1 in 45 people had the virus.

The position in the hospitals in Leeds remained pressured due to the significant number of people presenting at Accident and Emergency and the lack of available beds for those admitted. System wide work was underway to relieve the position. Neighbourhood Teams continued to accept patients referred by 2pm for visits the following day. Ambulance handovers were happening within the required timescales but there were challenges in securing reablement and home care for patients medically fit for discharge. A significant piece of work on integrating reablement with the Trust's intermediate care services was taking place, with a target to make progress on this by October 2022. Key elements of this work included the creation of a single queue for reablement and Neighbourhood Teams, an integrated allocation process, and a more transparent reporting system so that the system could monitor pressures 'at the door' of community services.

Non-executive Director (IL) asked how many of the patients had remained in hospital because Leeds Community Healthcare (LCH) could not accept them.

The Executive Director of Operations reported that no discharges had been delayed by LCH.

Organisational update
The Board noted that Neighbourhood Teams were currently reporting either Opel level 3 or Opel level 3e, with Silver Command arrangements in place at a Trust level. Planning for the four day Bank Holiday weekend was underway to ensure resilience in teams.

Outcome: The Board:
- received and noted the Chief Executive's report and the update on system pressures.

Item 2021-22 (7)

Discussion points:
Assurance reports from sub-committees
a) Audit Committee 22 April 2022
Non-Executive Director (KR), Chair of the Committee presented the report and highlighted the key issues discussed, namely:
- **External Audit (Mazars):** the auditors had confirmed that overall audit progress was on track for the end of year reporting with no significant issues arising.
- **Annual report and accounts 2021/22:** the Committee was advised of the Trust's progress with the Trust's annual report, accounts and associated activities were proceeding to schedule.
- **Anti-crime services annual report (fraud) (TIAA):** the Anti-Crime Specialist had attended the Committee meeting to present his annual rep**o**rt.
- **Audit Yorkshire Counter-fraud risk assessment:** Audit Yorkshire fraud staff presented a paper which considered current and emerging fraud risks for the Trust for 2022/23 and determined the direction anti-fraud work will take during the forthcoming financial year.
- **Board sub-committees' annual reports 2021/22:** the Audit Committee's draft annual report was received and agreed that it accurately reflected the Committee's activities for

the year. The Committees terms of reference were reviewed, and it was agreed that some minor changes needed to be made which the Board would be asked to approve.

- **Quality Committee 25 April 2022 and 23 May 2022 (verbal report)**

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

- **Cancelled and rescheduled visits:** the Committee received a paper on cancelled and rescheduled visits, welcoming the transparency of the paper and acknowledging the challenged position of capacity and demand in the Neighbourhoods, taking only some reassurance from the detail provided verbally and the improvement intentions that were offered.
- **Spotlight on the spinal pathway collaboration and improvement:** the Committee heard about the introduction of a new system in all interventional services, where these were not in place previously and a significant transformation of the spinal injection clinic resulting in a more efficient and effective team approach resulting in increased capacity. In addition, an improved pathway for acute spinal radicular pathway was resulting in cost and pathway efficiencies and a more patient centred evidence-based approach to care.
- **Pressure Ulcer steering group:** the annual summary was presented. The expanding role of the self-management facilitators was discussed and it was confirmed that a meeting was in place to discuss the role in pressure ulcer prevention. The Committee felt the report provided reasonable assurance.

d) Business Committee 27 April 2022 and 25 May 2022 (verbal report)

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

- **Service focus:** the Committee received a presentation from the Podiatry Team which covered the challenges of the pandemic, its impact on the service, staff and patient care, current pressures and challenges, and future plans for the Podiatry Service. The Committee noted that the service had been paused while some staff were re-deployed and there had been an impact on patients, in terms of incidents and complaints, and on staff.
- **E-Rostering update:** the Project Manager delivered a presentation on the e-rostering project closure. The rollout of e-rostering had concluded and the Trust had achieved the NHS England Level 1 target. The project had been a helpful solution for the Trust to utilise during the pandemic. 90 per cent of services now utilised the system to manage capacity, and neighbourhood teams were now able to do this in line with clinical skills. The team were now looking to transition the project to a business as usual service.

Outcome: The Board

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

Item 2022-23 (8)

Discussion points:

a) Performance Brief April 2022

The Executive Director of Finance and Resources presented the summary of performance for April 2022.

The report focused on performance against the Key Performance Indicators (KPIs) which were agreed before the commencement of the financial year and is provided to highlight trends and provide assurance.

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

In relation to filling vacancies, the Director of Workforce, System Development and Organisational Development (LS) reported that all options were utilised. In terms of the pay cap on agency workers the Senior Management Team approved all 'break glass' request.

b) Annual performance brief summary (2021/22)

This report provided a summary of performance against the 2021/22 KPIs.

The Trust Chair asked if the Executive Director of Operations for any reflections on the challenge to reduce waiting lists. The Executive Director of Operations reflected that the wave of escalation in March 2022 had limited the progress and hindered improvements that had been made to that point. A number of temporary staff and locums had been recruited to assist with this work and some of these had subsequently been offered permanent employment. The Quality and Business committees would receive an update on the waiting lists work being undertaken, by the Head of Strategy, Change and Development at the meetings in June or July 2022.

There were no further questions raised about the Performance Brief reports. Both had been considered in depth at the Quality and Business Committee meetings.

Outcome: The Board:

- noted present levels of performance against KPIs in April 2022 and for 2021-22.

Item 2022-23 (9)

Discussion points:

Strategic 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.

Board assurance framework

Levels of assurance were provided for sixteen out of the 21 strategic (BAF) risks within March and April 2022, with reasonable assurance given to the majority. Two risks received limited assurance during this time: risk 1.4 (engaging patients and the public) and risk 3.4 (embedding a suitable health and safety management system).

Risk register recent changes

There was one extreme risk scoring 16 (extreme) currently on the risk register, this had been recently escalated:

- Risk 877 Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand

There were 12 risks scoring 12 (very high) listed in the report.

Outcome: the Board

- noted the new and escalated risks.

Item 2022-23 (10)

Discussion points:

Guardian of Safe Working Hours (GoSWH)

a) Quarter 4 report

The Guardian presented the report for 2021-22 Q4 which provided the Board with assurance that trainee doctors and dentists working within the Trust were working safely and, in a manner, consistent with the Junior Doctors Contract 2016 Terms and Conditions of Service.

The Board noted the current plan and work in progress to address CAMHS ST historic rota compliance and payment issues, improved engagement with Junior Doctors in the Junior Doctor Forum (JDF) and the progress made with current CAMHS ST rota work schedule

In relation to the CAMHS Historic ST rota issue the GoSWH explained that in the last year it had become apparent that there has been no monitoring of the hours worked by doctors in training on CAMHS ST on- call rota for a few years. An exercise was carried out to monitor the out of hours worked in Autumn 2021. A plan is in place to address any underpayments and compliance issues. There is a risk a fine is levied (by GoSWH in conjunction with the British Medical Association) in response to compliance of CAMHS ST on call historic rota and there could be a financial impact on the Trust if any underpayments are identified.

Outcome: The Board

- Noted that a sustainable long term solution in regard to rota assurance and JD workplans is yet to be agreed.
- Received assurance regarding the plan in place for addressing issues related to CAMHS historic rota compliance and payment issues.
- Supports GoSWH with the on-going work related to CAMHS ST historical rota compliance and payment issues.
- Noted the risk of a fine being levied in response to compliance of CAMHS ST on call historic rota and the possible financial impact on the trust if any underpayments are identified.

b) Annual report 2021-22

This report covers the period from May 2021 to May 2022.

There has been two exception report during this time period.

Significant progress has been made around i patient CAMHS on-call rota and Red Kite View (new CAMHS inpatient unit). The ST (specialist trainee) 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 Leeds and York Partnership NHS Foundation Trust.

A compliant rota has been introduced for CAMHS ST non-resident on call rota covering community CAMHS that still sits with the Trust.

Plans are in place to review the CAMHS historic ST on-call rota for compliance and payment issues.

Outcome: the Board

- Received assurance regarding Junior Doctor working patterns and conditions within the Trust.
- Received assurance regarding plan in place for addressing issues related to CAMHS historic rota compliance and payment issues.
- Noted that a sustainable long term solution in regard to rota assurance and Junior Doctor workplans is yet to be agreed.
- Noted that there is a risk a fine is levied (by GoSWH in conjunction with the BMA) in response to compliance of CAMHS ST on call historic rota and potential financial impact on the trust if any underpayments are identified.
- Support GoSWH with the on-going work related to CAMHS ST historical rota compliance and payment issues

ITEM 2022-23 (11)

Discussion points:

Ockenden Report

The Executive Director of Nursing and AHPs presented the paper which set out the implications for the Trust from the recent Ockenden Report published in March 2022 in response to the concerns at Shrewsbury and Telford Hospital NHS Trust.

Whilst the concerns were raised in relation to maternity care at the hospital, there was learning from the report for all NHS Trusts and specifically in relation to four key pillars:

- Safe staffing levels
- A well-trained workforce

- Learning from incidents
- Listening to families

The conclusion of the Ockenden report identified seven immediate and essential actions (IEAs) to improve care and safety in maternity services. Whilst this focusses on maternity services, it was felt diligent for this Trust to consider these principles across its services.

The report set out the key elements that the Trust must consider and suggests an appropriate set of actions to ensure these are considered as required. The Executive Director of Nursing and AHPs highlighted some of the key actions:

- The Director of Nursing and AHP's and the FTSUG will write to all staff and managers to remind them of the importance of speaking up and how to do this.
- The Trust will review its preceptorship programme for newly registered nurses and AHP's to ensure this is fit for purpose and meets the nationally mandated requirements that are currently being developed.
- Work on developing safe staffing standards across the Trust will continue and report via the bi-annual safe staffing report to Quality Committee and Board.
- A conflict of clinical opinion policy will be developed and updates on its progress reported to Quality Committee.
- Work will continue to establish the patient safety strategy in the Trust and this work continues to be reported to Quality Committee and Board.
- Business Unit clinical leads will review multi-disciplinary training across their respective areas to ensure this is happening as required and report back any discrepancies.
- The closed culture work led by the Director of Nursing and AHP's will continue, ensuring prompts in Quality Walks. to illicit information and ensure staff are able to speak up and challenge concerns.

Updates on these actions will be reported via the Clinical Governance report to Quality Committee, which is produced bi-monthly, alongside the updates on the closed culture work.

Outcome: the Board
- noted the report, the work already underway in the Trust and supported the proposed actions.

ITEM 2022-23 (12)

Discussion points:
Workforce Strategy update
The Director of Workforce, Organisational Development and System Development (LS) introduced the biannual update and highlighted that the pandemic had impacted on the focus of the Strategy between October 2021 and March 2022.

The Board noted that recruitment and retention continued to be a challenge with significant wok underway to address this, in addition to a review of processes and time to hire. The fourth cohort of the Allyship programme was underway and this, and reverse mentoring continued to thrive. The Equality, Diversity and Inclusion Forum had been established with a focus on inclusion-related issues and driving organisation-wide action. The organisation had received improved Staff Survey results for 2021 and health and wellbeing continued to be an area of focus both locally and at an organisational level. Teams within the Workforce Directorate continued to see high levels of demand and the Well-led indicators reflected the challenges that remained.

Outcome: the Board
- noted the update on the Workforce Strategy

ITEM 2022-23 (13)

Discussion points:
Children, Young People and Families Strategy 2022:25

The Executive Director of Operations presented the revised 2022-2025 strategy, highlighting the involvement and engagement with the Trust Youth Board, the engagement with practitioners in the Children's Business Unit, commissioners and Third Sector colleagues when revising the strategy.

Board members felt that the strategy did not reflect the community the Trust served and references to ethnicity and equity should be strengthened. It was also suggested that it was not clear how the strategy would achieve better outcomes for children and young people and some key performance indicators should be included in the implementation plan.

Subject to some revision in line with the above points the strategy was approved.

Outcome: the Board

- approved the Children, Young People and Families Strategy 2022:25.

ITEM 2022-23 (14)

Discussion points:

Infection Prevention Control (IPC) Annual Report 2021-22

The Executive Director of Nursing and AHPS presented the report which covered the period 1 April 2021 to 31 March 2022 and provided information on:

- IPC activities undertaken within the organisation and collaboratively with partners across the healthcare economy inclusive of the cooperation partnership agreement and additional commissioned services.
- Description of the (IPC) arrangements.
- Healthcare Associated Infections (HCAI) statistics and surveillance.
- Forthcoming IPC programme 2022/23.

It described the continued focus on Covid-19 over the last 12 months and acknowledging the movement towards recovering the pro-active work and particularly audit activity.

The Board felt the report positively showcased the work the Infection Prevention and Control Team did in different areas with different people.

Non-Executive Director (IL) noted the data for compliance with completing hand hygiene audits within each business unit and sought assurance that this would be an area of focus for 2022-23.

The Executive Director of Nursing and AHPs acknowledged that there had been a varied response across the Trust to these audits, and it had been difficult to quantify compliance in any meaningful way leaving any assurance less than optimal.

It had been agreed that a more structured approach be investigated with a sample being audited on a quarterly basis with the emphasis on added value.

Outcome: the Board

- noted the content of the IPC Annual Report 2021-22 and approved its publication.

ITEM 2022-23 (15)

Discussion points:

Quality Account

The Executive Director of Nursing and AHPs presented the Trust's Quality Account for 2021/22. The report detailed the quality of services offered by the Trust as an NHS healthcare provider.

The last 12 months have continued to see significant impact from the COVID-19 pandemic and the Trust response has remained a major part of the work in 2021/22. As an organisation, the Trust has innovated and continued to develop new ways of working to ensure it continued to deliver high-quality care.

The focus of the 2021/22 Quality Account continues to be the response to the pandemic but includes details of the many service and quality improvements that have been initiated or completed this year.

An additional dedicated Equity, Inclusion and Wellbeing section had been included this year to highlight the Trust's commitment to addressing health inequity, inclusion and wellbeing, for communities but also for teams and colleagues.

The Core Indicators were also presented for information.

Outcome: The Board:

- Reviewed the content of the 2021/22 Quality Account and approved it for publication on the Trust website.

ITEM 2022-23 (16)

Discussion points:

Corporate Governance

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

a) Audit Committee annual reports 2021-22 – The purpose of this report is to fulfil the annual review of the Trust's governance processes. As such a revised draft of the Audit Committee's annual report 2021/22 was attached for approval.

b) Committees' terms of reference – between February and April 2022, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness. The Board noted the summary of the changes and approved the amendments.

c) Details of the use of the Trust's corporate seal – In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal during 2021/22. The report contained a copy of the register of sealings.

Outcome: the Board

- Received and approved the Audit Committee's annual report for 2021-22.
- Approved the amendments made to the terms of reference of Board sub-committees.
- Noted the use of the corporate seal for recent legal transactions and noted the content of the sealings register in 2021-22

ITEM 2022-23 (17)

Discussion points:

CEO and Chair's action (to ratify): three 'Chief Executive and Chair's action' have been recently taken which required ratification by the Board.

a) Losses and special payments

Losses and special payments ('Flowers' case leave entitlement payments)

An Employment Appeals Tribunal in July 2018 between Flowers and the East of England Ambulance Trust ruled that extra hours worked should attract additional annual leave entitlement. This resulted in trusts being instructed to include an accrual for the payments owed in respect of leave not taken by staff for 2019/20 and 2020/21 in their 2020/21 accounts. This was funded by a central allocation of income. The Trust, in line with all other NHS organisations, had been instructed to record this special payment in 2021/22. This payment required Board approval, in line with the Trust's standing financial instructions.

The action was approved by the Chair and Chief Executive in April 2022, in consultation with two non-executive directors: Richard Gladman and Khalil Rehman who are also both members of the Audit Committee.

Losses and special payments (Maternity pay entitlement error)
An error regarding an employee's entitlement to maternity pay. An employee was incorrectly informed in writing that she would receive Occupational Maternity Pay (OMP) when, due to her length of service, she was entitled to Statutory Maternity Pay (SMP) only. The employee had made personal decisions based on the incorrect information. The special payment of £11,123 is the difference between the OMP the employee was led to believe she would receive and the SMP she was actually in receipt of.

This payment required Board approval, in line with the Trust's standing financial instructions

The action was approved by the Chair and Chief Executive in April 2022, in consultation with two non-executive directors: Richard Gladman and Khalil Rehman who are also both members of the Audit Committee.

Outcome: the Board

- ratified the decision to approve the payments.

b) **Seacroft clinic refurbishment**
At its meeting on 1 October 2022, the Board received and approved a business case for the refurbishment of Seacroft Clinic. The Board granted delegated authority to the Chief Executive and Executive Director of Finance and Resources to approve the scheme on the basis that the scheme budget of £1,762,088 was not exceeded by over 5%.That should the scheme budget be exceeded by over 5% but less than 10%, Business Committee be granted authority to approve the scheme. Should the scheme budget be exceeded by over 10%, a further report be invited to be presented to full Board.

A tender exercise had now been completed using the Procure Partnerships framework.

The total project cost had increased to £2,317,680 including VAT, which exceeded the approved budget by £555,592 or 31.5%. An element of the VAT is expected to be recoverable, but even if it is fully recovered the approved scheme budget will be exceeded by over 10%, requiring a further report to the Board.

Need for Chair and Chief Executive's Action
There was a need for approval in advance of the next full Board meeting because the tender price was based on a start date on site of 16 May 2022. Delaying this decision would have risked the contractor seeking to negotiate an increased price, especially should there be a further increase in the price of construction materials.

Approval
The Vice Chair (in the Chair's absence) and Chief Executive were asked to approve the project cost of £2,317,680.38 (incl. VAT), which they did on 27 April 2022. In accordance with the Trust's governance procedures, two members of the Business Committee, Richard Gladman and Khalil Rehman were consulted and agreed to support this decision.

Outcome: The Board

- ratified the decision made to approve the additional costs

ITEM 2022-23 (18)

Discussion points:
Leeds Health and Care Partnership Memorandum of Understanding
The Chief Executive presented the paper which recommended that the Trust Board agree the Leeds Health and Care Partnership (LHCP) Memorandum of Understanding (MoU) and note the Leeds Committee of the Integrated Care Board (ICB) Terms of Reference (for recommendation for approval by the West Yorkshire ICB on 1 July 2022). A working group had met over a number of months to develop proposals for future governance arrangements to reflect the changes to

legislation set out in the Health and Care Parliamentary Bill which is due to be enacted in July 2022.

Outcome: the Board

- Approved and signed up to the Leeds Health and Care Partnership Memorandum of Understanding.
- Noted that the Leeds Committee of the Integrated Care Board Terms of Reference. These will be recommended for approval by the West Yorkshire ICB on 1 July 2022.

Item 2022-23 (19)

Discussion points:

Any other business including questions on Blue Box items

There were no matters of any other business to discuss, or questions raised on any items in the Blue Box.

Item 2022-23 (20)

Discussion points:

Close of the meeting

The Trust Chair closed the meeting at 12noon.

Date and time of next meeting
Friday 5 August 2022 9.00am-12.00 noon

Additional items (Blue Box)	
2022-23 (21)	**Quality Strategy update–** reviewed by Quality Committee May 2022
2022-23 (22)	**Trust Priorities – 2021-22 Quarter 4 update and end of year report - reviewed** by Quality Committee and Business Committee April 2022
2022-23 (23)	**Mortality Reports – 2021-22 Quarter 4 update and Annual Report** – reviewed by Quality Committee May 2022
2022-23 (24)	**Procurement Strategy update** - reviewed by Business Committee May 2022
2022-23 (25)	**Board workplan – for noting**
2022-23 (26)	**Committee minutes for noting:** a) Audit Committee 11 March 2022 b) Quality Committee 21 March 2022 c) Business Committee 23 March 2022

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 5 August 2022

Agenda item number: 2022-23 (37b)

Title: Trust Board meeting held in pubic – draft minutes 17 June 2022 (Extraordinary meeting – end of year business)

Category of paper: for approval
History: N/A

Responsible director: Chief Executive
Report author: N/A

Attendance

Present:	Brodie Clark, CBE	Trust Chair
	Thea Stein	Chief Executive
	Richard Gladman (RG)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Helen Thomson (HT)	Non-Executive Director
	Alison Lowe , OBE (AL)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Steph Lawrence, MBE	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	Diane Allison	Company Secretary
Minutes:	Liz Thornton	Board Administrator
Observers:	Gillian Hodgson	Deputy Director for Infection Prevention and Control at Leeds Teaching Hospitals NHS Trust
Members of the public:	Two in attendance (For Item 29 only)	

Item 2022-23 (27)

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, attendees and observers that the meeting was live streamed and could be accessed via a link on the Trust's website.

Apologies

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

Introductory remarks

The Chair made some brief introductory comments. He said that he was pleased to have attended a number of events across the Trust in recent weeks including a Third Sector Strategy session, the launch of the Children and Young People and Families Strategy and a clinical quality session. All had been extremely positive events which had provided the opportunity for him to meet with members of staff face to face.

Item 2022-23 (28)

Discussion points:

Declarations of interest

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

Item 2022-23 (29)

Discussion points:

Questions from members of the public

Mr Stephen Treece attended the meeting and asked the following question: "Could you please inform me of your performance targets, including timescales, for responding to information requests from coroners' offices and your performance against these targets over the past 2 years? "

Mr Treece went on to describe a particular case that he is involved in, where there had regrettably been some delays.

The Executive Director of Nursing and AHPs responded on behalf of the Trust.
She began by extending her apologies that there had been some delay in providing the information to the coroner's office in this case and offered condolences to the family involved.

She explained that the Trust did not have internal targets as the coroner's office set the date for return of information. She was able to report that staff absence and the need to take legal advice had caused a delay in the Trust responding to two requests from the coroner's office in the last two years.

She said that she felt that it was not appropriate to share more information about this particular case in a Board meeting held in public and she suggested that she that a separate conversation with Mr Treece would be an appropriate way forward.

Mr Treece confirmed that he was satisfied with this approach.

Item 2022-23 (30a,b and c)

Discussion points: Annual report and accounts, letter of representation and external auditors' opinion

The Executive Director of Finance and Resources stated that the Audit Committee had given full and proper scrutiny to the Trust's accounts for 2021-22. At the Audit Committee meeting on 13

June 2022, the Committee had also reviewed the draft letter of representation and the audit memorandum on the Trust's financial statements issued by the external auditors, Mazars.
The Executive Director of Finance and Resources confirmed that, as noted in the draft letter of representation, directors had provided written confirmation that, to the best of their knowledge, all information relevant to the financial statements had been disclosed. The external auditors had confirmed their confidence that this had been the case. The Executive Director of Finance and Resources gave the Board members the opportunity to raise any "events after the reporting period" that needed to be included in the accounts and bring to the auditor's attention. The Board members confirmed that there were no such events.

Referring to the external auditors' opinion on the accounts, the Executive Director of Finance and Resources said he could report that the auditors would issue an unqualified opinion on the Trust's accounts. A list of the uncorrected misstatements was attached to the letter of representation as an appendix with one addition that he had notified to Board members by email on 16 June 2022. He confirmed that it did **not** impact on the primary financial statements or the financial results.

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

He drew attention to one section of the annual governance statement remained in draft: Head of Internal Audit Opinion (red text in the report). He advised that the Head of Internal Audit had now confirmed that the opinion which was that based on the work undertaken in 2021/22 reasonable assurance could be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives. No emerging risks were identified which could have an impact on the overall effectiveness of the governance, risk and internal control framework of the organisation.

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

- adopted the draft annual report and accounts (as supported by the external auditors' opinion)
- approved the letter of representation, which, amongst other matters, required that:
    - the Board considered and agreed that there are no "events after the reporting period" to include in the accounts and bring to the auditor's attention

The Board noted that the Chief Executive and Executive Director of Finance and Resources' e-signatures would be applied to relevant documents for submission to NHS England.

Item 2022-23 (31)

Discussion points:

NHS Provider licence self-certification

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

She advised that providers were required to publish a statement that they are compliant with the following two conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (condition **G6**)
- The provider has complied with the required governance arrangements (condition **FT4**)

The Trust must publish a statement on its external website declaring compliance with condition G6 and must also confirm that it complies with condition FT4.

The Board reviewed and agreed the statement that would appear on the Trust's website, within a month for Conditions G6 and FT4.

Outcome: the Board

- Agreed that the self-certification against required NHS provider licence conditions is accurate (noting particularly sections G6 and FT4) and that a statement of compliance with condition G6 and FT4 as described above may be published on the Trust's website.

Item 2022-23 (32)

Discussion points:

Any other business

No matters of any other business were raised.

Item 2021-22 (33)

Discussion points:

Close of the public section of the Board

The Trust Chair thanked everyone for attending and concluded the public section of the Board meeting. Closed at 9.20am

Date and time of next meeting
Friday 5 August 2022 9.00am-12.00 noon
Boardroom Stockdale House

AGENDA ITEM 2022-23 (37c)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 5 August 2022

Agenda Number	Action Agreed	Lead	Timescale	Status
17 June 2022				
	None to note			
27 May 2022				
	None to note			

Actions on log completed since last Board meeting on 17 June 2022	
Actions not due for completion before 5 August 2022; progressing to timescale	
Actions not due for completion before 5 August 2022; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding at 5 August 2022; not having met agreed timescales and/or requirements	

Leeds Community Healthcare NHS Trust

Public Board Meeting held in public: 5 August 2022

Agenda item number: 2022-23 (38)

Title: Chief Executive's report

Category of paper: for information

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:

- Seasonal Staff Influenza Vaccination Campaign
- Monkey pox vaccine programme
- International Nurses recruited
- Successful bid to increase "virtual ward" services
- NHS Pay Awards 2022-2023
- Leeds Health and Care Partnership update

A further verbal update will be provided at the Board meeting, including the most up to date information about 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. Seasonal Staff Influenza Vaccination Campaign - Winter 2022/23

Leeds Community Healthcare NHS Trust (LCH) CH Infection Prevention and Control (IPC) Team are working collaboratively across the system to deliver this year's seasonal influenza vaccinations. A citywide group has been formulated to work in partnership on the delivery of a Covid-19 Vaccination Programme and a staff influenza programme across all main NHS providers.

Learning from the Australian government influenza surveillance has indicated an early high increase of influenza cases, this often acts as a barometer for our forthcoming flu season in the northern hemisphere. There is however early indication that there is a good match with the strains circulating in the southern hemisphere.

Our vaccination programme is therefore of increased importance this winter, due to the last two winters where we have seen Covid-19 restrictions there have been low numbers of flu notifications, because of this there are low levels of immunity in the population which may results in an increase in vulnerability.

Programme of work:

The LCH IPC Team are leading on;

- LCH Seasonal staff influenza campaign
- Leeds City Council Adult and Children's social care staff programme
- Care Home staff programme

There will be a joint offer for staff to receive both a Covid-19 booster (awaiting confirmation of cohorts) and an influenza vaccine. These can be delivered at the same time or through separate bookings. This year for influenza we are working towards a 90% uptake of the vaccine amongst frontline health care staff (NHS). It is anticipated that we will receive the influenza vaccines by late September 2022 and clinics will be made available to staff soon thereafter. We continue to work with CLaSS to support the staffing of these programmes and where possible will be supplemented by IPC.

We are working to establish a joint tracking system for Covid and Influenza which will assist with accurate data assurance for submission, as well as detailing consent and a booking system. There is an annual cost associated with this system however it will improve efficiency around data.

A communication plan is in place, it is of great importance to work with staff to ensure the most optimum delivery of this campaign to provide safety and staff safety, particularly as we expect to see influenza in early circulation in the Autumn as experienced in the southern hemisphere.

3. Monkeypox vaccine programme

A large and increasing number of cases of monkeypox are being reported across the UK and several other countries across the world. Monkeypox is a rare disease caused by infection with monkeypox virus. Community transmission is now occurring, with a high proportion of cases currently (though not exclusively) affecting gay, bisexual and men who have sex with men. The majority of cases in the UK have been in men aged 20 to 50 and illness appears to be generally mild and not life-threatening.

There are currently regular meetings led by NHS England which take place across both the Leeds and West Yorkshire system to review the evolving picture. These meetings are attended by key LCH managers and other key partners from across the City.

LCH will deliver the MVA-BN vaccine through collaborative working between Leeds Sexual Health (LSH) and through LCH Infection Prevention Control (IPC). LSH will deliver the vaccine to those meeting pre-exposure prophylaxis eligibility criteria via opportunistic vaccination of those who are attending LSH for other reasons and via recall of those meeting highest risk criteria through data searches of previous coding. IPC will deliver the vaccine for post-exposure prophylaxis of contacts of monkeypox and will scale up as recall of those meeting highest risk through data searches of previous coding managed and facilitated by LSH. This offer will include both adults and children.

The LCH contacts clinic is due to commence on Monday 18 July 2022 (9-11am) Monday to Sunday and will run from Woodsley Health Centre.

The first vaccines were received by LCH on 13 July 2022 and NHS England has advised a regular supply will be provided from September 2022.

LCH staff meeting the criteria to receive the vaccine will be offered this initially by Leeds Teaching Hospitals NHS Trust (LTHT) occupational staff services.

4. Bid to increase “virtual ward” services

The Leeds system has recently been successful in a bid to to NHS England & Improvement, as part of a West Yorkshire Integrated Care System proposal, for additional investment to increase “virtual ward” services for our local adult population.

Virtual wards deliver a safe and efficient alternative to NHS bedded care and support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. The use of technology and remote monitoring is key to achieving this.

The Trust currently delivers effective Virtual Ward (Respiratory) and Virtual Ward (Frailty) services.in collaboration with Leeds Teaching Hospitals NHS Trust, Leeds GP Confederation, Age UK Leeds, Leeds York Partnership Foundation NHS Trust and Leeds City Council Adult Social Care. This means we have a solid foundation to build upon, and we have been actively sharing our learning on developing these services with others across the country as they develop their local plans.

This extra investment will provide £2.6m of additional investment to increase our current virtual ward offer to an availability of 65 places by April 2023; including services for people with frailty, acute respiratory exacerbations and dementia and delirium. In addition, and a new area of development for the city, will be the creation a GP led virtual ward remote monitoring clinical hub delivering 50 additional places. This will be delivered through a team comprised of GPs, advanced practitioners, nurses, pharmacists and administration staff utilising a technology-based platform and working with a range of acute specialities to manage people at home who would benefit from continuous remote monitoring. We envisage supporting people on a range of pathways for example cardiac, respiratory, diabetes, renal, surgical and oncology.

5. NHS Pay Awards 2022-2023

On 19 July 2022, Steve Barclay, the Secretary of State for Health and Social Care, announced the NHS pay awards for the current financial year (2022-23). Government accepted in full the recommendations of the pay review bodies.

Headline pay awards (All awards are backdated to April 2022).

Agenda for Change staff: £1,400 full-time equivalent consolidated uplift for bands 1 to mid-band 6. This figure is additional to the uplift for Band 1 and Band 2 staff given in April this year, in order to ensure that these salaries did not fall below the legally mandated national living wage. An enhanced 4% uplift has been applied for staff at the top of band 6, and at all points in band 7 (meaning all staff will see at least a 4% nominal terms pay rise). The Agenda for Change uplift represents a more progressive pay award than in recent years, in which the PRB and government have favoured flat rate percentage rises (e.g. 3% for all staff at all pay points). Lower banded staff have gained proportionately more than those in higher bands. However, given the current rate of annual inflation, the pay award represents a real terms loss for all staff, regardless of band and spine point. For example, a 3.7% decline (just over £1,000 in cash terms) for those at the entry point in band 5 and a 5.1% real terms loss (just over £1,800) for those at the intermediate point of band 6.

Junior doctors: 2% pre-agreed uplift, as per the 2018 pay and contractual agreements (no new pay deal).

Specialty and Associate Specialist (SAS) doctors: 3% pre-agreed uplift for SAS doctors on the new 2021 specialist and specialty doctor contracts (no new pay deal)
• 4.5% uplift for SAS doctors who remain on the 2008 contracts

Consultants: 4.5% uplift. No uplift to Local Clinical Excellence Awards, and seemingly no uplift to the recently reformed National Clinical Impact Awards

Very Senior Managers (VSM): 3% uplift, with organisations given flexibility to award an additional 0.5% to "ameliorate the erosion of the differential with the top of Agenda for Change (AfC) band 9 and to make it easier to facilitate the introduction of the new VSM pay framework."

Funding for each of these pay awards is to be taken from existing national health budgets, except for the 3-3.5% VSM uplift, which will "come out of local budgets". The NHS funding settlement only accounts for a pay uplift of 3% across the board. As such there is a reprioritisation exercise ongoing between Department of Health and Social Care (DHSC) and NHS England (NHSE) to address the shortfall. Current understanding is that NHSE is currently working through the detail of exactly how much additional funding needs to be found from its budgets in this financial year, and where it can most easily be redirected from. However, NHSE has confirmed that commitments on community-based diagnostics and technology will be delayed and funds for improving Electronic Patient Records reduced. DHSC and NHS England are continuing to discuss the financial impact of the pay uplift in future years given that the pay uplifts are a recurrent commitment. DHSC has stated that "the 22/23 pay uplift for NHS staff directly employed by NHS providers will be funded by NHSE through system allocations."

Funding for the cost of the pay award for staff employed in services commissioned by Local Authorities (LA) is being made available through the above mechanisms in 2022/23 only. Unless LA budgets are uplifted in 2023/34 by the cost of the 2022/23 pay award in addition to any pay award for 2023/24 this clearly raises the possibility of funding challenges for LA commissioned services.

6. Cost of Living

Whilst the current escalation in cost of living is outside of an employer's control, we are taking appropriate action to support employees during this period and to offset costs attributable to the employer. The Trust has recently increased mileage rates in light of fuel price increases, temporarily, by 10p above Agenda for Change standard rates, to ensure that members of staff undertaking business travel are adequately reimbursed for the business mileage they undertake.

Last month also saw the rollout to all staff of InstantPay, following a successful pilot within the LCH Bank. InstantPay enables staff to access up to 35% of their month's income in advance of payday. As part of the Trust's overall Health & Wellbeing offer, we also offer and signpost support for staff including debt advice, counselling and assistance with household budgeting.

7. International Nurses recruited

The Trust has committed to recruiting 10 internationally educated nurses (IEN's) in the 2022/23 financial year. Of the 10 applicants who were offered posts 3 then declined the offer. The remaining seven have now arrived in the UK and started in post on 20th June 2022. They come to us from the Philippines, India and Nigeria and bring a wealth of experience. The recruits will work within the Neighbourhood Teams and Recovery Hubs.

Following an initial two-week induction and orientation they have commenced a five week training programme to prepare them for their OSCE (Objective Structured Clinical Examination) which they will sit in late August 2022. They must pass this exam in order to register with the Nursing and Midwifery Council. A bespoke Preceptorship and pastoral support programme is being developed to support them in their transition to living and working in the UK, the NHS and the community and they have all been assigned a 'buddy' to provide informal pastoral support.

We are working with citywide colleagues to recruit to the remaining three nursing posts and considering the opportunity to expand our international recruitment to include podiatrists and occupational therapists.

8. Leaders Network goes live

Since approximately May 2020 I have been calling a meeting of all leaders across LCH on MS Teams to update them on the weekly situation which was rapidly changing. This meeting quickly established itself as a key meeting point in the week and an essential venue for up-to-date information and promotion of key events and ideas. Pre pandemic we had met as a leaders' network six times a year in real life for a two-hour slot. This was again always popular but inevitably with the time taken to drive, be in the event and get away – led to lower attendance. Online meetings regularly get attendances of over 100 people and the notes are circulated to over 300. This a well-read piece of weekly communication.

The meeting still takes place (due to popular demand) and is now 30 minutes. It still has high attendance rates. We have however now moved to in person events and the aim is to hold them every few months.

The first in person event took place on 30 June 2022 and we had approximately 100 leaders across the Trust. It was a great opportunity for people to meet and connect. I spoke to all the attendees about where we have come from, the demands of leadership in complex times and our strategic direction. We then had six workshops and participants could choose to attend two.

These workshops were :

- What gets in the way of inclusive leadership?
- Making stuff better – embedding continuous quality improvement at LCH
- Making flexible and hybrid working – work!
- Leadership, looking after ourselves and each other

- Making change better
- Cost of living crisis

Feedback has been good and the conversations started in the workshops will continue. The next in person event is being planned for October 2022.

9. Listening to staff

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

The Senior Management Team have recently joined the following teams, events or meetings to listen and learn:

- Transfer of Care Hub
- CUCS at Halton Clinic
- Clinical Conference
- Dietetics at Chapeltown HC
- Breastfeeding Event at Temple Newsam
- Twilight Hub at Armley
- CAMHS Outreach, CAMHS Crisis Team, and Crisis Helpline at Stockdale
- Self-management team

10. Steph Lawrence Executive Director of Nursing and AHPs MBE

We are delighted that Steph Lawrence Executive Director of Nursing and AHPs has been awarded an MBE for services to district nursing. Steph is an outstanding nurse who has done so much to raise the profile of district nursing both nationally, locally and across the wider Integrated Care System (ICS). She is an inspirational leader and always a system partner. Responsible for infection prevention and control throughout the pandemic on behalf of Leeds she was regularly out on the front line – as she is every week – working alongside our community staff and providing support. She works nationally and continues to be the lead nurse for community nursing for Ruth May and the CQC lead and advisor for community services. We are fortunate to have her working alongside us at ‘Team LCH’ and across the partnership in Leeds as a key member of ‘Team Leeds’.

11. Sustainability

The Trust’s Sustainability Department has been focused on completing the sustainability travel options appraisal which will outline and scrutinise a variety of the larger and financially committing projects for the Trust to consider within the next 1-3 years. The appraisal includes areas such as transitioning to a green-grey fleet,

electric charging point infrastructure and investment in active travel facilities across our estate. We anticipate this document will be ready for circulation in the next 2-3 months.

In other areas the sustainability and estates departments collaborated to apply for the Phase 3 Public Sector Low Carbon Skills Fund (Phase 3 LCSF) through Salix Finance. A Government grant which provides public organisations the opportunity to apply for funding the aid their heat decarbonisations ambitions. The sustainability and estates teams applied for funding to create a Heat Decarbonisations Plan, which if granted would see us achieve our objective of completing an estates feasibility study earlier than anticipated. We will know if we have been successful by the 31 August 2022.

The team are also working hard to reduce paper use and ordering throughout the Trust, aligning our goals with that of the central NHS Greener team. We strive to commit to reducing our overall paper use by 50% and for the remaining paper that cannot be eliminated only order 100% recycled products. Both ambitions we hope to achieve by 2025.

12. Children's, Young People and Families Strategy launch

On 7 June 2022 the Children's Business Unit (CBU) successfully launched the Children, Young People and Families Strategy 2022-25. The event was attended by colleagues and practitioners from a variety of organisations across Leeds who work with children, young people, and their families. The 100+ attendees had a great opportunity to network and to engage with LCH practitioners who are delivering community services to children, young people, and families.

The afternoon was a fun filled event where attendees were "invited" to participate in the occasion. The facilitators and the CBU youth board members gave a flavour, with enthusiasm and passion, of the work that was underway. The children's business unit's focus on the delivery of innovative, flexible, effective of services was highlighted throughout the presentations as was their genuine commitment to inclusivity and reducing the inequality gap.

The feedback from the event from both colleagues and delegates across the system was very positive. The "vibe" of the event was described by many as excellent. The Twitter feed was alive both during and after the event with very positive comments. More importantly, connections were made and awareness raised of the breadth of services provided by LCH to children, young people and their families.

13. Clinical Conference

Clinical Conference – We held our first joint medical, dental, nursing and AHP conference on the 14 June 2022 at Headingley Stadium. The overarching theme of the agenda was focused on the learning over the last two years with a view to what we can do in the future. The conference was well attended from across the organisation and staff appreciated the time to connect in person and spend time

reflecting on their achievements. The programme was a mix of internal and external speakers and breakout sessions covering topics such as trauma informed care, outcome measures, patient safety, patient experience and health equity. There was also an opportunity for each business unit to share their achievements. We are extremely grateful to Debra Hazeldine for sharing so powerfully her experiences as a carer and the changes that can be bought about by truly listening to patients and their family.

14. Summer of learning

On 1 July 2022 we launched a series of 'lunch and learn' sessions as part of the Summer of Learning. These sessions will run during lunchtime every day through July and August. They will provide staff with the opportunity to find out more about all the learning and development opportunities that are available through the organisation for both clinical and non-clinical staff. The timetable for the sessions is available on the Love to Learn website that has been developed as a catalogue for all learning and development opportunities on offer.

15. Making Stuff Better Update

In partnership with the Improvement Academy, we have delivered Silver Quality Improvement Training – Learning by Doing, to 30 staff from across the business units, with further delivery planned for September 2022. The training is delivered over two half days, with a follow up session three months after the training to support the practical application of the learning.
A space has been created for staff across the Trust to share and celebrate their improvements at Making Stuff Better monthly sessions, and an opportunity for staff to learn from these. The first session in June 2022 heard about improvements from services in each business unit.

The Trust is now part of the new Leeds Improvement Collaborative with Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership NHS Foundation Trust and the Yorkshire Ambulance Service to share learning between Improvement functions working across the city and develop an approach to how we work together as part of the Leeds Health and Care Partnership.

16. Leeds Health and Care Partnership update

The Health and Care Act came into effect in July 2022 making wide-ranging changes to the legislative framework underpinning the NHS, aimed at facilitating greater collaboration and integration. Under the new legislation, ICSs became statutory bodies with a two-part structure comprised of an integrated care board (ICB) and an integrated care partnership (ICP).

ICBs will manage NHS funding and performance. They will include members from trusts, local government and primary care. ICPs will be formed in each ICS as joint committees of ICBs and the relevant local authorities in the system, bringing together

a range of local stakeholders to create an integrated care strategy that meets the health, care and wellbeing needs of local populations. The NHS West Yorkshire Integrated Care System (ICS) began operating on a statutory basis on the 1 July 2022.

The ICB has established committees in each of its places, including Leeds. The Leeds Clinical Commissioning Group (CCG) has now ceased to exist. We note our thanks and appreciation for all the work they have done with us and with Leeds over their time and we continue to work closely with the newly formed Leeds Office of the West Yorkshire Health and Care Partnership, which is led by Tim Ryley.

The first meeting of Leeds Committee of the ICB took place on 14 July 2022. Bryan Machin, Executive Director of Finance and Resources attended the meeting as I was on leave. The agenda included the approval of the ambitions set out in the 'Embedding Involvement in the Leeds Committee', the allocation of Healthcare Inequalities Funding 2022/23**,** the financial plan resubmission 2022/23, and a number of governance related items. An update on this meeting including the City-wide and ICB financial position can be provided at the Board meeting.

Membership of the Leeds Committee of the ICB membership is as follows:

Independent Chair	Rebecca Charlwood
Independent Member – Finance & Governance	Cheryl Hobson
Independent Member – Health Inequality and Delivery	Yasmin Khan
Chair of Healthwatch Leeds	John Beal
Executive Members of the Leeds Office of the WY ICB Place Lead Place Finance Lead Place Nurse Lead Place Medical Officer	 Tim Ryley Visseh Pejhan-Sykes Jo Harding TBC
Partner Members, representatives from the following: Leeds Teaching Hospitals Trust Leeds & York Partnership Foundation Trust Leeds Community Healthcare Trust Leeds City Council Primary Care Third Sector Director of Public Health	 Julian Hartley Sara Munro Thea Stein Cath Roff Chris Mills Shanaz Gul Victoria Eaton

17. Leeds Health and Social Care Hub

A new Leeds and Social Care Hub was launched on 19 July 2022, bringing together the Department of Health and Social Care and a community of experts to improve

healthcare in the region for patients. Members of public, private and third-sector organisations, including the NHS, local government, universities and other health organisations, will work to address challenges including tackling health disparities and improving employment opportunities in the sector.

The aim is to position Leeds as the natural choice for professionals looking to pursue a career in health and social care spanning local government and public and private organisations, as well as for start-ups seeking to establish or expand their base in the city. This will help to retain and develop talent, while providing a boost to the local economy. It will also promote the health and social care sector as a career of choice for local residents and graduates, so that workforces reflect the communities they serve.

The partners include:

- Leeds City Council
- Leeds Community Healthcare NHS Trust
- Leeds Teaching Hospitals NHS Trust
- NHS England
- West Yorkshire Integrated Care System
- University of Leeds
- Leeds Beckett University
- Yorkshire and Humber Academic Health Science Network
- Leeds Health and Care Academy
- Leeds and York Partnerships NHS Foundation Trust

The Hub has established a steering group, which will provide strategic direction and oversight. The group includes representations from across the health and social care sector in Leeds and the West Yorkshire region. Additionally, it has set up a working group with representatives from education, health, public health and local government who will oversee the hub’s planned activities.

.

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (39)

Title: System Flow Issues and Developments

Category of paper: Assurance/Information
History: N/A

Responsible director: Executive Director of Operations

Report author: Executive Director of Operations

Executive summary (Purpose and main points)

Improving system flow is the number one priority for the Leeds health and social care system in 2022/23 as Leeds is one of the most challenged systems in the country. This paper provides an overview of the system pressures being experienced, the key headlines from the System Flow Plan and the role Leeds Community Healthcare NHS plays in supporting the system

In addition the paper details some of the innovations and development in train to support the system by creating more community capacity

Recommendations

The Board is recommended to:

- Note the pressure in the system and the priority to improve system flow
- Take assurance that LCH is playing a full role in the System Flow plan
- Note the numerous developments in place to increase community capacity

SYSTEM FLOW ISSUES AND DEVELOPMENTS

1 INTRODUCTION

Improving system flow is the number one priority for the Leeds health and social care system in 2022/23 as Leeds is one of the most challenged systems in the country. This paper provides an overview of the system pressures being experienced, the key headlines from the System Flow Plan and the role Leeds Community Healthcare NHS (LCH) plays in supporting the system

In addition the paper details some of the innovations and development in train to support the system by creating more community capacity

2 CONTEXT

The Leeds system is one of the most challenged systems in the country with very high hospital occupancy. This results from a high number of people without a reason to reside, waiting for services in the community including long term care placement, rehabilitation in a bedded setting or care at home.

The potential impact on quality of care is significant:

- Deconditioning whilst waiting for discharge
- Emergency Department (ED) overcrowding and waits
- Worse outcomes and patient experience due to slower access to elective services
- Very high occupancy increases the possibility of patients being treated in non-specialty wards and multiple moves within the hospital for patients
- People more likely need longer term and more intensive support packages after periods of delay

There are also financial consequences which include:

- Direct costs from additional bed capacity
- Direct costs from crowding in ED
- Direct costs from people in intermediate care beds waiting for care in their own homes
- Income not achieved from Elective Recovery Fund
- Demand failure and significant downstream costs from deconditioning and longer term care needs

A series of multi-agency discharge events held in the spring identified the main causes of delay and a System Flow plan was agreed. A Programme Director has been appointed to implement the plan and ensure the system is prepared for winter. The plan focuses on a number of process improvements as well as a longer term intention to invest in community services. It is essential that community providers work together to ensure capacity is created through productivity gains, reduction in duplication and new ways of working.

This paper is structured to first discuss the System Flow plan, the accountability of each organisation in the system and potential impact of any changes. The paper then outlines the steps taken particularly by LCH and Leeds City Council (LCC) and the third sector to increase community capacity.

3 SYSTEM FLOW PLAN

The objectives of the Leeds System Flow programme are:

- To increase the numbers of people able to return home either immediately from hospital or after a period of rehabilitation/recovery
- To increase the ability of the system to implement a Discharge to Assess model
- To reduce wasted bed days for people not requiring hospital care and the impact this has on people's wellbeing, experience, function and resource use longer term
- To increase investment in community health and care provision and reduce spend on hospital care for people not requiring it

The System has been set the challenge to free up 150 beds prior to the winter period.

The System Flow Programme covers the following areas:

- LTHT discharge planning process improvement work – this workstream is focused on reducing internal delays, improving communication with onward services to support readiness for timely discharge of patients. Lead: LTHT
- Optimising the Transfer of Care (ToC) Hub and process – evidence suggests that having a multi-agency discharge hub is the most effective way of ensuring patients leave hospital on the right pathway. This workstream includes optimising the ToC team, clarifying the accountability arrangements and process improvement to reduce delays in facilitating transfers of care Lead: LCH
- Capacity for rehabilitative and recovery care at home – this strand of work aims to reduce delays on pathway 1 (people leaving hospital (or CCB) with a new, additional or restarted package of care from health and/or social care). This includes improvements in productivity in reablement, recruitment of staff, initial work on Active Recovery integration. Lead: LCH
- Capacity for rehabilitation or recovery in residential settings – this workstream looks to improve the flow of people from hospital into community care beds (CCBs) or discharge to assess beds. Lead: Leeds office of the ICS
- Reducing delays for people waiting for access to care homes. Lead: LCC
- Intermediate Care redesign – this is a large project looking to right-size the intermediate care offer at home and in community care beds

Lead: Leeds Office of the ICS

- Improving pathways for people with dementia – this work includes ensuring specialist dementia support is available in hospital settings and work with care home providers to improve confidence in accepting patients. Lead: LYPFT

The plan is being closely monitored by the Programme Office with regular reporting to system Chief Officers via the System Resilience and Reset Assurance Board (SRARAB)

4 INCREASING CAPACITY IN COMMUNITY SERVICES

The System Flow plan addresses the main issues that contribute towards unnecessary delays in hospital. It is recognised that additional investment will be necessary in community capacity to facilitate greater admission avoidance and timely discharge home. The Intermediate Care redesign work is in its infancy and is unlikely to provide the detailed financial and capacity modelling to inform an investment plan in this calendar year. However some modelling has been undertaken to estimate the requirement for investment in the current year. This was discussed at the SRARAB meeting in July and agreement made to recruit to the following areas:

- Self-management facilitators for hospital and intermediate care settings - These roles work with people to maximise their ability to manage their own care needs. The proposal would increase the capacity of the service to provide regular in-reach to community and hospital beds. The proposal is to increase the numbers of self-management facilitators and, to support the growing service, to invest in additional roles to provide leadership and support to this function in our system. From evaluation of our current service there is strong evidence that investment in this service reduces demand on neighbourhood teams and supports people to live independent lives. It is estimated that the new investment would enable 2000 neighbourhood team visits per month to be redirected to same day response and proactive care
- Community Therapy to support active recovery – this will enable more people to be better supported to achieve independence in community settings, with a reduced requirement for inpatient care in hospital and community beds. The proposal will enhance existing therapy capacity in Neighbourhood Teams and support people to leave hospital on pathway 1. The new investment would enable 150 new patients to be seen each week
- SKiLS (reablement) workers (to be employed by LCC). This investment would increase the caseload by 14 people.
- Night sitters – this will prevent admission as it will enable people who have attended ED late in the evening to return home. The new investment would allow a further 9 families to be supported overnight.

5 THE ALLIANCE WITH ADULT SOCIAL CARE

A provider alliance has existed since 2018 between Leeds City Council and Leeds Community Healthcare Trust for the provision of two Recovery Hubs.

The Alliance now has a vision to bring together all urgent response and short-term rehabilitation and reablement functions to create one co-ordinated health and social care delivery model. In addition to the Recovery Hubs the Alliance will provide the multi-agency Transfer of Care hub, develop Active Recovery and develop a Community Wellbeing Service which will integrate home care with NHS and social care services.

The Alliance Board has been established and the main focus of the work at the moment is on Active Recovery.

Active Recovery brings together the rehabilitation elements of LCH Neighbourhood Teams (NTs) and SkILS Reablement to create a joint health and care rehabilitation and reablement offer. The service will enable a better, more responsive offer to support people to maintain their independence at home (avoiding hospital and community bed admissions where possible and supporting timely discharge once someone is ready to come home).

The Active Recovery Service will work with a wide range of partners and will be part of the Leeds response to deliver Ageing Well priorities (2 hour/2 day) and respond to the Intermediate Care Redesign and System Flow improvement work.

The Active Recovery programme is moving from the initial phase of programme set up (Phase 1 - March to July) into Phase 2 (July to October) to consider and implement agreed key priorities.

Phase 1 actions completed include:

- Megan Rowlands has been appointed as Programme Director and started in post at the beginning of July
- Project team – Project and Programme Managers in place – joint resource from LCH and LCC
- Active Recovery Project mandate and Governance agreed
- Initial Milestone Plan for key priorities for Phase 2 approved
- Initial scoping work including service offer, systems in use, referral pathways

The agreed priorities for **Phase 2** are:

- Creating a single point of access and single allocation process
- Initial service design and operating model development, including identification and implementation of quick wins
- Joint reporting and escalation process

Work to manage the **interrelationships** is a key focus. These are between the Active Recovery programme and:

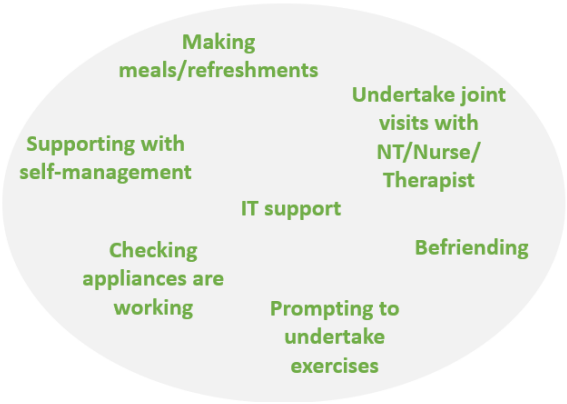
- internal improvement programmes within SkILS Reablement (ARCC) and Neighbourhood Teams (NMTP)
- other Alliance Projects, and

- related system work within the Intermediate Care Redesign programme and the System Flow Programme (Pathway 1).

Phase 3 (October 2022 onwards) will provide scope to further develop the joint service model (taking account of other related programmes of work, particularly the Intermediate Care Redesign Programme) and implement further changes including joint approaches to training and development

6 ENHANCE

The Enhance programme links Neighbourhood Teams with 14 third sector organisations to enhance capacity in both sectors and to avoid both delayed discharges and readmissions. The programme went live in June 2022. The third sector partners act as "proxy family" and provide in-home and community services to recipients across the city. Interventions include:



An evaluation is underway which aims to demonstrate the impact on NT workload as well as benefits for patients, staff and the system

7 VIRTUAL WARD/HOSPITAL AT HOME

Leeds has been successful in its bid for funds to further develop our hospital at home and virtual ward offer.

Building on the success of the existing Virtual Wards, the Leeds system will increase the caseload to 65 by April 2023 and the ward will support frailty, respiratory, cardiac and dementia and delirium. This will increase hospital avoidance and reduce length of acute hospital stay. The current hospice at home model is also being considered for inclusion. A medical MDT is being developed to provide clinical leadership to the ward in addition to the medical responsibilities currently being provided by Geriatricians. Referral pathways will be strengthened with referrers from LTHT, Primary Care and Yorkshire Ambulance Service.

Fifty additional places will be provided through a remote monitoring clinical hub. This will see the creation of a core hub team (GPs, advanced practitioners, nursing and administration staff) utilising a tech-based platform and working with a range of acute specialities to manage people at home. It

is envisaged that the hub will support people on a range of pathways for example cardiac, respiratory, diabetes, renal, surgical and oncology.

8 RECOMMENDATIONS

The Board is recommended to:

- Note the pressure in the system and the priority to improve system flow
- Take assurance that LCH is playing a full role in the System Flow plan
- Note the numerous developments in place to increase community capacity

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 5 August 2022
Agenda item number: 2022-23 (40a)

Title: Nominations and Remuneration Committee – 17 June 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 17 June 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 February 2022.

Items discussed:

Chief Executive and Directors' pay disclosure report:

The Committee noted the report relating to Directors' pay disclosure and which had also been included in the Trust Board papers for the meeting that had taken place earlier in the day.

Review of Annual Workplan:

The Director of Workforce confirmed that this was approved at the previous meeting of the Committee. A discussion ensued about adding to this workplan a review of the Trust's approach to reward and recognition overall and in light of recent discussions relating to winter financial incentives. It was agreed a review of the Trust's approach to reward both current and for the future should be added to the workplan and brought back to the Committee for discussion.

Additionally the Committee briefly discussion succession planning and development for the senior team and it was agreed that there should be a further discussion on the detail of this outside of the meeting.

Winter Incentives:

The Committee retrospectively ratified the virtual approval of a further extension of the LCH Winter Incentives package up to and including 5 June 2022 to cover the Jubilee Bank Holiday weekend.

Additionally, the Committee considered the future use of particular incentives and these were approved for use up to the date of the next meeting in September, but it was noted that several additional actions and clarifications were needed prior to their use. Further discussion is to take place on this package of incentives at the September meeting.

Temporary Local Adjustments to Mileage Rates:

The Committee ratified the decision made by email earlier in the week to increase the uplift to the mileage rate by 3 pence per mile to 10 pence per mile from 1 July 2022 to 30 September 2022.

Recommendations

The Board is recommended to note this information.

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (40b)

Title: Charitable Funds Committee June 2022: Committee's Chair assurance report

---

Category of paper: For assurance and decision
History: N/A

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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board from the Charitable Funds Committee held on 22 June 2022.

Recommendations

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

Charitable Funds Chairs Assurance report

1 Introduction

The Charitable Funds Committee is a sub –committee of the Trust Board who also act as the Board of Trustees for the Charity. The Committee oversees the strategic director of the LCH Charity and provides assurance to the Trust Board following each quarterly meeting.

2 Background

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

3 Current position/main body of the report

Charitable development updates

- Following discussions at the last meeting, a further discussion was held to decide the way forward with regards recruiting to a charity fund raiser. This was a follow up from last meeting after a review of the reserves policy. It was agreed there is not enough money in the charitable funds to allow this to happen.
- The committee therefore discussed what next for the charity as this means there is no one to steer this. It was agreed that a conversation will be pursued with the Leeds Cares Charity at Leeds Teaching Hospitals. This did happen previously but several years ago, and therefore it is felt appropriate to re-visit this now.

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.

Request to purchase a mini bus for Hannah House

The Director of Finance presented the case and this was agreed by the committee that a mini bus can be purchased up to the value of £40,000.

4 Impact:

4.1 Quality

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

4.2 Resources

As above in terms of the potential risks regarding the suggested fundraiser post.

4.3 Risk and assurance

As above in relation to the potential financial risk.

5 Next steps

N/A

6 Recommendations

The Board is recommended to:
Receive this report.

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (40ci)

Title: Quality Committee Chair's Assurance Report 27 June 2022

Category of paper: For Assurance

History: N/A

Responsible director: Quality Committee Chair

Report author: Quality Committee Chair

Executive summary:
This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 27 June 2022. This meeting was held via MS Teams. The Committee received a number of apologies, and whilst the meeting was quorate, it was agreed that the workshop item on Health Equity would be deferred to a future meeting (October 2022).

Recommendations:
The Board is recommended to note this information.

Items discussed:

System pressures update

The Committee received information on the current Covid infection rates, the number of outbreaks in local care homes, and staff Covid-related sickness. A recent review of system pressures by the National Discharge Team had concluded that the Trust and its local partners were doing everything possible across the system in terms of discharge. Further information about the numbers of staff affected by long-Covid would be brought to a future meeting. The Committee also discussed the impact that the rising cost of living including fuel costs was having on staff and the action being taken by the Trust to support staff in these difficult circumstances.

Quality Assurance and Improvement Group (QAIG) escalations

Open and closed cultures were the topic of discussion at the recent QAIG workshop style meeting. The feedback from the Group was that it was important to focus on what a good, open culture would look like and to promote this. As a result of the feedback, some of the questions in the Quality Walk have been amended to help find out whether services do have an open culture.

Risk Register

The risk register report was presented by the Chief Executive. The Committee noted the revisions to the risk register. There had been consideration of the risk concerning capacity pressures in Neighbourhood Teams that were impacting the ability to deliver full range of clinical supervision and annual appraisals. SMT had reviewed this risk and agreed that it would remain a ‘12’ (high risk), and this was relayed to the Committee.

Safeguarding Annual Report

The Committee reviewed the draft annual report, which will be presented at the Board in August 2022 for approval to publish. The Committee provided feedback and requested that additional information should be provided about the impact that the activities described in the report had made. It was also suggested that the increased volume of referrals that the team had dealt with should be acknowledged as well as the team’s engagement with the Prevent Strategy and the role they had played in early interventions.

Safeguarding strategy update

The strategy objectives were mostly on track. The Committee discussed the Safeguarding Team's current pressures and challenges and the pattern of referrals for concerns relating to school aged children.

Other business

The Executive Director of Nursing and Allied Health Professions advised the Committee that the two parents who had attended Board in May 2022 to describe their son's experience of healthcare, had now met with herself and the Clinical Lead for the Children's Business at their home to relay their experience as parents and to share some of their memories of their dearly loved son who died last year. Sessions with staff are to be planned, involving the parents, so that staff learn first-hand about the importance of listening to parents and regarding them as experts in their child's care.

Assurance levels

The Committee considered the strategic risks on the Board Assurance Framework and agreed that items on reduced agenda were not sufficient for the Committee to determine assurance levels.

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (40cii)

Title: Quality Committee Chair's Assurance Report 25 July 2022

Category of paper: For Assurance

History: N/A

Responsible director: Quality Committee Chair

Report author: Quality Committee Chair

Executive summary:
This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 25 July 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.

System pressures update
The Committee received an update on system pressures – a similar update will be provided to Board. The Committee was advised that analysis of Accident and Emergency attendance was underway to see how the system could provide support to reduce this pressure.

Quality Assurance and Improvement Group (QAIG)
The number of overdue incident reviews was escalated as a concern. The backlog of incidents was due to reduced resource in the Clinical Governance Team and staff pressures in the Adult Business Unit. The resource issue within Community Dental Service (paediatric) was also escalated and the Committee was advised that a new senior dentist had been recruited and there was ongoing dialogue with Leeds Teaching Hospitals Trust regarding a revised staffing model.

Cancelled/rescheduled visits
An audit was carried out in July 2022 to provide a better understanding of the number of cancelled and rescheduled Neighbourhood Team (NT) visits and the arrangements made to deliver care to mitigate the impact on the patient. SystmOne cannot be used at present to produce reliable data for these audit purposes therefore a manual audit process was developed as a temporary measure until Allocate software is in place. The latest audit data suggest that the management of Neighbourhood Teams visit capacity is slowly improving with a reduction in the number of overall cancelled and rescheduled visits. 19 patients did not receive a safety netting phone call during the 3 audited dates out of the 115 that were cancelled or rescheduled, and as these phone calls are an important part of clinical decision-making, this will be an area of focus to ensure this position improves. The Committee agreed that this paper provided greater assurance than the previous paper on this topic that was received in May 2022. A further update will be provided in September 2022.

Service spotlight: Children's Business Unit waiting lists
Representatives from the Children's Business Unit presented information about the waiting lists and back logs, with a focus on the quality of care being provided. The context and challenges those services were working within included: the pandemic, the pausing of services, redeployment of clinicians, the impact on children, young people and families, health equity and inclusion issues – access to digital had widened the equity gap. They showcased the Audiology Service to demonstrate improvement and good practice and advised the Committee that those principles of improvement were being shared across the Business Unit. A great piece of work had previously been conducted across the Business Unit on sustainable waitlists to help understand and plan for demand and capacity, and this would be utilised for service modelling. A recruitment video was being planned to encourage people to apply to work for children's health services in Leeds. Digital exclusion risks were being mitigated by ensuring that various communication methods were available.

Medication waiting times were discussed, and the Committee was advised of the plan for increasing the number of non-medical prescribers.

Performance Brief – June 2022 (see copy in Board papers pack)
The Committee appreciated the additional section that has been introduced on inquests. It was agreed that more narrative was required on what the Trust's involvement was for these inquests. The Committee also asked for additional information on upheld complaints, claims that were being pursued further than the initial disclosure stage, serious incidents, and duty of candour incidents.

The Committee was assured that whilst there were pressures to resource the Police Custody Service, there had not been a breach of contract as response times were being adhered to.

Safe staffing report (see copy in Board papers pack)
The Committee was assured that safe staffing was being maintained in the inpatient unit (Hannah House). Referral rates into this service were currently low and the Committee discussed the possible reasons for this including parents' perceptions of risk. Areas that were challenging to maintain safe staffing levels were Police Custody and Wetherby Young Offenders Institute.

The Committee agreed that the information presented in tabular form was useful to demonstrate the pressures and asked for the next report to be enhanced further to include an indication of risk levels.

Serious incidents report (see copy in Board papers pack)
The Committee discussed the ways in which learning from incidents was being shared, including neighbourhood teams' quality meetings and other shared learning events, and how it could be shared more widely. The Committee also discussed the Duty of Candour regulation and how patients/families had the right to refuse to engage with any part of the Duty of Candour process, although the Trust had a legal and contractual duty to inform them of an incident and of the process.

Patient safety report (see copy in Board papers pack)
The Committee discussed the detection of Vaccine Derived Polio Virus type 2 in London sewage samples and was advised of the programme of child immunisation catch up clinics.

Medical Directors report (see copy in Board papers pack)
The Committee endorsed the submission of the Medical Director's statement of compliance.

Service visit – Twilight Hub
The Executive Director of Nursing and AHPs and a Non-Executive Director, Alison Lowe visited the (combined) Twilight Hub in June 2022. Since the visit, the hub has now reverted to having three hubs in response to the risks from having a lot of staff occupying a small space at a time when Covid infection rates were rising and the problems of the noise levels that staff were having to work in. It was clear from the visit to the Hub that a high level of flexibility and commitment was being displayed by staff members, which was commendable.

Clinical governance report
The Committee was advised that an inspection had been completed in North Police Custody by Her Majesties Inspectorate of Constabulary, Fire and Rescue Services

(HMFRCS) including the Care Quality Commission. Initial feedback is positive, and the report will be shared in 6 to 8 weeks

Clinical outcomes project
The Committee was apprised of the closure stage of the Clinical Outcomes project, which had reached the end of its three-year project life and would now be integrated into business as usual. Concerns were raised by Committee members that there were risks involved in doing this and the paper evidenced variations in maturity between different services. It was agreed that it was important that the Board and Committee had sight of performance against a range of outcome measures and that the conversion to business as usual needed to be robust. The Committee agreed that outcome measures performance should be retained on its agenda.

Patient experience report (see copy in Board papers pack)
Complaint numbers were increasing back towards pre-pandemic levels. The Committee requested more information to be provided about upheld complaints. The Committee was advised that the Trust was exploring the possibility of recording phone calls, as a record of the clinical advice provided by phone.

Clinical Audits report
The Committee noted that there had been a decrease in audit activity within the Adult and Children's Business Units. This was explained in the report as being due to increased service pressures. As clinical audit was a marker of quality, it was recognised that it was important for the clinical audit programme to get back on track. The Committee requested that future reports demonstrated learning and improvements from all clinical audits.

Levels of assurance assigned by Quality Committee

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 Assurance report • Clinical Governance report • Risk register report • Mortality Report Q1 • Outcome measures update report • Safe staffing report • Clinical audit • Medical director's revalidation report • Patient safety incident report • Service spotlight – CBU waiting lists • Cancelled and rescheduled visits: update	Reasonable	See comments in assurance report on Clinical audit report (2021/22) and audit of Cancelled and rescheduled visits
Risk 1.2 The risk that there are insufficient **clinical governance arrangements in place for new care models**	**9 High**	• Mortality report • Serious incidents reports (any joint investigations)	Reasonable	
RISK 1.3 The risk that the Trust does not maintain **and continue to improve service quality**	**8 High**	• Covid / system pressures update • Performance Brief (safe) • QAIG Assurance report • Clinical Governance report • Safeguarding Children's and Adult's Group: minutes • Risk register report • Serious Incidents Report • Board service visits reports • Service spotlight - CBU waiting lists • Patient safety incident report • Cancelled and rescheduled visits: update	Reasonable	

RISK 1.4 The risk that the Trust does not **engage with patients and the public effectively**	**12 V High**	• Performance Brief (caring) • QAIG Assurance report • Patient Experience and Engagement Report • Clinical Governance report (service visits) • Service spotlight - CBU waiting lists	Reasonable	
RISK 1.5 The risk that the increased demand for services will **affect the provision of timely, equitable, quality** services and patient outcomes	**12 V High**	• Covid-19 / system pressures update • Performance Brief • Clinical Governance report • Risk register report • Serious Incidents Report • Outcome measures update report • Service spotlight - CBU waiting lists	Overall reasonable, with elements that were limited	Pressures being experienced that are within the Trust's control are being managed well. The Committee recognised that some of the systems pressures and challenges were external, and they had to be managed by the system

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (40d)

Title: Business Committee Chair's assurance report 29 June 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 29 June 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.

Report: Fire Risk Assessments
The Committee was advised of the current situation regarding the backlog that had built up within the fire risk assessment programme, and the reasons for this. The Committee recognised the pandemic had prevented assessments taking place as they require witnessing staff but measured and plans are in place to perform the assessments. A target date of June 2023 has been set for all fire risk assessments to be brought up to date, and a commitment to maintain and monitor a sustainable programme of regular fire risk assessments going forward. There are concerns that some of the buildings occupied but not owned by the Trust may not have had recent fire risk assessments conducted as it was proving difficult to access that information.

Report: Tackling our backlogs
The Committee received a comprehensive report that described the existing organisational initiatives that were focussed on improving the organisation's backlogs and waiting list position and it considered how work could be better aligned and how to create a more impactful and sustainable approach to managing people who are waiting for care. The Committee agreed that there were a comprehensive set of measures in place to manage and reduce the backlogs which was welcomed. There remains a concern that there are hidden waits (secondary waits within services) for patients within the health system that are not as closely monitored, and this area requires more focus. The Committee also agreed further work with patients to better understand the impact on them was required.

Board Assurance Framework (BAF) review
The Committee reviewed the BAF strategic risks assigned to the Committee and agreed a number of additional sources of assurance that would be either incorporated into existing reports or added to the workplan as additional items of assurance.

Major Change Programmes
The Committee discussed the criteria that should be applied to determine which of the current programmes and projects should be major change programmes. Senior Management Team will discuss this further and consolidate their views.
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**	• Major Change Programme report (verbal)	Reasonable	More work is needed to gain clarity on the scope and reporting of major projects and their relationship with projects reported through strategy updates.
RISK 2.2 The risk that the Trust does not deliver its **contractual requirements**	**6 Moderate**	• Operational and non-clinical risks register • Waiting list update report	Reasonable	
RISK 2.8 The risk that **waiting times** for appointments are not reduced	**12 V High**	• Covid / system pressures update • Waiting list update report	Reasonable	The Committee noted the significant amount of work being done to understand and manage the waiting lists and reduce the backlog. The data on backlogs requires further enhancements to give the full wait list picture
RISK 3.1 **The risk that** the Trust does not have **suitable and sufficient staff capacity and capability** and is it	**16 Extreme**	• Covid update • Waiting list update report	Reasonable	

maintaining a low level of **sickness absence**				
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 escalations • Fire risk assessment programme report	Reasonable	The plan to reduce the backlog of fire risk assessments, and the monitoring process provided reasonable assurance to the Committee.
RISK 3.6 The risk that the Trust is not maintaining **business continuity** in the event of significant disruption	**12 V High**	• System pressures update • Risk register report	Reasonable	

Public Board Meeting: 5 August 2022

Agenda item number:

Title: Business Committee Chair's assurance report 27 July 2022

Category of paper: For assurance
History: Not applicable

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

Executive summary (Purpose and main points)
This report identifies the key issues for the Board from the Business Committee held on 27 July 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, other information received and the Committee's discussion.

Items discussed:

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. An updated picture will be provided at the Board meeting.

Service Focus: Liaison and Diversion Service
The Operational Head of Service attended the Committee meeting to present information about the Liaison and Diversion Service. The service supports vulnerable people who are in the criminal justice system who need help to access appropriate health and social care services. The regions the service operates within is Hull and East Riding, and Lincolnshire. The team have built up good relationships with stakeholders: the police, probation services, substance misuse services and the courts. Bringing a team together from staff who previously worked within various other organisations had been challenging but ultimately rewarding. Other challenges included the large geographical area the service covers, and the effect of the pandemic. The Committee heard of the innovative recruitment programmes where value-based interviewing techniques were used to best effect. A case study of one service user was provided to demonstrate the life-changing difference this small service can make to very vulnerable people.

Third Sector Strategy (see copy in Board papers pack – blue box item)
The Committee was advised that notable developments included:

- Launch of the 1 year Enhance programme with most of the 14 third sector delivery partners going live with referrals from 20 June 2022.
- Success in the Children's Business Unit developing a network of 3rd sector organisations who publicise to their members the involvement opportunities across LCH children's services and who also promote LCH's Youth Board.
- Work with BASIS (NHS Charities Together funded project which LCH partnered) to develop services' awareness and understanding about the needs of women sexworkers and / or women who are sexually exploited and the barriers they experience, develop services to be accessible and inclusive, and BASIS supporting women to access services.

A recent focus has been the heightened workforce challenges experienced widely across the third sector, and more information will be provided to the Committee in due course. The Committee agreed that the strategy was progressing well.

ERIC submission report
Annually, the Department for Health and Social Care mandate all NHS Trusts in England to provide information relating to the cost of providing, maintaining and servicing NHS estate, called the Estates Return and Information Collection (ERIC). This is a benchmarking exercise. The Committee was advised that sites with no inpatient beds and a gross internal floor area of 500m2 or more are to now be reported as individual sites, whereas in previous collections they would have been included in the 'Other reportable sites' return. For LCH

this means that the individually reported sites have increased from 2 in 20/21 to 29 in the 21/22 return. The Committee discussed the challenges in collating all the information and the benefits of receiving the benchmarking data. Work had commenced to understand differences in costs per site and when the national data was made available, this would be utilised to understand any outliers from the benchmarked data. The results of the benchmarking exercise will be available in the autumn.

Change Management (projects) update
The LCH Change Programme was launched in April 2022 to bring all major pieces of change and transformation work together into a comprehensive change programme, with change projects aligned to organisational priorities. The programme is overseen, on a monthly basis, by the Change Management Board, which receives exceptions reports from change projects. The Committee reviewed the information presented and was assured that projects were being progressed.

5-year Konica multifunction printer contract
The Committee approved the award of a new contract to Konica for multi-function printers over a 5-year term.

Performance Brief June 2022 (see copy in Board papers pack)
The Committee discussed the possible reasons behind the number of staff leaving within the first 12 months of their employment and the work being undertaken to support new staff. The Committee was interested in knowing more about the recent recruitment of international nurses and any lessons to be learned and shared about this. This will be included in a future Workforce report.

Finance quarterly report
The Executive Director of Finance and Resources presented the current financial forecast for the Trust including the year-to-date surplus versus a break-even plan. He explained the financial risks for the Trust and across the wider system (Leeds and West Yorkshire), which included non-recurrent funding, inflation rates and the recently announced pay award. The Committee acknowledged the complexities of the system risks and that where there were financial issues within a system, there was a need for a collaborative response.

Partnership traded contract performance 2021/22
There are six services the Trust delivers in formal partnership with other providers. Five of these are within the Specialist Business Unit. The services are the Leeds Sexual Health service, the Leeds Mental Well-being service, the Forensic Youth Service, the Humber Court Liaison and Diversion service and the Tier 3 Weight Management service. The final service is the Community Care Beds Service (CCBS) providing 30 general and 10 dementia care beds in the Adult Business Unit. The Committee was apprised of the financial performance of each service: three services had made a profit, two had made a loss and one had broken even.

Health and Safety compliance report (see copy in Board papers pack – blue box item)

This report provided the Committee with details of the review of the health and safety management arrangements, legal compliance, accident performance data and health and safety activities and described further planned activities which are required to strengthen the management system and fulfil the Trust's health and safety obligations.

The Committee queried the areas of non-compliance noted in the report. It was explained that there was a currently a much greater focus on audit rather than inspection, and this would continue to identify areas of non-compliance and prioritise the actions required to mitigate risks to staff and others. The Committee remained concerned and has requested that regular update reports are received to provide assurance of progress and highlight areas of risk.

EU Exit plan
The Committee was updated on the impact of EU Exit on workforce issues following the introduction of the EU Settlement scheme and recruitment of EU nationals since leaving the European Union on 31 January 2020. The report reflected the positive news that the Trust has not had any staff affected by the changes required to live and work in the UK and the workforce has seen an increase in the number of EU nationals employed by the Trust.

Workforce quarterly report
The report provided an update from LCH's Workforce portfolio, with particular focus on wellbeing, resourcing, leadership and equality, diversity & inclusion. The Trust continues to operate in a context of higher than usual sickness absence, exacerbated by Covid infection rates across the region during quarter one. With increasing fuel costs and the highest national inflation for a generation, there was a strong focus on financial wellbeing at present. The Equality Diversity & Inclusion Forum has grown in size and reach, with key pieces of work being developed including a "No Bystanders" summit scheduled for the autumn.

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 Strategy update report • Change Management Board update (projects update) • List of major change programmes • Business case: new Head Office	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) • Operational and non-clinical risks register • Service focus	Reasonable	
RISK 2.3 The risk that the Trust is not **improving productivity, efficiency and value for money**	**9 High**	• Estate strategy update • 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) • Quarterly Finance Report • Estate Strategy update report • Partnership finance 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**	• Change management reports • Service focus	Reasonable	

RISK 2.8 The risk that **waiting times** for appointments are not reduced	**12 V High**	• Covid / system pressures update • Performance Brief • Service focus		
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**	**16 Extreme**	• Performance Brief (turnover and stability) • Covid / system pressures update • Internal audit reports • Safe staffing report • Third Sector Strategy report • Service focus • EU Exit plan report • Workforce report	Reasonable	
RISK 3.3 The risk that the Trust is not investing in developing **managerial and leadership capability**	**9 High**	• Workforce report	Reasonable	
RISK 3.4 The risk that the Trust does not develop and embed a suitable **health and safety management system**	**12 V High**	• Health and Safety compliance report • Performance Brief (staff RIDDOR incidents) • Performance Brief (statutory mandatory H&S compliance) • Health and Safety Group minutes	Limited	See Chair's assurance report information on the Health and Safety compliance report
RISK 3.5 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	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 • Partnership finance report • Third Sector Strategy report	Reasonable	

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (41)

Title: Performance Brief (June 2022)

Category of paper: for assurance
History: Quality Committee – 25 July 2022
Business Committee – 27 July 2022

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

Performance Brief – June 2022 / Q1 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.

Committee Dates

- Quality Committee – 25th July 2022
- Business Committee – 27th July 2022
- Trust Board – n/a

Recommendations

Committees and the Board are recommended to:

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

Main Issues for Consideration

Safe

- 63 incidents were reviewed of which 4 were escalated to a Serious Incident (SI).
- There were 13 Central Alert System (CAS) notifications in the period. 11 of these required a response, and actions are on track to complete within timescale.
- This is a new section of the report following discussion with Executive Director of Nursing. Currently there are 7 open inquests which have been notified to LCH in 2022/23. There are 2 cases where there has been learning for the Trust in terms of process.

Caring

- There were 1070 Friends and Family Test (FFT) responses in May and June 2022 and 93% respondents rated their care as good or very good.
- There were 21 complaints received in May and June 2022, an increase from the last reporting period (14).
- There were 173 concerns received in May and June 2022, an increase from the last reporting period (105).
- There were 181 compliments received in May and June 2022, an increase from the last reporting period (145).

Effective

- For 2017/2021, there are seven NICE Guidance outstanding.
- For 2021/2022, there are 19 NICE Guidance currently open.
- For 2022/2023, there are 11 open NICE Guidance.
- The five NICE Guidance that predate 2019/2020 will be reviewed with a recommendation for closure made to Quality Committee where appropriate.

Responsive

- Consultant-led RTT waits continue to be below target, achieving 83.4% in June 2022
- Non-reportable waiting times have held firm at 90.0%
- DM01 performance has remained consistent during Q1, showing good improvements compared to Q4 2021/22. Performance for June stands at 46.9%
- LMWS continues to see patients in line with 6-week and 18-week targets, but further declines are reported in screening targets
- CAMHS waiting time performance has improved dramatically for eating disorder patients, but has remained consistently low for ACBI and NIA referrals

Well-led

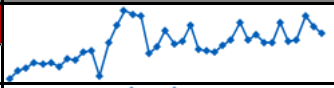
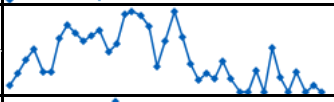
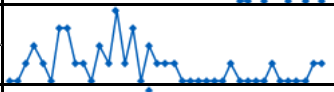
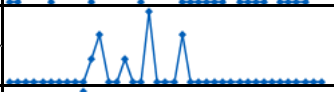
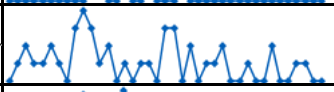
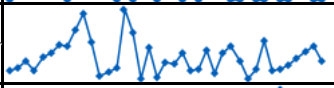
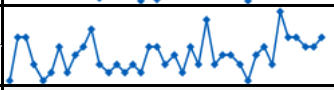
- Turnover continues to hover just below target and continues to be of concern
- Overall sickness remains high and above target for all areas, other than Corporate Directorate. This is mainly attributable to long term absence, with nearly 1% of all long-term absences due to Infection Diseases/Covid related absences
- Appraisal rates have shown an improving trend since October 2021, but remain some way below the target
- Overall statutory and mandatory training compliance remains below target, largely due to the introduction of new Patient Safety requirement for all staff
- Leavers within 12 months continues to stabilise and remains within the target for the second consecutive month
- Overall BME representation in the workforce continues to trend well

Safe – June 2022

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

Leeds Community Healthcare NHS Trust

Data

Safe - people are protected from abuse and avoidable harm	Responsible Director	Target - YTD	Financial Year	Apr	May	Jun	Q1	YTD	Time Series (from Apr-19)
Patient Safety Incidents reported as Harmful (per 1K contacts)	SL	1.42 to 2.09	2022/23	2.30	2.11	1.99	2.13	2.13	
			2021/22	1.68	1.65	1.76	1.70	1.70	
Serious Incidents (per 1K contacts)	SL	0 to 0.1	2022/23	0.00	0*	0*	0*	0*	
			2021/22	0.02	0.02	0.04	0.03	0.03	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	8 per year	2022/23	0*	1*	1*	2*	2*	
			2021/22	0	0	0	0	0	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	2022/23	0*	0*	0*	0*	0*	
			2021/22	0	0	0	0	0	
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	10 per year	2022/23	1*	0*	0*	1*	1*	
			2021/22	1	1	2	4	4	
Number of Falls Causing Harm	SL	NULL	2022/23	51	55	45	151	151	
			2021/22	52	36	50	138	138	
Number of Medication Errors Causing Harm	SL	NULL	2022/23	5	5	6	16	16	
			2021/22	8	3	4	15	15	
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	RB	100% by year end	2022/23				68%	68%	
			2021/22				63%	63%	
Percentage of Incidents Applicable for DoC Dealt with Appropriately**	*SL*	100%	2022/23	100%	0%	100%	100%	100%	
			2021/22	100%	100%	100%	100%	100%	
Attributed MRSA Bacteraemia - infection rate**	*SL*	0	2022/23	0	2	0	2	2	
			2021/22						

** Reported by exception

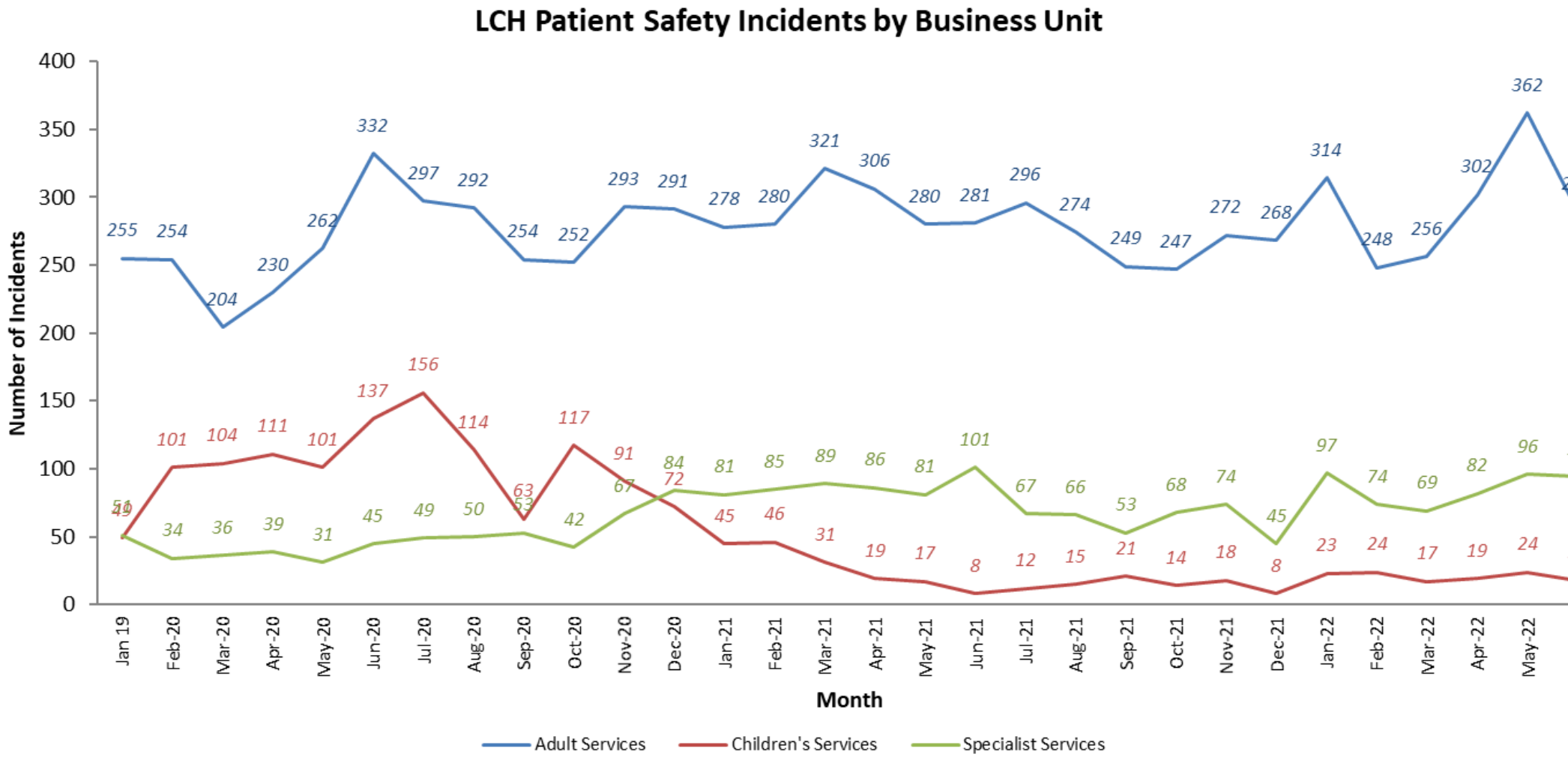
* These numbers are subject to revision pending completion of investigations

Narrative

May/June 2022 Incident Report. Narrative by Exception.

There were 1271 incidents recorded in Datix during the reporting period. Of these, 883 (69%) were recorded as LCH patient safety incidents.

Chart One: *Patient Safety Incidents over two years by Business Unit*



The Adult Business Unit (ABU) reported 651 (74%), Children's Business Unit (CBU) 42 (5%), and Specialist Business Unit (SBU) 190 (21%). May 2022 saw a rise in incidents across the Business Units, with the ABU showing a rise in Medication and Skin Damage incidents. The CBU and SBU saw a slight increase in all categories.

Table 1: *LCH patient safety incidents by month and level of harm*

	No injury	Minimal Harm	Moderate Harm	Major Harm	Total
Nov 2021	140 (40.2%)	171 (49.1%)	27 (7.8%)	10 (2.9%)	348
Dec 2021	117 (36.3%)	156 (48.5%)	45 (14.0%)	4 (1.2%)	322
Jan 2022	117 (33.5%)	181 (51.9%)	45 (12.9%)	6 (1.7%)	349
Feb 2022	92 (30.6%)	177 (58.8%)	29 (9.6%)	3 (1.0%)	301
Mar 2022	116 (35.3%)	163 (49.5%)	42 (12.8%)	8 (2.4%)	329
Apr 2022	128 (33.4%)	198 (51.7%)	53 (13.8%)	4 (1.0%)	383
May 2022	219(45.4%)	222(46%)	32(6.6%)	9(2%)	482
June 2022	180(45%)	190(47.3%)	29(7.2%)	2(0.5%)	401
Total**	**1109 (38%)**	**1458 (50%)**	**302(10.4)**	**46 (1.6%)**	**2915**

Figures may change as incidents are reviewed after reporting and updated when required. This does not always occur in the month.

Moderate Harm Incidents by exception

There were 61 moderate harm incidents reported during May/June, compared to 95 during the March and April reporting period.

Summary of Major Harm Incidents

Eleven major harm incidents were recorded during this reporting period. These are:

Table 2

Category	Number
Pressure Ulcer (PU)	1
Falls	10

Two of the falls' incidents have been reviewed at the Rapid Review Meeting (RRM), one in May 2022 and the other in July 2022. One was concluded with no lapses in care. The other required further information to support an outcome and together with the remaining nine reports are awaiting completion of the Rapid Review reports.

The delay with reports is related to an escalated position across the Trust, which has impacted the timeliness of Rapid Reviews reports. There is an active recovery plan in place, led by the Quality Development Facilitator. A risk assessment has been completed and a risk added to the Risk Register, the position is under the ongoing review of the Clinical Lead, Assistant Director of Nursing and Clinical Governance and Head of Clinical Governance.

Rapid Review Meeting Outcomes for May / June 2022

There were 63 Rapid Reviews completed in May and June 2022; 17 were from incidents reported in Quarter 4 and 46 incidents reported in Quarter 1 of 2022/23.

Forty-three (68%) incidents required no further action on review, 10 (16%) required additional information and a second review, 3 (5%) progressed to Internal Concise Investigation, and 4 (6%) had been reported as a Serious Incident.

The remaining 3 (5%) were rejected after review as they were not reportable incidents.

Serious Incident Investigations May / June 2022

Four incidents reviewed at the Rapid Review Meeting progressed as Serious Incidents and were reported via the Strategic Executive Information System (StEIS) and remain under investigation. These are:

- a failed diagnosis of a pregnancy prior to a contraceptive implant being inserted.
- an Unstageable Pressure Ulcer due to a delay in establishing pressure risk management and a lack of skin assessments.
- a catheterisation resulting in haematuria.
- administration of a second dose of insulin & medication due to a staff member undertaking tasks they were not allocated to do.

National Reporting Compliance

StEIS reporting has been completed for all relevant incidents. Two out of four were reported within 48 hours of the Rapid Review Meeting decision, in line with national requirements. The remaining two incidents were reported on day four. The two delays were related to an IT issue and were escalated to the Leeds Integrated Care Board (ICB) who supported completion.

LCH identified 4 incidents that met the Duty of Candour Regulation and is currently compliant with 3. One was not within compliance as a letter was not sent to the family within the required timescale by the team, this was not followed up by the Patient Safety Team due to human error as a result of reduced capacity within the Team. However, a duty of candour conversation was held between the Service and family within ten working days and a letter has subsequently been sent.

Central Alert System (CAS) Notifications

There were 13 Central Alert System (CAS) notifications in the period. They are all on track to complete within the timescale. They will be closed at a planned monthly meeting between the Head of Clinical Governance, the Quality Leads, and the Incident Manager, as is the process to ensure collective approval before closure.

Inquests

For this report, there will be a summary of the two cases where there has been learning (Table 4). Future reports will consist of new inquest requests, closure of inquests and recommendations for the Trust, and anywhere escalation was required.

Table 3 – Summary of Learning from Inquests

Case	Date Trust notified	Summary	Current position	Learning
7870	04/03/2022	Care following a fall at home and the patient subsequently died in hospital.	Statements were taken from staff	There has been a delay in the statements being taken from staff involved due to staff sickness and lack of clarity and understanding of our current process. These have now been completed and returned to the coroner. A new Standard Operating Procedure (SOP) for the LCH inquest process is now completed and has been approved by the Director of Nursing and AHP's. The SOP will be shared with staff with the support of the Clinical and Quality Leads and the Incident& Assurance Manager.
7868	23/02/2022	A 2-year-old child with swallowing problems choked in the bath.	Awaiting statement from staff	Delay due to the current Sudden Unexpected Death in Children (SUDIC) processes (City wide) and different processes being followed. A new SOP will contain information linking the SUDIC and Inquest processes to ensure improved communication and timelier responses.

Ethnicity Data/Incidents Review

The Clinical Governance and Business Intelligence Teams supported by the Health Equity Lead have collaborated to produce an equity dataset. The Business intelligence Team will now develop the dataset to map all incidents against deprivation deciles, ethnicity, age, postcode and hopefully gender/protected characteristic information. This work is ongoing.

Business Units Updates by Exception

Adult Business Unit (ABU)

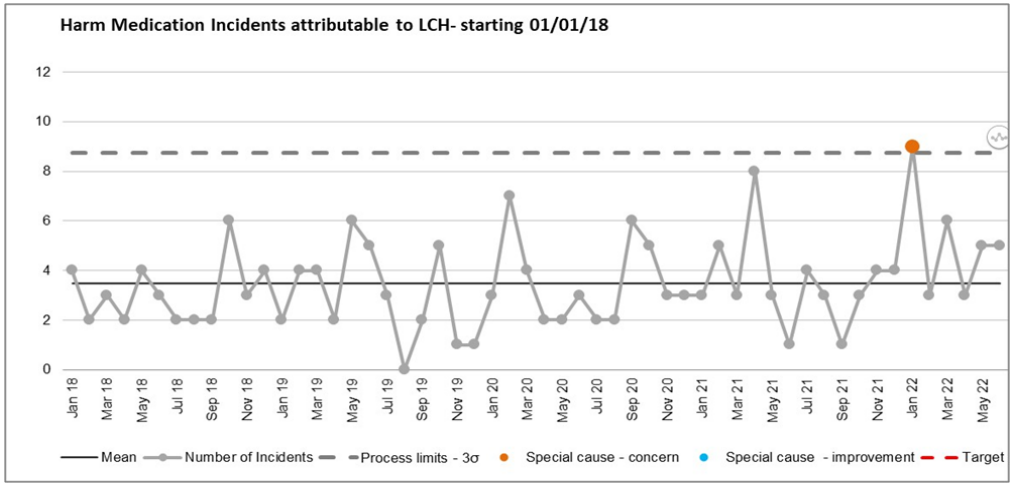
There were 651 LCH patient safety incidents recorded for ABU in May / June 2022.

There were 46 moderate and 11 major harm incidents recorded. The highest reporting category remains skin damage and medication incidents.

Highlights

This data reflects medication harm incidents that are attributable to LCH

The Statistical Process Control (SPC) chart shows a variation of monthly medication harm incidents reported was within expected limits since January 2018 apart from



January 2022, where we saw a rise, that potentially reflected services pressures in the Neighbourhood Teams at that time.

Following review by the Medicines Safety Officer, most harm incidents occur in the Neighbourhood Teams where there are high levels of medicines administration activity. The teams are involved in supporting many patients with two groups of medicines with a higher risk of causing harm; these are Insulin and Palliative Care Medicines such as Opioids or Midazolam.

The medicines management team has put in place a number of measures, such as safety checks for completed visits, a bespoke injectable diabetic medication chart, the use of pharmacy technicians to transcribe Medication Administration Record (MAR) Charts, and specific End of Life (EOL) Palliative Care Subject Expect Leads within the NTs supporting Palliative patients. These measures will continue to be monitored.

Children's Business Unit (CBU)

There were 42 LCH patient incidents reported in May / June 2022.

Of these, 38 were no harm incidents and 4 minimal harm incidents, there were no moderate or major harm incidents recorded.

Key escalations this period relate to there being several overdue incidents for the Children's Business Unit. There are 20 overdue LCH patient incidents. The Quality Lead for the CBU has escalated through the Clinical Lead for the service, discussed at the quality forum, and escalated via the Business Unit report.

Update from last report:

Information Governance incidents remain the highest recorded incident this reporting period; a further review concluded all incidents had caused no harm. These were:

- Communication failure between teams
- Incorrect documentation
- Confidentiality Breach

Two learning memos have been developed and shared with the Business Unit.

Incidents will continue to be monitored.

Specialist Business Unit (SBU)

During May / June 2022 there were 187 no harm and 3 moderate harm incidents. A sexual health incident in October 2021 was reported in June 2022, with a major harm level. This was reviewed at RRM and escalated for further serious incident investigation. The top 3 reported categories are Abusive, Violent, Self-Harming Behaviour: Access, Appointments and discharges, and Medications, a similar trend to previous months.

Highlight

Leaning from the major harm incident report in sexual health, highlighted that the service might not be following the national contraception implantation pathway in young and vulnerable girls. The Clinical Governance team and service are planning to complete an audit to review the caseload to identify any further missed opportunities and non-adherence to the national pathway.

Update from the last report:

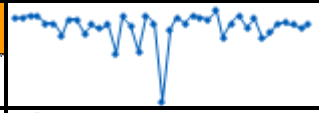
A deep dive into the self-harm incidents within the secure unit has identified an increasing number being reported over the last 6 months. The severity of the incidents has also escalated with more moderate harms being reported. On review at the rapid review meetings, no lapses in care have been found. The service has concluded that the increase is as a result of a developing safety reporting culture.

Caring – June 2022

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

NHS Leeds Community Healthcare NHS Trust

Data

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Responsible Director	Target - YTD	Financial Year	Apr	May	Jun	Q1	YTD	Time Series (from Apr-19)
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%	2022/23	92.8%	91.9%	92.9%	92.2%	92.2%	
			2021/22	95.4%	94.9%	98.1%	95.7%	95.7%	
Total Number of Formal Complaints Received	SL	No Target	2022/23	4	10	11	25	25	
			2021/22	5	7	6	18	18	

Narrative

Friends and Family Test (FFT)

In May and June 2022, there were 1070 responses to the FFT, an increase from the last report with 93% (992 out of 1070 respondents) of community patients/service users reporting their experience as good or very good.

The Patient Experience Team continue to work with Engagement Champions and Business Unit Quality Leads to ensure all services use the FFT with users, review the information from the test, and explore service improvements based on comments.

Service Specific Surveys

In addition to the FFT, services continue to develop specific surveys with the support of the Patient Experience Team. These surveys compliment the FFT and allow focused feedback and insights from patients and carers. Examples of survey's implemented in May and June 2022 are below:

- Leeds Sexual Health Service Young People's Survey Under 18 was developed to find out the views of this group of clients on current service provision
- Leeds Mental Wellbeing Service Helpful Conversations Survey was developed to find out user's views of this approach when contacting the service.
- The outcome and changes from these surveys will be reported through business unit/service performance reports and this performance brief.

Complaints, Concerns and Claims

There were 21 complaints received in May and June 2022, an increase from the last reporting period (14), of which 10 were in May and 11 in June. This is consistent with previous months. All new complaints were acknowledged within three working days.

Additionally, three concerns were escalated to complaints as the complainant's were unhappy with the concern response. All these concerns were managed by Community CAMHS and related to waiting times for Neurodevelopment Assessments and medication clinics. The service is reviewing how it manages waiting times as part of its transformation programme.

In May and June 2022, 18 complaints were closed, of which four were passed on to another organisation, and one withdrawn by the complainant and managed as a concern.

Of the thirteen complaints responded to by Leeds Community Healthcare NHS Trust (LCH) 100% were responded to within 180 days. Ten out of thirteen complaints met the internal Trust target of 40 working days. The three complaints not meeting the Trust internal target were due to staff leave and in one case due to a request from the complainant. All were responded to within 48 days, and complainants were kept informed, and their agreement obtained for the delay.

Eight out of thirteen complaints were partially or fully upheld following investigation. Learning from the closed complaints continues to be the need to improve on communication with patients, especially to return telephone calls from patients as soon as possible and document this in the clinical records.

There were 173 concerns received in May and June 2022, an increase from the last reporting period (105). Most concerns (26) were received by Leeds Sexual Health Services in relation to difficulty in contacting the services. The service is reviewing these concerns to identify learning for the service which will be shared in the Specialist Business Unit Performance report. Twenty concerns were received by Leeds CAMHS Service in relation to access to appointments, including Neurodevelopment Assessments, with Clinical Partners. As a result of these concerns regular conversations with colleagues at Clinical Partners are now in place to provide more timely responses to feedback. In addition, changes have been made to the Datix® recording system to ensure these concerns are more easily identifiable.

There were 181 compliments received in May and June April 2022, an increase from the last reporting period (145). The highest number of compliments (39) were regarding the Neighbourhood Teams.

Claims

There are 8 claims being managed by the Trust and 10 potential claims. In May and June 2022 one clinical claim was received, which has been shared with NHS Resolution and is in the information gathering stage. Two non-clinical claims were closed following settlement, one related to slippage on leaves outside a clinic used by LCH staff and the other related to disabled staff able to leave buildings safely during a fire alarm. Learning from both claims has resulted in changes to LCH policy and procedures. Wider sharing of learning is planned for fire exit planning for disabled colleagues.

Covid-19

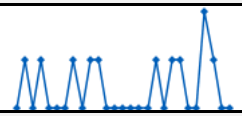
In May and June 2022, the Trust received one complaint and four concerns where the Covid-19 pandemic was mentioned as a factor. The complaint related to provision of appointments in MSK services, the four concerns again were related to provision of appointments (MSK, Community CAMHS and Podiatry).

Effective – Q1 2022

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

Data

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Responsible Director	Target - YTD	Financial Year	April	May	June	Q1	YTD	Time Series (from Apr-19)
Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH	RB	100% by year end	2022/23				96%	96%	
			2021/22					81%	
Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH	RB	No Target	2022/23				95%	95%	
			2021/22					90%	
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload**	RB	No Target	2022/23	1	0	0	1	1	
			2021/22	0	0	0	0	0	
NCAPOP audits: number started year to date versus number applicable to LCH	RB	100% by year end	2022/23				100%	1	
			2021/22				100%	100%	
Priority 2 audits: number completed year to date versus number expected to be completed in 2021/22	RB	100% by year end	2022/23				0%	0	
			2021/22				100%	100%	
Total number of audits completed in quarter	RB	No Target	2022/23				3	3	
			2021/22						

Narrative

Audit

The Audit programme continues, however there has been a reduction in audit registrations from the Business Units due to pressure in Teams. The number of local audits has reduced in Children's and Adult's Business Units which is being monitored by the Audit and Effectiveness Team. Audit summaries that include any learning from audits

has also reduced. The Audit and Effectiveness Team are reviewing the full process including the audit summary process to ensure learning and associated actions can be monitored for assurance. Due to absence in the team this a medium-term action. There is a consideration of whether audit can be added to Datix.

NICE

Concordance with NICE Guidance is now fully in force across the Business Units with the support of the Clinical Governance Team. There are five open NICE Guidance for 2017/18 and 2018/19 that will be reviewed for risk. Closure where appropriate, will be proposed to Quality Committee.

NICE programme – 2017-2021.

There are currently seven open NICE Guidance.

Programme for 2021 – 2023.

For 2021/22 there are 19 open NICE Guidance, and 11 for 2022/23.

Data for core indicators

Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH (expressed as a %):

1. 95.2% fully compliant (represents 40 of 42)
2. 2.4% non-compliant (represents one)
3. 2.4% previously agreed non-compliance by Quality Committee (represents one)

Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH (expressed as a %):

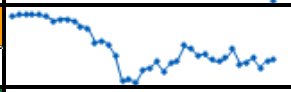
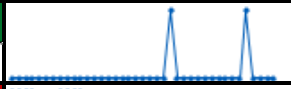
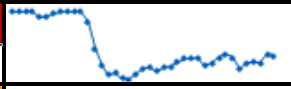
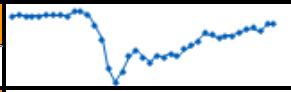
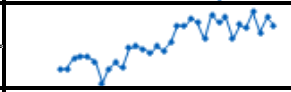
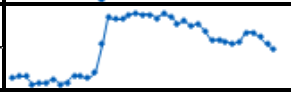
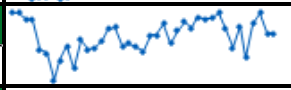
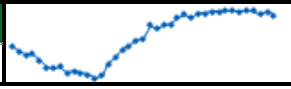
- 95.5% full compliance (represents 21 of 22)
- 4.6% non-compliant (represents one)

Responsive – June 2022

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

NHS Leeds Community Healthcare NHS Trust

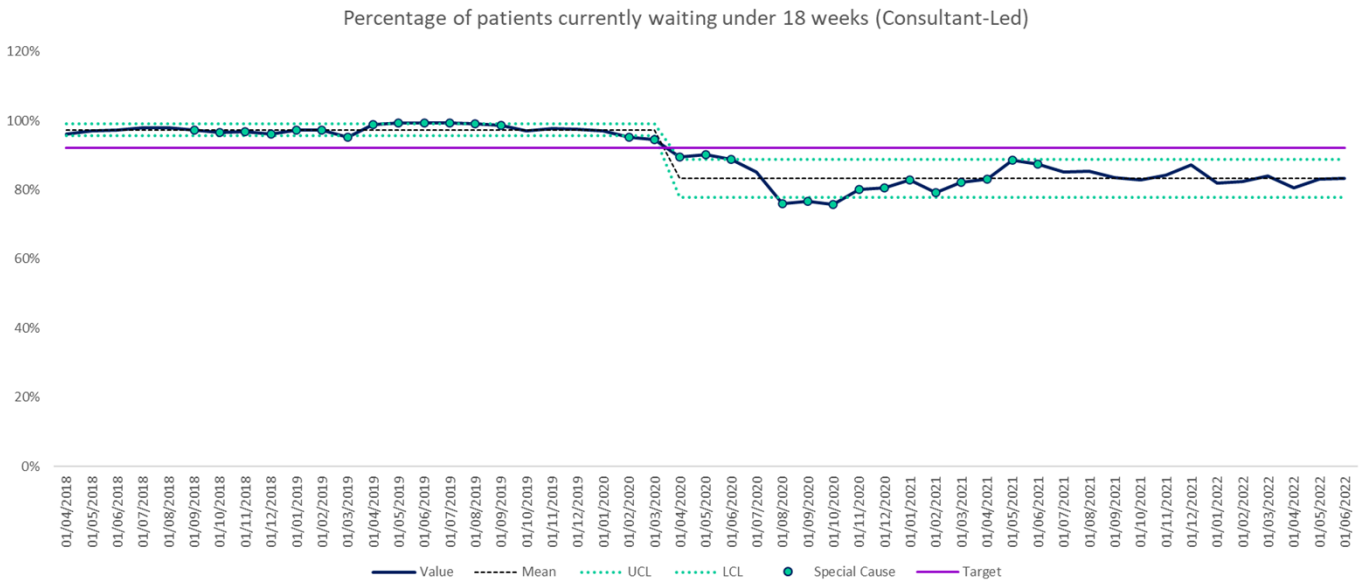
Data

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	Financial Year	Apr	May	Jun	Q1	YTD	Time Series (from Apr-19)
Percentage of patient contacts where an ethnicity code is present in the record	SP	No Target	2022/23	95.8%	95.6%	95.4%	95.6%	95.6%	
			2021/22	95.6%	96.0%	95.9%	95.8%	95.8%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	2022/23	80.6%	83.2%	83.4%	83.4%	83.4%	
			2021/22	83.1%	88.5%	87.3%	87.3%	87.3%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	2022/23	0	0	0	0	0	
			2021/22	0	0	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	2022/23	38.3%	49.4%	46.9%	46.9%	46.9%	
			2021/22	39.2%	44.0%	43.7%	43.7%	43.7%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	2022/23	86.4%	90.2%	90.0%	90.0%	90.0%	
			2021/22	73.8%	77.3%	79.0%	79.0%	79.0%	
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	SP	>=95%	2022/23	66.7%	92.3%	94.1%	94.1%	94.1%	
			2021/22	90.9%	84.6%	100.0%	100.0%	100.0%	
% CAMHS ACBI & Neurodevelopmental Initial Assessment patients currently waiting less than 12 weeks for treatment	SP	No Target	2022/23	38.5%	42.0%	42.3%	42.3%	42.3%	
			2021/22	69.4%	61.3%	56.0%	56.0%	56.0%	
LMWS – Access Target; Local Measure (including PCMH)	SP	24456	2022/23	2310	2694	2499	7503	7503	
			2021/22	2479	2472	2660	7611	7611	
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	SP	No Target	2022/23	59.7%	52.3%	46.6%	52.7%	52.7%	
			2021/22	73.6%	76.6%	71.5%	73.8%	73.8%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	2022/23	100.0%	99.4%	99.4%	99.6%	99.6%	
			2021/22	99.5%	99.7%	99.6%	99.6%	99.6%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	2022/23	92.1%	94.3%	91.3%	92.5%	92.5%	
			2021/22	88.3%	91.9%	88.6%	89.6%	89.6%	

Narrative

Consultant-led RTT Pathways

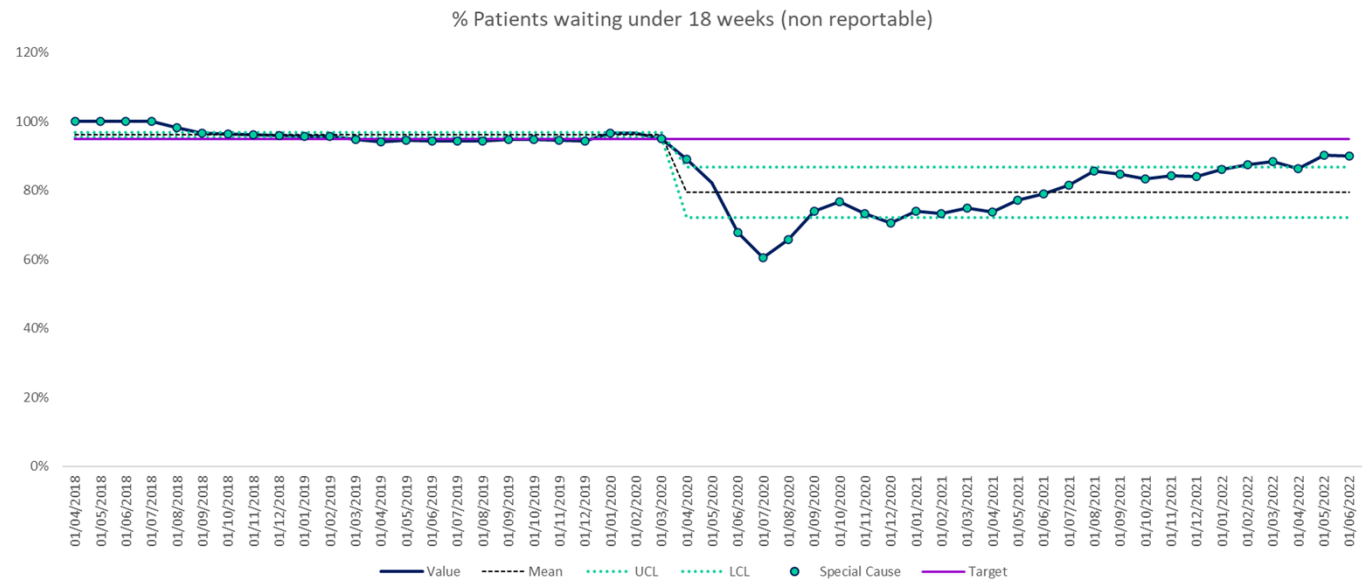
	May 2022						Jun 2022					
Specialty	**Pct Currently Waiting Under 18Weeks**	**Total**	**Waiting Over 18Wks**	**Average Wait (weeks)**	**Median Wait (weeks)**	**95th Percentile**	**Pct Currently Waiting Under 18Weeks**	**Total**	**Waiting Over 18Wks**	**Average Wait (weeks)**	**Median Wait (weeks)**	**95th Percentile**
CH - P AUD	99.2%	918	7	7.0	6.7	14.4	98.5%	932	14	7.3	6.4	15.3
CPC (CHICS)	75.0%	240	60	12.3	8.0	37.1	76.7%	262	61	11.6	8.0	34.3
GAN	87.5%	8	1	7.2	5.9	17.3	90.9%	11	1	6.0	3.1	18.0
Gynaecology	30.2%	53	37	22.7	21.6	42.0	49.2%	65	33	19.7	19.3	34.0
PND	68.8%	695	217	13.6	12.1	28.9	69.5%	731	223	13.8	13.1	29.4
Total	**83.2%**	**1914**	**322**				**83.4%**	**2001**	**332**			



Performance against the 18-week Referral to Treat (RTT) standard remains below expectations, with 83.4% of patients being seen within 18 weeks (target 92%). This has remained static since May 2022. The total number of patients waiting beyond this target has increased since May and now stands at 332, and the total number of people being seen within these pathways has also increased from 1,914 in May to 2,001 in June 2022. However, some improvement is visible within a few pathways, including GAN and Gynaecology, but the small numbers of patients on these waiting lists has influenced this performance. Gynaecology has shown consistent improvements to date, and their June Performance of 49.2% is the highest recorded by the service since Dec 2020.

Long-term trends show stable patterns with a slight hint of a gradual decline in performance since May 2021.

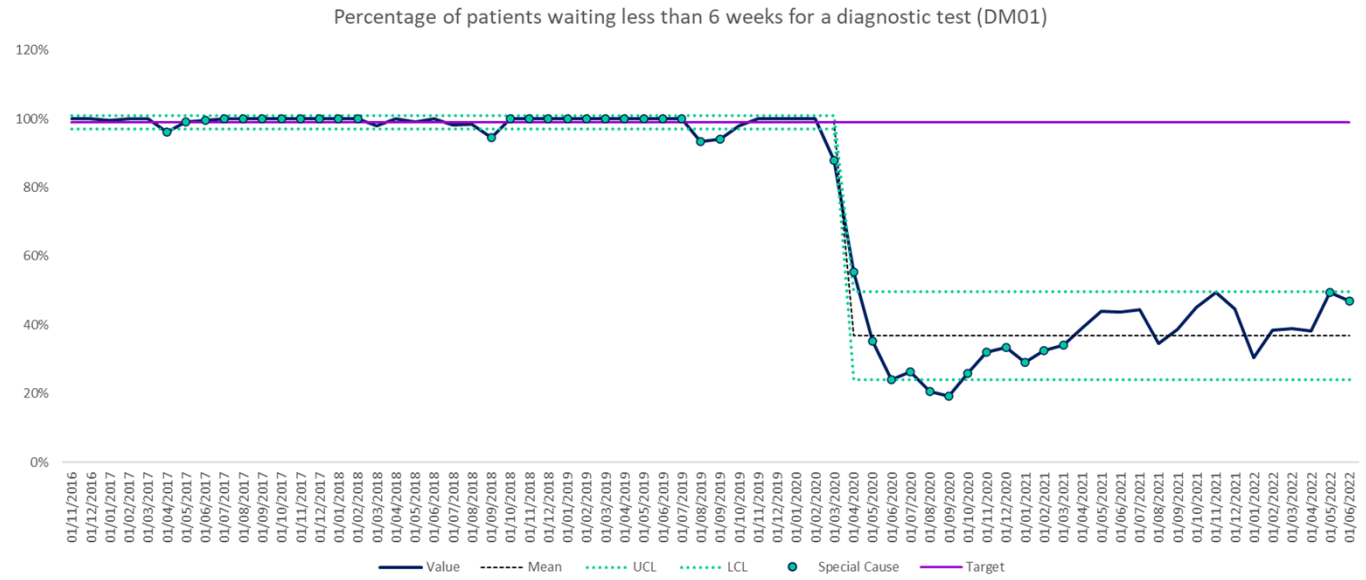
Non-Consultant led Pathways



Performance continues to show steady improvement, with 90.0% of patients now being seen within 18 weeks, which is unchanged from last month. Performance remains below the Trust-set target of 95% but commendable progress continues to be made.

Where services continue to hold long waiting times, there is good evidence of patients with the most pressing needs, who have waited longest being given priority. For example, in PND, where the service is prioritising appointments for patients who have waited over 18 weeks with the most significant developmental delays.

Diagnostic Pathways (DM01)



Audiology has not met the DM01 6-week standard for diagnostic tests in June, achieving 46.9% (against a target of 99%). However, recent improvements have held. There has been a steady reduction in the total waiting list size, now standing at 964 patients, down from 1,191 in Jan 2022. There have also been steady, consistent reductions in the number of patients waiting more than 18 weeks, (now at 20, down from 76 in Jan 2022) and between 12 and 18 weeks (now at 199, down from 338 in Feb 2022). The service now seems to have returned to its pre-Omicron position.

Improving Access to Psychological Therapies

Performance has deteriorated further for the percentage of people receiving their first screening appointment within 2 weeks of referral, falling to 48.7% in June compared to 58.9% in May 2022. The service is reporting 15WTE vacancies amongst Psychological Wellbeing Practitioner roles, which, along with increasing complexity of referrals, is the primary driver of the trend. Several short-, medium- and long-term actions are being pursued:

- Short term – use of agency staff on short contracts
- Medium term – working collaboratively with partners to allow them to contribute more practitioners to the service. There is potential for approx. 13 new practitioners to join this way, for a 1-year term
- Long-term – increases have been made to training establishments for next year and 8 newly qualified staff will be joining in March. The service is also working on several internal and system-level improvements to pathways and processes

All other IAPT performance measures are above target (see Appendix 4).

CAMHS Access Measures

The Eating Disorder Service has shown excellent improvement in ensuring that routine patients are seen within 4 weeks of referral. In June 2022, 94.1% of routine patients were seen within 4 weeks, against a target of 95%. This is an improvement against 66.7% in April, and 92.3% in May, however, small numbers of patients can make this indicator susceptible to high variability (see Appendix 5).

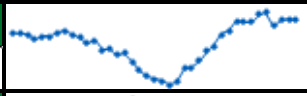
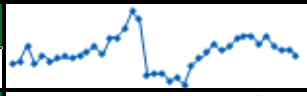
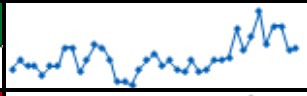
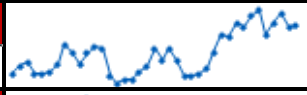
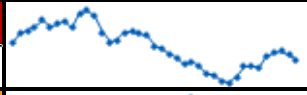
There has been limited improvement over recent months for patients referred to Assessment, Consultation and Brief Intervention (ACBI) Clinics or Neuro-disability Initial Assessments (NIA), with 42.3% of patients in these services being seen within 18 weeks. Large numbers of clinical vacancies have prevented improvement to date.

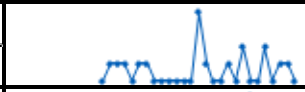
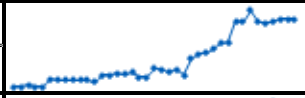
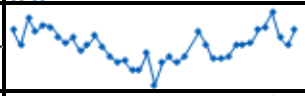
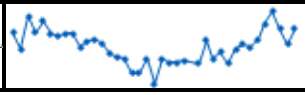
Well-Led – June 2022

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.

NHS
Leeds Community Healthcare
NHS Trust

Data

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	Financial Year	Apr	May	Jun	Q1	YTD	Time Series (from Apr-19)
Staff Turnover	LS/JA	<=14.5%	2022/23	14.4%	14.5%	14.4%	14.4%	14.4%	
			2021/22	10.3%	10.9%	11.7%	11.7%	11.7%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	2022/23	19.2%	19.5%	18.4%	18.4%	18.4%	
			2021/22	16.5%	17.8%	18.8%	18.8%	18.8%	
Short term sickness absence rate (%)	LS/JA	<=3.0%	2022/23	2.8%	2.0%	2.1%	2.1%	2.1%	
			2021/22	1.7%	1.3%	1.4%	1.4%	1.4%	
Long term sickness absence rate (%)	LS/JA	<=3.5%	2022/23	5.1%	5.2%	5.2%	5.2%	5.2%	
			2021/22	3.0%	3.6%	3.7%	3.7%	3.7%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=6.5%	2022/23	7.9%	7.2%	7.3%	7.3%	7.3%	
			2021/22	4.7%	4.8%	5.1%	5.1%	5.1%	
AfC Staff Appraisal Rate	LS/JA	>=90%	2022/23	79.0%	78.1%	76.7%	76.7%	76.7%	
			2021/22	76.2%	75.0%	72.9%	72.9%	72.9%	
Statutory and Mandatory Training Compliance	LS/JA	>=90%	2022/23	88.1%	86.2%	85.6%	85.6%	85.6%	
			2021/22	89.9%	87.9%	89.2%	89.2%	89.2%	

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	Financial Year	Apr	May	Jun	Q1	YTD	Time Series (from Apr-19)
'RIDDOR' incidents reported to Health and Safety Executive	BM	No Target	2022/23	1	1	0	2	2	
			2021/22	0	4	1	5	5	
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	LS/JA	No Target	2022/23	7.8%	7.8%	7.8%	7.8%	7.8%	
			2021/22	5.1%	5.5%	5.5%	5.5%	5.5%	
Total agency cap (£k)	BM		2022/23	352	307	394	1053	1053	
			2021/22		382	308	690	690	
Percentage Spend on Temporary Staff	BM	No Target	2022/23	6.3%	5.4%	6.3%	6.3%	6.3%	
			2021/22		4.2%	5.6%	5.6%	5.6%	

Narrative

Staff Turnover

Staff turnover has seen values above the upper control limit since October 2021 and whilst below target, continues to be of concern.

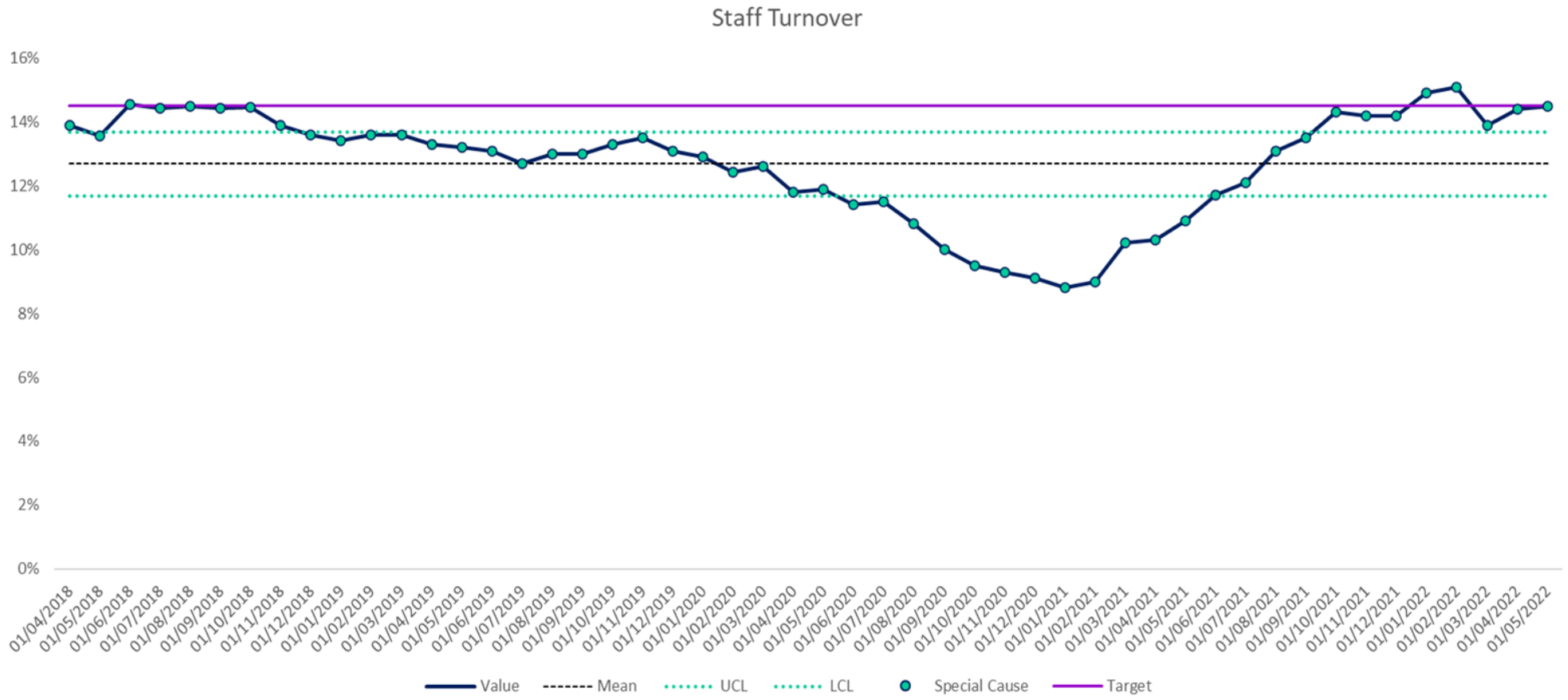
The most prevalent reason for leaving is work life balance, promotion, and health reasons. ABU Neighbourhood Teams and SBU have the highest turnover rate for June.

Local retention conversations have started with a plan to hold a 'Retention Summit' in the autumn to fully explore this topic. We are also reviewing our approach to flexible working with a pilot in ABU with the aim of embedding an increasing culture of flexible working.

Our resourcing initiatives to increase supply continue, and we have recently welcomed 7 international nurses and in addition the first four apprentice nurses successfully completed their programme and gained registration with the NMC this month with a further 6 due to complete in 2023.

We continue to promote our vacancies in our local communities and have secured 11 HSCWs including 4 offers of apprenticeships in this cohort.

The Trust continues several Employee Engagement initiatives paying particular attention and focus to employee Health and Wellbeing.



Reduce the number of staff leaving the organisation within 12 months

This indicator continues to stabilise and remains within the target for the second consecutive month.

The new starter forum hosted by the Chief Executive with the Director of Workforce and Chair of the Race Equality Network (REN) continues and we are seeing more positive experiences as new starters join our Trust.

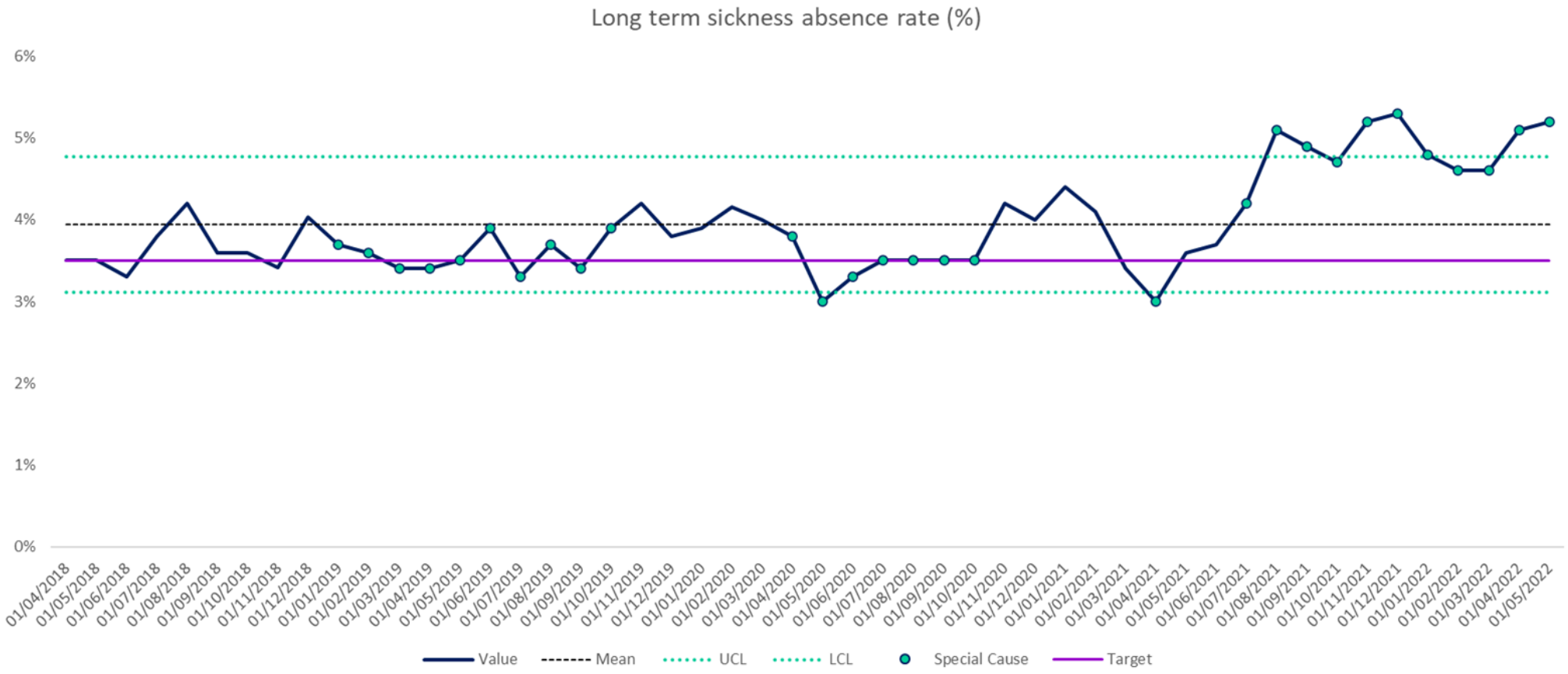
We are continuing to review induction and onboarding processes, for candidates, new starters and managers. Onboarding checklist for managers and new starters has been drafted, with a bespoke induction document for those new to clinical roles. We are reviewing a process map for onboarding (from appointment to 3 months in role) and will engage with stakeholders to streamline process and test these with key stakeholders.

In addition, we are undertaking an options appraisal regarding transport, to ensure that the LCH workforce is fully enabled to deliver effective community services by mitigating any barriers in accessing transport, where travel remains a requirement of the role. This will review options for pool cars, driving lessons and current salary sacrifice and lease car processes.

Total sickness absence

Other than the Corporate Directorate which remains below target at 3.9%, the overall sickness absence levels for the Trust have remained high, and above the 6.5% target for all areas[1]. This is mainly attributable to long term absence (see below).

Long-term sickness absence



[1] 3 x Business Units, Operations and Corporate Directorate (excludes PCN)

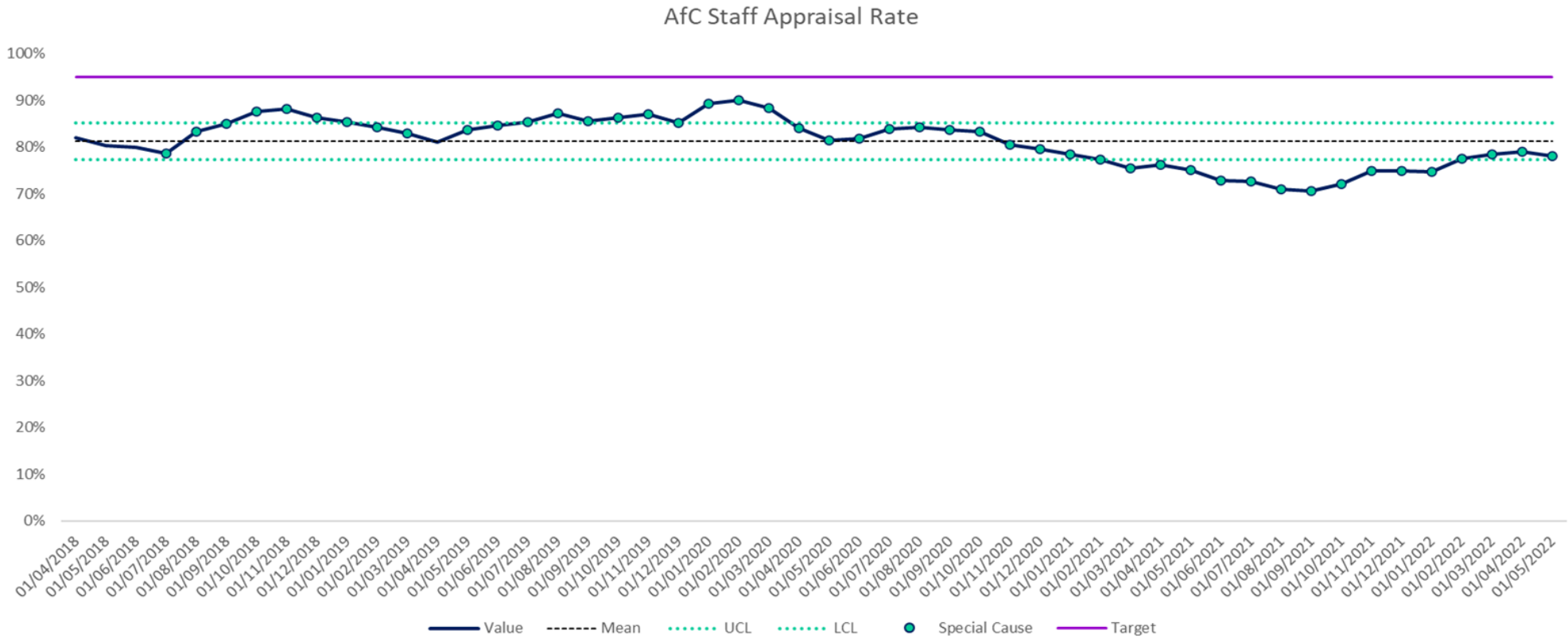
Long-term sickness absence remains of significant concern, with all areas[1] of the Trust significantly above the 3.5% target, which has climbed above the upper control limit for the last 3 months. Whilst there is a welcome reduction in long term absence due to stress, anxiety, and depression, nearly 1% of all long-term absences are due to Infection Diseases/Covid related absences. The HR Business Partner has been linking in with each of their areas to review all long terms absences to ensure robust and supportive plans in place to manage this.

Short-term sickness absence

Short-term sickness absence for all areas[1], has remained below target during the last 5 months. The main reason continues to be Infectious Diseases/Covid related absences.

With the Covid situation escalating within the general population, the IPC team continue to provide support and guidance to keep our staff and patients safe. At the date of writing 12 teams are in an outbreak situation.

Appraisal



Appraisal rates have shown an improving trend since October 2021, but this is not yet significant. The ODI (Organisational Development & Improvement) Team continue to support Business Units with reporting and highlighting service and team hotspots. Neighbourhood Teams continue to be our highest areas of outstanding appraisals. With the aim of meeting the current KPI of 90% the ODI team are devising a plan to relaunch appraisals across the Trust. This will include a trust wide communication plan, a revised approach and training offer, which has recently been successfully piloted and the consideration of an appraisal window to aid overall compliance. Our aim is to complete these actions by the end of the year prior to any winter pressures.

Statutory and Mandatory Training

Overall training compliance has dropped -2% since April (86% from 88%) this is largely due to the introduction of Patient Safety compliance into the report. This new requirement will continue to be monitored through Business leads and Corporate Directorate and we expect this to improve over coming months which will in turn have a positive impact on our overall compliance rate.

WRES (Workforce Race Equality Standard)

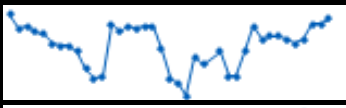
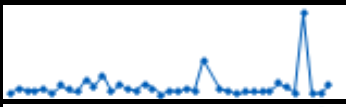
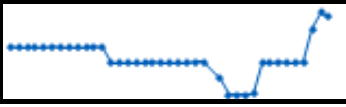
Overall BME representation in the workforce continues to trend well. Engagement currently taking place with key stakeholders to help shape the WRES action plan for 22/23, which includes actions to support the increase of BME representation in LCH.

Finance – June 2022

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

NHS Leeds Community Healthcare NHS Trust

Data

Finance	Responsible Director	Target - YTD	Financial Year	Apr	May	Jun	Q1	YTD	Time Series (from Apr-19)
Net surplus (-)/Deficit (+) (£m) - YTD	BM	0.0	2022/23	0.1	0.1	0.3	0.5	0.5	
Capital expenditure in comparison to plan (£k)	BM	3700	2022/23	0	30	231	261	261	
CIP delivery (£k)	BM	1065	2022/23	226	275	261	762	762	

Narrative

For 2022/23 the Trust Board initially approved a breakeven draft financial plan. In June 2022 additional NHS funding was provided nationally for inflationary cost pressures. The original breakeven plan was based on estimated expenditure run rates and agreed developments to deliver both the Trust's and Leeds system objectives plus an estimate of the impact of the hyperinflation. Considering this the national expectation has been that the additional funding is to flow directly to the Trust's surplus to support the NHS achieving an overall balanced financial position.

The revised financial plan for 2022/23 is to deliver a surplus of £1.04m.

The position is not without significant financial risk in that the income to fund several developments totalling £7.5m agreed with Leeds Place is not included in the Place contract agreed with the CCG/ICB. The costs and associated income are included in the Trust's financial plan to achieve the £1.04m surplus. The expectation is that current vacancy levels will mitigate much of this risk; the Leeds Place will closely monitor the Trust's expenditure as the year progresses with a few to funding any costs that impact on achievement of the surplus.

The financial performance reported here has been reported to the West Yorkshire Integrated Care Board and NHS England.

Income & Expenditure (I&E) Summary

At the end of June, the Trust is reporting an overall surplus of £0.5m which is in line with the plan for Quarter 1. This is being driven by underspending on pay due to the number of vacancies and these have been offset by the underachievement of income.

The forecast outturn for the year is a surplus of £1.04m as expenditure rates are expected to increase as the year progresses.

Income

Income positions have been updated to include an additional 0.7% tariff uplift on NHS contracts within this month 2 position. This results in the total tariff uplift for 2022/23 NHS contracts of 2.4% plus 2.0% growth. There is an assumed efficiency requirement of 1.1%.

The Leeds Place contract includes a top up payment of £12.9m and there is £3.6m of non-recurrent COVID income from the ICB.

The income reported here includes the uplifts for 2022/23.

Contracts have been signed with NHS Commissioners.

Year to date contract income is running £0.1m less than the plan. This is as a result of contract penalties for the 0-19 children's service and Police Custody service; the forecast income for the year reflects continued penalties.

Appendix 1 – Measures with Financial Sanctions

Measures with Financial incentives/Sanctions	Responsible Director	Threshold - YTD	Financial Year	Q1	YTD	Potential Financial Impact
LMWS - Number of people from Black, Asian and Minority Ethnic (BAME) groups entering IAPT treatment (access)	SP	TBC	2022/23	15.5%	15.5%	
LMWS - Number and % of people from BAME groups who have accessed IAPT treatment moving to recovery	SP	TBC	2022/23	35.0%	35.0%	
LMWS - % of older people (65+) entering IAPT treatment (access)	SP	TBC	2022/23	2.3%	2.3%	
LMWS - Number and % of older people (65+) who have accessed IAPT treatment moving to recovery	SP	TBC	2022/23	65.2%	65.2%	
T3WM - Percentage of patients currently waiting under 18 weeks	SP	>=92%	2022/23	**99.1%**	**99.1%**	
0-19 - % of infants who had a face to face newborn visit within 14 days of birth.	SP	>=87%	2022/23	**85%**	**85%**	
0-19 - % of 6-8 week reviews completed within 12 weeks of birth.	SP	>=83%	2022/23	**91%**	**91%**	
0-19 - % of 12 month reviews completed within 12 months.	SP	>=80%	2022/23	**82%**	**82%**	
0-19 - Number of PBB Programmes commenced	SP	0	2022/23	**21**	**21**	0.25% of contract value (annual)
0-19 - Number of HENRY Programmes commenced	SP	0	2022/23	**21**	**21**	0.25% of contract value (annual)
0-19 - Percentage of actual staff in post against funded establishment	SP	>=95%	2022/23	**86.0%**	**86.0%**	
0-19 - % of 0-19 staff (excluding SPA) co-located in Children's Centres	SP	0.425	2022/23	**0.0%**	**0.0%**	
PolCust - % of calls attended within 60 minutes	SP	>=95%	2022/23	**88.8%**	**88.8%**	0.50% deduction from monthly invoice
PolCust - % of calls attended within 60 minutes	SP	>=90%	2022/23	**95.7%**	**95.7%**	£350 deduction per missed shift

Appendix 2 – Safety Trends

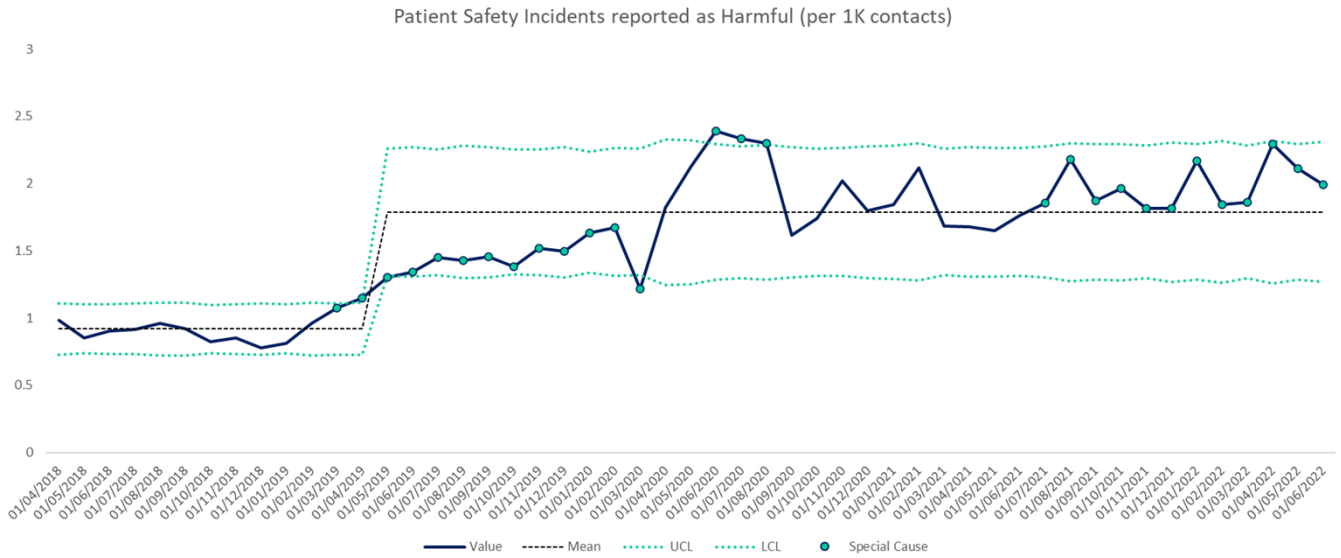


Table 1: Patient Safety Incidents Reported in Month Reported as Harmful

The SPC shows a significant increase in incidents at the beginning of the pandemic in 2020. These included unexpected deaths from COVID-19 and an increase in deteriorating pressure ulcers, we saw a reduction in incidents reported towards the end of 2020 and have since remained stable into 2021/22. In April 2021, Little Woodhouse Hall transferred to another provider which significantly reduced the number of incidents being reported for the Children's Business Unit in 2021/22.

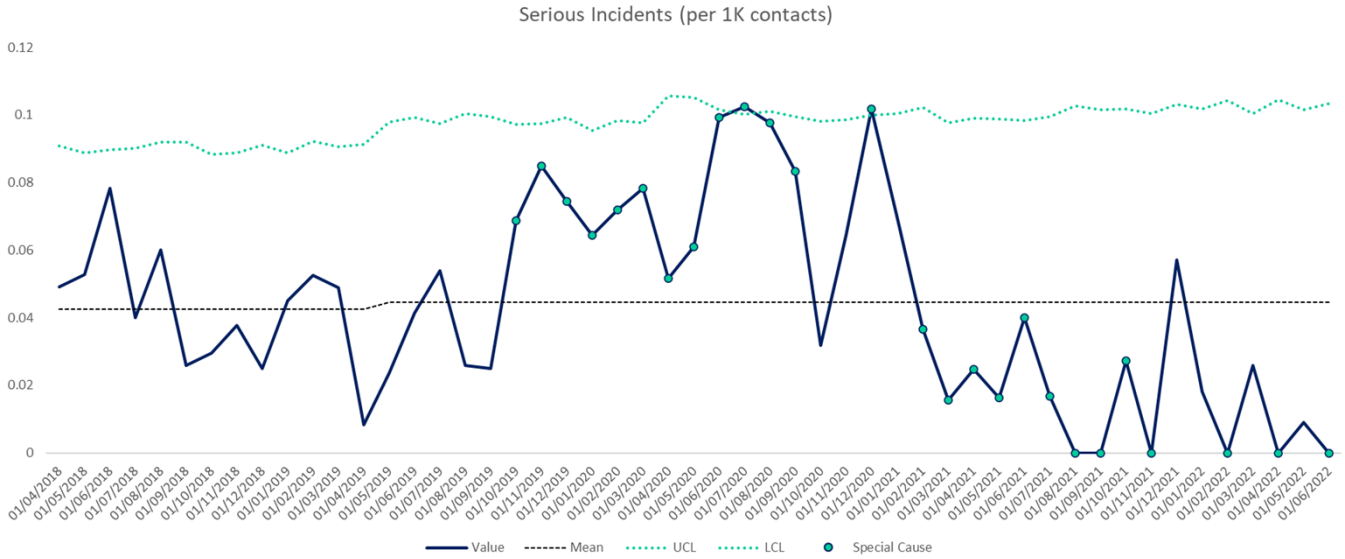


Table 2: Serious Incident Rate

Recent trends of reduced number of SIs have continued, but this data may change by backlogs for concluding investigations. An update will be provided in the 6-month SI report.

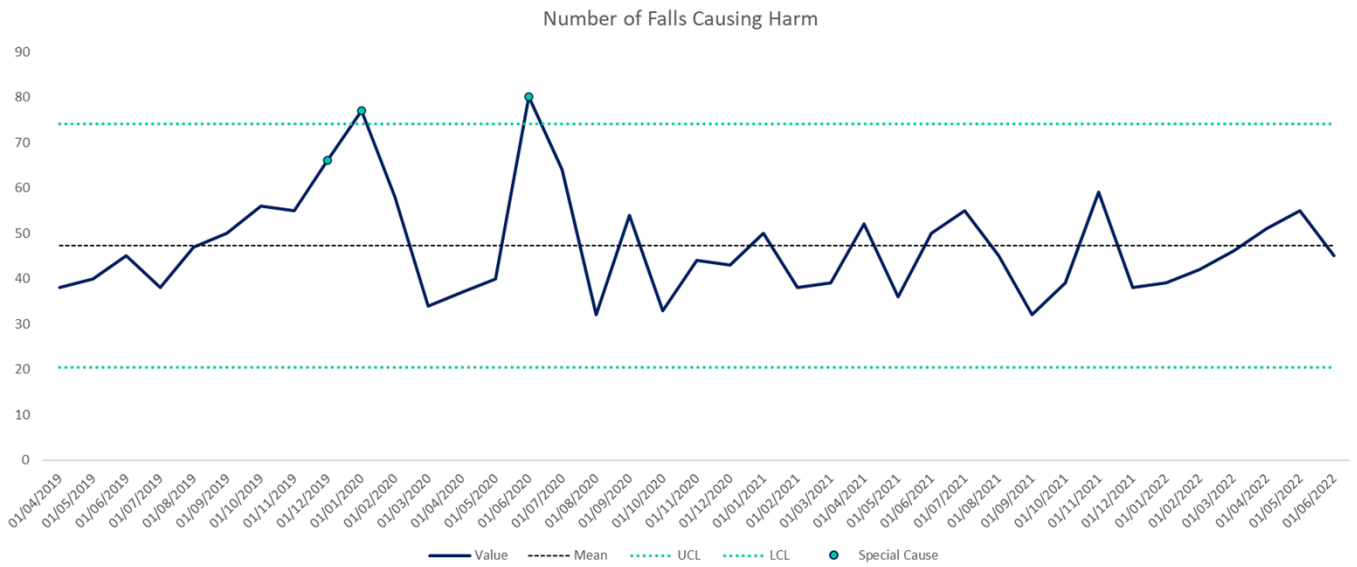


Table 3: Number of Falls Causing Harm

This is a new indicator that will be added to the Performance Brief from July onwards. No significant trends are visible in this data. The obvious spike round June 2020 was when the first lockdown eased and patients were starting to be more active but had become deconditioned, but equally it could be that patients were wanting to be seen again and so staff aware of reporting again.

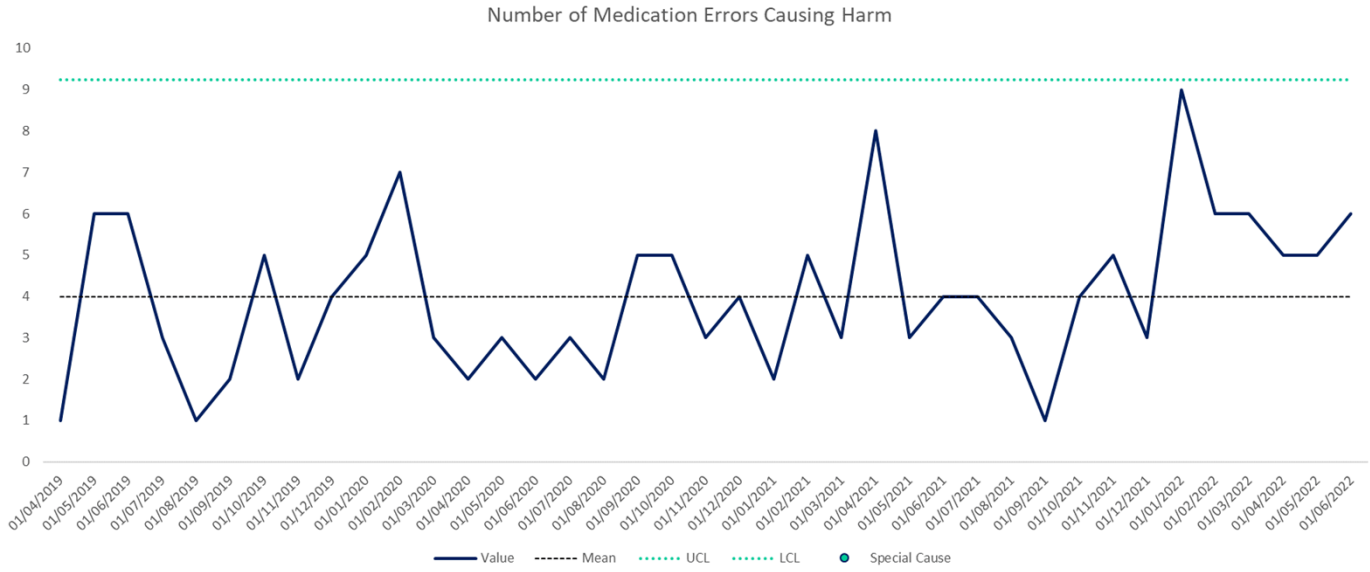


Table 4: Number of Medication Errors Causing Harm

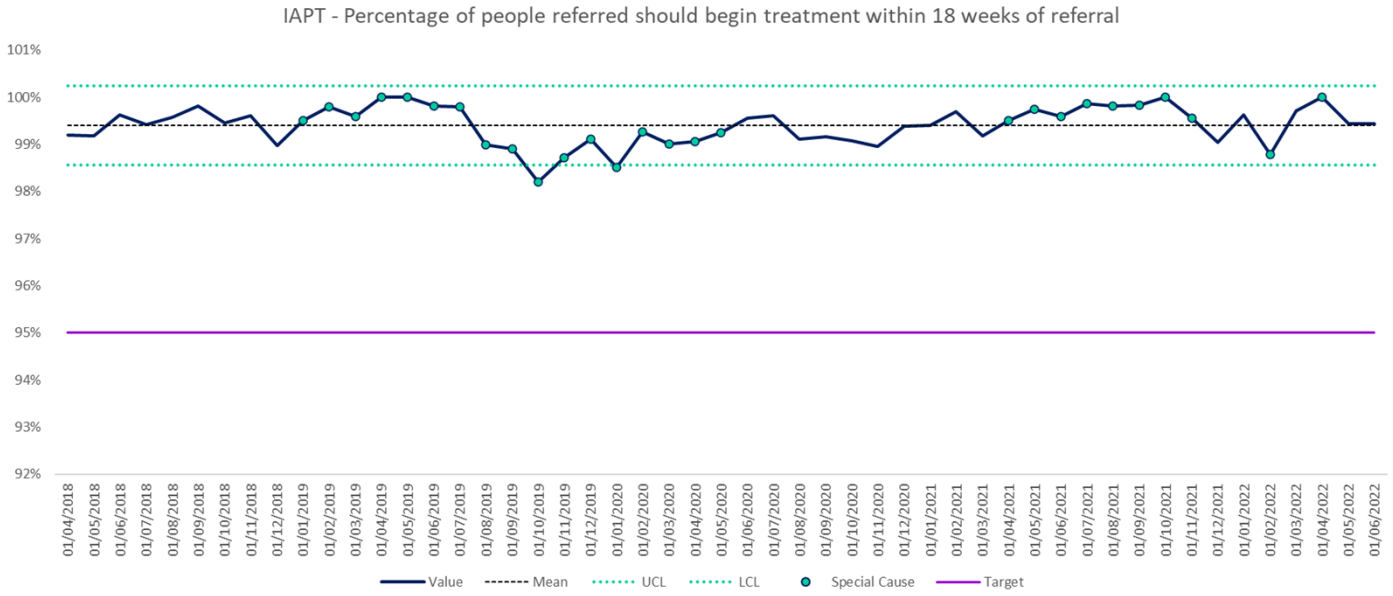
The Statistical Process Control (SPC) graph shows variation of monthly incidents reported is within expected limits, and there have been no statistically significant changes since April 2019.

There was a spike in January 2022 (but still within control limits) that likely reflected services pressures in the Neighbourhood Teams at a particular challenging period.

Monthly Community Indicator reporting 2021/22

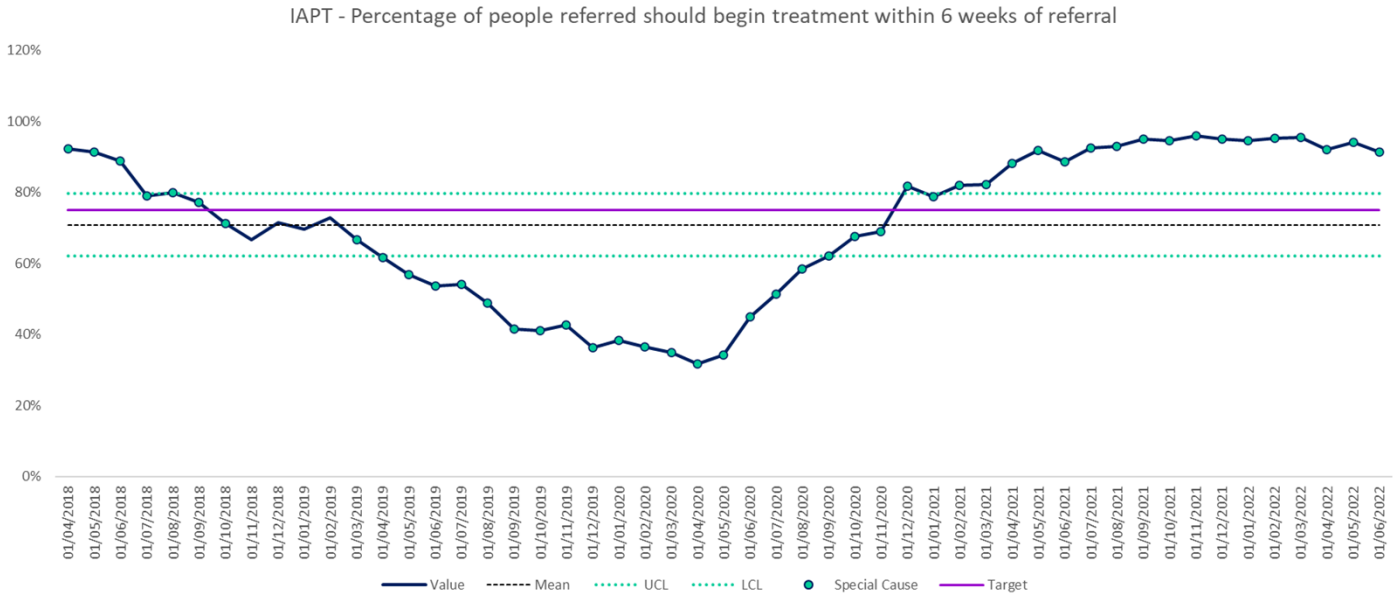
Benchmark domain	Indicator	Benchmark	Ref	Apr-22	May-22	Jun-22
Finance	Better Payment Practice Code by Volume (%)	90%	**F1**	N/A	97.6%	98.2%
	Cost Improvement Plan (CIP) Performance against Plan (%)	100%	**F3**	N/A	100%	100%

Appendix 4 – IAPT Performance Measures



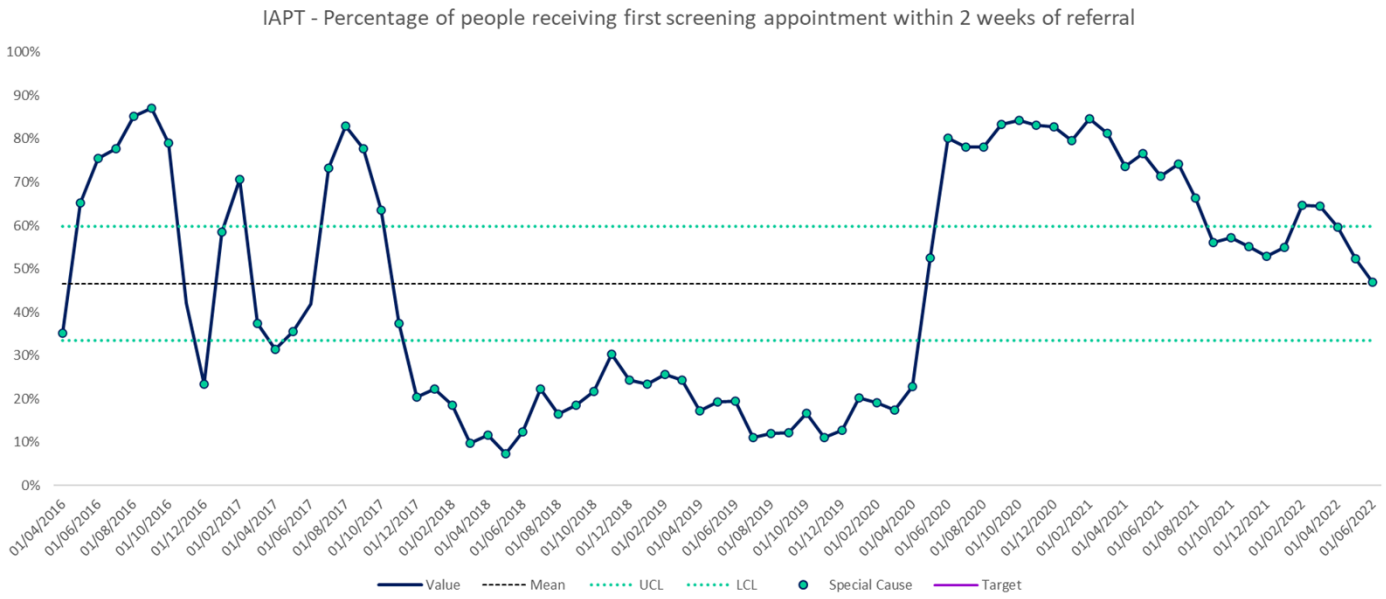
Percentage treated within 18 weeks

Performance remains stable and above the target.



Percentage treated within 6 weeks

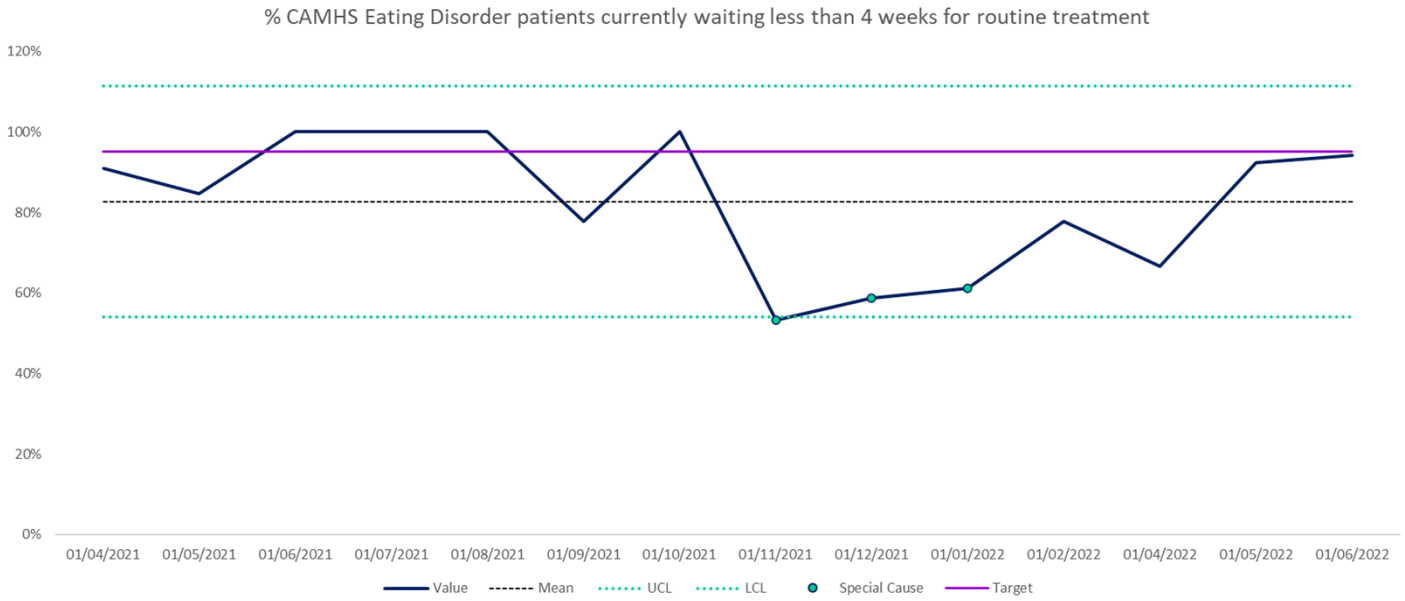
Performance remains stable and above the target.



Percentage screened within 2 weeks

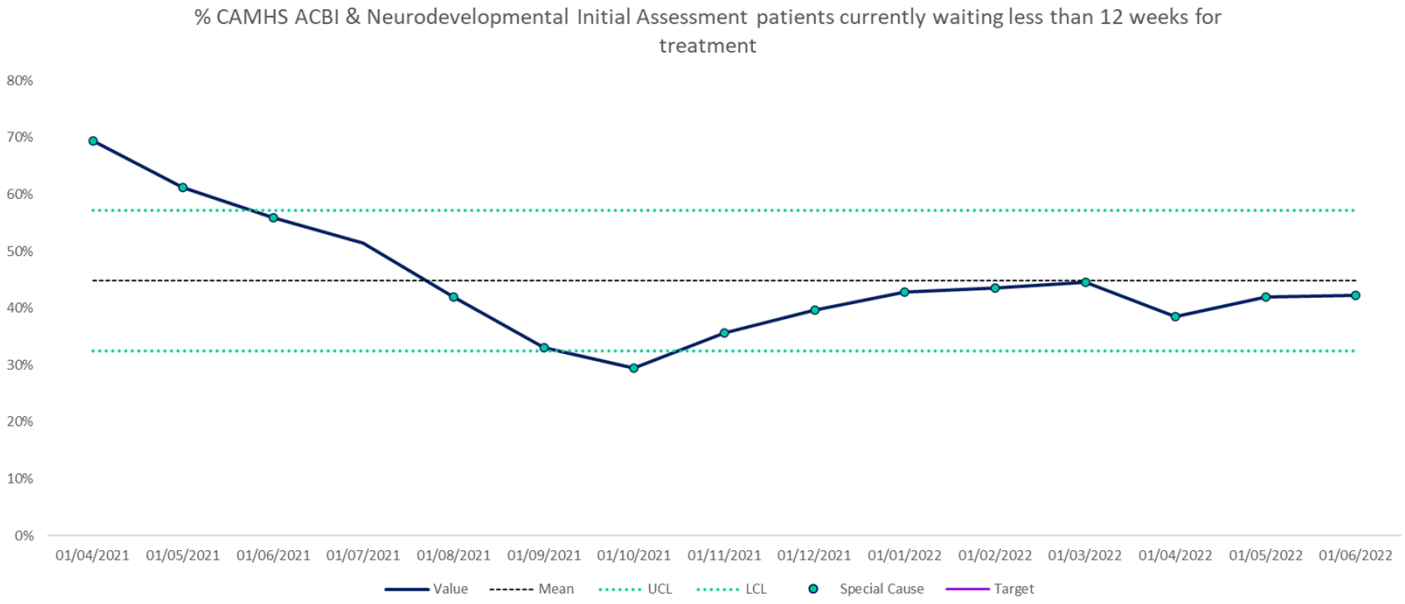
Performance continues to trend downwards. Although no formal target exists for this indicator, further investigation is required to support improvement.

Appendix 5 – CAMHS Performance Measures



Eating Disorders – Routine Patient seen within 4 weeks

Steady improvement can be seen over time, and the service has now nearly achieved the target of 95%.



ACBI and NIA – Seen within 12 weeks

Some improvement visible over the medium term, and gains have held steady within recent months. Performance remains significantly below the target of 95%.

Public Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (42)

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

---

Category of paper: for assurance
History: Senior Management Team 20 July 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 May and June 2022, with substantial assurance being given to one strategic risk, reasonable assurance given to twelve strategic risks although limited assurance given in part to two of those strategic risks (see comments in appendices).

Risk themes
The strongest theme found across the whole risk register is staff capacity, the second strongest theme is related to Information Technology (IT) systems. There is also a theme concerning the lack of and/or implementation of suitable processes and procedures

Risk movement
There is one risk on the Trust risk register that has a score of 15 or more (extreme); this risk has been recently escalated.

- Risk 994: Waiting times for Community Dental Services (escalated)

There are a total of 16 risks scoring 12 (very high).

One risk has recently been escalated to 12:

- 1002 Coronavirus (Covid-19) increased spread of infection

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 (May 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 Board Assurance Framework Summary

2.1 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 any 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)

2.2 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.

2.3 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.

2.4 Levels of assurance have been provided to the Board for thirteen out of the 20 strategic (BAF) risks during May and June 2022, with substantial assurance being given to one strategic risk, reasonable assurance given to twelve strategic risks although limited assurance given in part to two of those strategic risks (see comments in appendices). Details of the assurance levels and commentary about specific risks is provided at Appendix A (please also refer to the Chairs' assurance reports in the Board papers pack).

2.5 The Board should note that BAF Risk 1.3 and 1.5 received reasonable assurance however the information received about the management of cancelled and

rescheduled visits in neighbourhood teams received only limited assurance. The Quality Committee has requested further sources of assurance.

Risk 1.3 is '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'.

Risk 1.5 is 'If, as a result of the increasing demand on services the Trust is unable to provide quality of care in a timely and equitable manner, then the impact will be potential harm to patients, additional pressure on staff and reputational damage'.

3 Risks by theme

3.1 For this report, the 62 risks currently on the risk register (the 'here and now' risks) have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a more holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

3.2 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:
Ten risks are related to staff capacity due to an increase in service demand[1]
Eight risks are concerned with vacancies and difficulties recruiting to posts[2]
Six 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 Information Technology (IT).
Specifically:

Seven risks relate to IT systems which are not sufficient to meet the requirements of the Trust or the services which use them[5]. One risk relates to the insufficient capacity within the Helpdesk to support staff who have IT problems[6].

There is also a risk theme relating to the lack of and/or implementation of suitable processes and procedures[7]. This includes the application of local safety standards for invasive procedures across teams, the application of 'constant supervision' at Wetherby Young Offenders Institute (WYOI), reviewing of closed-circuit television (CCTV), health needed assessments for looked after children, the introduction of female children into WYOI, and inconsistent criteria at care homes.

---

[1] 1047,957,913,904,877,1074, 954, 994,1072,1070
[2] 1060, 950, 979,980,1096, 772, 836, 1057
[3] 1036,984,1015,1021,1048,1098
[4] 874
[5] 963,974,1017,1040,1041,1050,1071
[6] 1025
[7] 1055,981, 952,1089,1067,1099

3.3 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: 27% (previously 26%)
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 59% (previously 61%)
Work in partnership to deliver integrated care and care closer to home 5% (previously 6%)

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.

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.

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

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

Risk register theme: Staff capacity
BAF Risk 3.1 having suitable and sufficient staff capacity and capability and reduced levels of sickness
BAF Risk 2.8 reducing the length of time that patients are waiting for appointments within our services

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
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

4 Risk register movement

4.1 There is one risk scoring 15 (extreme) or above on the risk register as of 7 July 2022:

Risk 944: Waiting times for Community Dental Services (this has been recently escalated see section 5.2 below)

5 New or escalated risks (scoring 15+)

5.1 There are no new risks scoring 15+ that have been added to the risk register since May 2022.

5.2 One risk has been escalated to a score of 15+ since May 2022:

Escalated Risk 994: Waiting times for Community Dental Services

Previous Score 6 (moderate)
Current Risk Score 15 (extreme)

Description:
Due to staff capacity not meeting the service demand within the Community Dental Service (with the exception of urgent domiciliary for End of Life and palliative care), there is a risk that children and adults are not able to access care in a timely manner. As a result there could be a potential deterioration of the patient's oral health leading to increased pain and risk of infection, a detrimental impact on the patient's general physical, mental and social health. In terms of service delivery contracted waiting times and specifications will not be met, there could be potential reputational damage, and a reduction in staff morale.

Reason for Escalation:
The risk has been increased from 6 to 15 (the original risk score)
There has been no specialist or consultant in paediatrics undertaking clinics since March 2020. Despite 2 attempts to fill the vacancy. National shortages are a contributing factor.

There have been two recent incidents where delays in treatment (6 month waiting times) have led to urgent referrals and harm to children because of weight loss and pain.

Controls and further planned mitigation

- Groups of patients are categorised on priority basis as per business continuity plan
- Additional support from dentist on CLASS
- General Aesthetic caseload and pathways ADULTS. The consultant and Band B dentist are managing this caseload and Band B dentists are supported to take on the cases.
- General Aesthetic caseload and pathways CHILDREN. Service can escalate children in pain and or with swelling to Leeds Dental Institute (LDI) but must see them face to face first. There is no pathway for children without pain and

swelling, who are not able to accept treatment with local or conscious sedation require General Anaesthetics (GA). There are children waiting for GA and a plan is needed to be in place for them.

- Meeting with LDI and commissioner regularly to review the paediatric offer.

- Options appraisal and proposed Paediatric sedation pathway for contract adjustment has been escalated and forwarded to the commissioner in February 2022. This has been passed onto the recommissioning group May 2022.

- Liaising with Safeguarding and ensuring new and existing children are reviewed with the team. They have offered to liaise with LTHT safeguarding if there are concerns.

- Changes to be made to internal pathways.

Expected date to reach target: 30/12/2022
Risk Owner: Service Manager
Lead Director: Executive Director of Operations

---

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

6.1 One risk has been de-escalated below 15 since May 2022:

Risk 877 Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand

Previous score 15 (extreme)
Current score 12 (v high)

Description: As a result of an imbalance in capacity and demand there is a risk of reduced quality of patient care in Neighbourhood Teams.
It is anticipated that this may have an impact on the responsiveness to referrals, potential increase in patient safety incidents and complaints and a reduction in positive patient experience and staff morale and health and wellbeing. This risk is increased in circumstances where this situation continues where capacity and demand are mis-matched and adequate mitigations are not achievable.

Reason for de-escalation: Having reviewed the impact of the current Neighbourhood Team (NT) capacity and demand imbalance and the balancing patient safety measures and stable position regarding the NT patient safety incidents and complaints/ concerns the risk score will be adjusted to 12

Date to reach Target: 31/10/2022
Risk Owner: Executive Director of Nursing and AHPs
Lead Director: Executive Director of Nursing and AHPs

7 Summary of risks scoring 12 (high)

7.1 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.

7.2 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
1002	Coronavirus (Covid-19) increased spread of infection	12
1025	IT (Helpdesk) Support Capacity	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
1070	Capacity pressures in Neighbourhood Teams impacting on ability to deliver full range of clinical supervision and annual appraisals	12
1096	High vacancy rate in the Community Care Beds	12
1109	Clinical Incident Management in Neighbourhoods	12

8 New or escalated risks (scoring 12)

8.1 One new risk scoring 12 has been added to the risk register since May 2022 and details of these risks have been provided to the Quality and Business Committees for scrutiny:

Risk 1109 Clinical Incident Management in Neighbourhoods

Initial risk score 15 (extreme)
Current risk score 12 (v high)
Target risk score 2 (low)

Description: As a result of staff capacity and Neighbourhood Team staff being required to work outside of their role, there is a risk that incident management and reviews will not be undertaken in a timely manner which would have an impact on the timely introduction of quality and safety improvements.

Controls in place:
Planned approach to working through Datix holding areas and ensure all incidents are reviewed within 48hrs as a priority,

Actions include:
Clarify role requirements and expectations
Formalise an integrated working relation and protected time to facilitate every NCQL protected time to complete at least 1 rapid review per week in order to support the backlog clearance.

Date to reach Target: 31/10/2022
Risk Owner: Executive Director of Nursing and AHPs
Lead Director: Executive Director of Nursing and AHPs

8.2 Two operational or clinical risks have been escalated to a score of 12 (high) since May 2022 and details of these risks have been provided to the Quality and Business Committees for scrutiny:

Risk 1025 IT (Helpdesk) Support Capacity

Previous risk score 9 (high)
Current risk score 12 (v high)

Description: Insufficient resources (IT Helpdesk staff) means some LCH staff are waiting excessively to access IT Helpdesk support or fail to obtain support altogether as demand for IT support has risen as a result of staff working from home, using new or unfamiliar technologies or having been redeployed to new and unfamiliar areas of the Trust.

There is a risk that staff may not being able to access or record patient information such assessments or care plans, they may not be able to access clinical appointments, corporate data to support meetings, or record incidents or risks. This may lead to increased complaints from staff and patients, staff delaying or cancelling work and increased anxiety and stress for clinical, management and administrative and Helpdesk staff.

Reason for Escalation: The IT Helpdesk Manager who was due on post on the 16 May 2022 failed to start because of personal circumstances. This post has been put out to advert once again 16/06/22.

A further IT Officer from the IT Helpdesk has provided their notice to leave whilst another member of staff is on long term sick leave, meaning there are currently 3.0 WTE out of a staffing complement of 7.0WTE (including the IT Helpdesk Manager) at work.

Controls

- Existing Helpdesk resources
- Self help guides to resolve many common access (password) issues
- Provision of self-serve password reset facilities for commonly used systems such as active directory and NHS Mail,
- Fixed estate to be used as a backup to laptops suffering from connectivity issue

Further planned mitigation

- Recruitment process
- Agency support

Expected date to reach target: 30/12/2022
Risk Owner: Deputy CIO/Head of Community Informatics
Lead Director: Executive Director of Finance and Resources

Risk 1002 Coronavirus (Covid-19) increased spread of infection

Previous risk score 8 (high)
Current risk score 12 (v high)

Description: As a result of the national situation of Covid-19 spread, and the planned introduction of asymptomatic staff testing, there is a risk of a local increase in positive cases +/- outbreaks in Leeds which could have an impact on workforce and service delivery.
.
Reason for Escalation: the COVID rate is increasing again in Leeds and is having a significant impact on the workforce. A number of outbreaks have been reported across the Trust.

Controls

Local actions in place where necessary e.g. return to mask wearing, limiting face to face meetings, social distancing etc.
IPC are monitoring outbreaks and putting appropriate actions in place as above.
Staff continue to be required to test twice weekly

Expected date to reach target: 31/08/2022
Risk Owner: Executive Director of Nursing and AHPs
Lead Director: Executive Director of Nursing and AHPs

---

9 Risk profile - all risks

9.1 The total number of risks on the risk register is currently 58. Of these there are 14 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	1	0	4	0	0	5
3 - Moderate	0	11	13	11	1	36
2 - Minor	2	1	9	2	3	17
1 - Negligible	0	0	0	0	0	0
Total	3	12	26	13	4	58

10 Impact:

10.1 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.

10.2 Resources

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

11 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)								Level of Assurance				
Risk		Risk ownership		Current risk score				Committee agreed level of assurance				Comments about assurance levels
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	
Deliver outstanding care	**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	2	4	**8**				✓		
	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**					✓	The item: Spinal Pathway – Collaboration and Improvement since a Never Event provided substantial assurance
	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	3	4	**12**			✓	✓		Reasonable assurance **with limited assurance specifically in relation to cancelled and re-scheduled visits in NT**
	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 increasing demand on services the Trust is unable to provide quality of care in a timely and equitable manner, then the impact will be potential harm to patients, additional pressure on staff and reputational damage.	SL	QC	4	4	**16**	New risk for 2022/23		✓	✓		Reasonable assurance **with limited assurance specifically in relation to cancelled and re-scheduled visits in NT**
	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**						

Use our resources wisely and efficiently	**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**						
	RISK 2.7 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.	SP	TB	2	3	**6**	New risk for 2022/23					
	RISK 2.8 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'.	SP	BC	4	3	**12**	New risk for 2022/23			✓		Challenges to managing this risk continue as there is still pressure on services. The Committee noted the significant amount of work being done to understand and manage the waiting lists and reduce the backlog.

Ensure our workforce community is able to deliver the best possible care in all of the communities that we work with	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development and a manageable level of absence) then the impact may be a reduction in quality of care and staff wellbeing and a net cost to the Trust through increased agency expenditure.	JA/LS	BC	4	4	**16**				✓		
	RISK 3.2 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.	JA/LS	TB	3	3	**9**						
	RISK 3.3 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 3.4 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 plan to reduce the backlog of fire risk assessments, and the monitoring process provided reasonable assurance to the Committee.
	Risk 3.5 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, care closer to home and reduce health inequalities	**RISK 4.1** If the Trust does not play an active part in the collaboration across the health and care system (ICB and PBP), 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**						

Board Meeting held in public: 5 August 2022

Agenda item number: 2022-23 (43)

Title: Freedom To Speak Up Guardian Report 2022

Category of paper: for assurance

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

Executive summary

This report covers the period of 6th August 2021 to 5th August 2022. It offers a record of the work of speaking up at Leeds Community Healthcare NHS Trust and wider work across the health and care system.

Twenty-seven concerns were raised formally by LCH staff members concerning LCH services through the Freedom To Speak Up Guardian (FTSUG). Thirty-one concerns were informally discussed or resolved via the FTSUG, Themes from these concerns are described in this report.

The Freedom To Speak Up Guardian has:

- Supported the Executive Director of Nursing and AHPs in her work to review and learn from the Ockenden Report.
- Is helping to provide support for our new International Nurses and is working with the Clinical Education Team to establish a forum for clinical students
- Has offered mentoring and support to guardians at different NHS trusts.
- Supported Leeds City Council to interview and appoint their first FTSUG.

Recommendations

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

1 Introduction

1.1 This paper provides an overview of the work of the Freedom To Speak Up Guardian (FTSUG), basic activity data and recommendations on the role and its development from August 6th 2021 to August 5th 2022.

2 Background

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

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

2.3 The trust has created a form of work to enable staff to speak up and be heard. The work has been recognised nationally and locally as a respected service.

3 Current position

3.1 The FTSUG work receives strong ongoing support from the Chief Executive, Directors, the Chair, the Non-Executive Director with responsibility for speaking up work, the NEDS, the trust's Race Equality Network (REN) and the wider Trust. A clear form of work has been established and is operating well. This work has several forms principally where individual staff approach the FTSUG and the Race Equality Network speaking up champions to discuss concerns. Other forms include managers inviting the FTSUG to work in their teams so staff voices can be heard to enable better team cultures and change projects in the organisation where speaking up is an additional source of support to staff and managers.

3.2 Work with the Race Equality Network Speaking Up Champions and the Clinically Extremely Vulnerable Staff Group continues. Career development work is offered to any staff member from an ethnic minority community by the FTSUG. This is a plan around their career development linking the staff to support mechanisms in the wider organisation such as mentoring, coaching, interview support and leadership courses.

3.3 The FTSUG works at local, regional, and national levels. The local work at LCH continues to develop. The learning and outcomes include work linking to the WRES, initiatives around mental health, leadership development and organisational processes. The FTSUG works regionally through the Regional Freedom To Speak Up Network for Yorkshire and the Humber and nationally with the National Guardian Office in developing speaking up in the wider health and care system.

3.4 Several NHS Trusts and national NHS bodies have had consultations and conversations with LCH about our work and approach to speaking up in the last year. The FTSUG has offered mentoring and support to guardians at different NHS trusts. The FTSUG also attends the national NHS Confederation Race and Health Observatory Stakeholder Engagement Group and the national NHS Employers Staff Experience Steering Group to support their work and thinking and share LCH work and approaches. We have supported NHS Digital to interview and recruit four FTSUG's for their organisation.

3.5 The FTSUG was Highly Commended in the 'Making a Positive Difference' Race Equality Award from the West Yorkshire and Harrogate Partnership.

3.6 We offered conversations with staff who were reticent about the Covid vaccine. This was focussed on health and wellbeing and to support conversations with the trust.

3.7 The FTSUG supported Leeds City Council to interview and appoint their first FTSUG. We understand this is the first such appointment for a local authority. We are working with local authority colleagues and the National Guardian Office to develop and share this work. Work supporting Leeds General Practice continues with Leeds CCG and the Leeds GP Confederation.

3.8 The FTSUG supported the Executive Director of Nursing and AHPs in her report on the Ockenden Report. This also included online clinical meetings to look at the report and its learning. These were well attended and looked at the practice of speaking up work and its challenges. Following this, reflective work on the Lothian Review and its learning with the LCH Community Paediatric Audiology service is planned.

3.8 The FTSUG has worked with ODI Leads for all staff survey comments which include speaking up to work with the Clinical Business Units to look at messages and actions. Work reaching out to staff who do not have regular access to IT has also started.

3.9 Work from the FTSUG with our new International Nurses has started as has work with the Clinical Education Team to establish a forum for clinical students which will have a special focus on wellbeing support and being able to raise concerns.

4 Activity data

4.1 The table below shows the volume and type of activity with which the FTSUG has been engaged between August 6th 2021 and August 5th 2022. The table also indicates the nature of the issues raised with the FTSUG.

4.2 The table below details speaking up concerns formally raised about LCH services.

Business Unit	Numbers of concerns formally raised	Issues
Adult Business Unit	5	Fuel, management, team dynamics, culture, violence from a patient, racism, bullying
Children and Families Business Unit	10	Lack of support, lack of disability understanding and support, workloads, impact on staff health and wellbeing
Corporate Services	3	Concern over how a service is operated, leadership,
Specialist Business Unit	9	Lack of inclusion, leadership. culture, recruitment issues, IT cover for night services.

4.2 Twenty-seven concerns were raised formally by LCH staff members concerning LCH services through the FTSUG.

Thirty-one concerns were informally discussed or resolved through the FTSUG. One LCH staff member raised an issue of race and behaviours while working at another trust. The FTSUG has supported the staff member to raise this concern with the other trust.

Eight concerns were raised formally to LCH as an organisation through the FTSUG. These covered mandated vaccinations, lateral flow, racism in the UK against people from Eastern European countries and our response, trigger alerts and leadership conversations.

The Speaking Up Champions had four issues raised with them (one of which involved the FTSUG).

This brings the overall concerns raised to seventy cases.

4.3 Five colleagues who formally raised concerns through the FTSUG are from Black, Asian and minority ethnic communities and of these concerns three were related to issues of race (one is for support with raising experiences in another NHS trust). Six staff colleagues who informally discussed concerns with the FTSUG are from Black, Asian and minority ethnic communities and one of these was related to issues of race. Four staff raised issues with the REN Speaking Up Champions. Two cases of mental health and two cases of disability were raised formally. Two cases of mental health were discussed and supported informally. One case of physical / neurological disability was informally supported,

5 Themes

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

5.1 Colleagues from Black, Asian and other ethnic communities are raising concerns around themes of inclusion and equity. We are working to develop the best ways to support and hear these staff voices. These staff colleagues

report being supported and heard. An East European colleague spoke about racism against people form East European countries in the UK and as a result an article about these experiences written by the staff member is now part of the EDI and REN pages on the trust intranet. Staff with disabilities have started to name issues. Staff with mental health issues are already speaking up and creating changes such as trigger alerts on all trust training which contains sensitive and distressing information and how we best work in supporting staff in processes and attending panels.

5.2 Leadership, culture and behaviours in teams are ongoing key factors that have featured historically. Health and wellbeing, ways of working and workloads are areas mentioned in concerns. Recent issues such as mandated Covid vaccinations and fuel costs have featured in the work.

5.3. We are seeing more cases resolved or supported informally which fits with our ambition that concerns are addressed via local conversations and work.

5.4 All staff with working with a formal and informal concern report the FTSUG work as supportive and responsive. The highest rate of referrals is still from staff who are advised to contact the FTSUG service by staff who have already used the service.

5.5 The issues staff raise about the work for wider reflection are one case of the difficulty of being in a team when the staff member has spoken up, the lack of change in a team (or initial change but then a return to what they reported) and that the FTSUG does not have power to lead change in services (something the independent role of the Guardian prohibits). We are looking at the issues raised.

5.6 In comparison to last year's annual report, there is a slight decrease in concerns raised formally (from 36 to 35). In last year's annual report there were six staff colleagues who formally raised concerns with the FTSUG from Black, Asian and minority ethnic communities and three of these concerns was related to issues of race. In this year's report there are five staff colleagues who formally raised concerns through the FTSUG from Black, Asian and minority ethnic communities and of these concerns three were related to issues of race (one is for support with raising a concern about their experience in another NHS trust). Last year's annual report had no other protected characteristics raised whereas this year four staff with disabilities / mental health have raised concerns formally and three cases have been informally supported.

.

6 Assurances and Future Work

6.1 **T**he assurances given to the organisation with the role are threefold – national engagement, organisational spread, and local comparison.

We are reporting quarterly to and work positively with the National Guardian Office. Secondly, the FTSUG is meeting staff from across all business units of the trust and at different roles / levels. Third, in terms of local comparison with neighbouring NHS trusts, we evaluate well in terms of staff who speak up.

6.2 The following are ongoing and future work and plans.

- To further support our speaking up work, we will undertake a new peer review of speaking up at the trust in 2022-23. The last peer review was in 2016. Locala have agreed to undertake this review and we will offer a peer review to Locala.

- The FTSUG will speak at the Patient Safety Congress in September 2022 and the FTSUG and a REN Speaking Up Champion are speaking at the national ‘Achieving A Culture of Candour ‘conference in August this year.

- There will be a special focus on staff with protected characteristics in the trust to see how speaking up can support these staff when needed. We have started to support staff with disabilities who are speaking up and will continue to support the work with REN and CEV colleagues. The FTSUG is working with LCH colleagues to look at a Disability Forum to hear the voices of staff with disabilities.

7 Conclusions

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

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

7.3 The FTSUG work supports the work of building new ways of working and our commitment and behaviours for excellent clinical care and compassionate culture.

8 Recommendations

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

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public : 5 August 2022

Agenda item number: 2022-23 (44)

Title: Quarter 1 Report 22.23 of the Guardian of Safe Working Hours

---

Category of paper: For assurance

History: Nil

Responsible director: Executive Medical Director

Report author: Guardian of Safe Working Hours

Executive summary (Purpose and main points)

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

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

Main issues for consideration

- Current plan and work in progress to address CAMHS ST historic rota compliance and payment issues

- Need for robust Human resources/medical staffing support for implementing and managing junior doctor contract, rota assurance and work schedule

- Dr Baljit Karda's appointment as the junior doctor trainee representative on the LNC.

Recommendations

Board is recommended to:

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

- Support GSWH with the on-going work related to CAMHS ST historical rota compliance and payment issues

- To note that work has been started to look into sustainable long term solution with regards to rota assurance and JD workplans and the need for dedicated HR support for Junior doctors working in LCH

- To note that there is a risk a fine is levied (by GSWH in conjunction with the BMA) in response to compliance of CAMHS ST on call historic rota and financial impact on the trust if any underpayments identified

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 full time 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 non resident on call 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. The current CAMHS ST on call rota is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota to double check the Locum shifts picked up by Junior doctors.

Progress has been made since last Board meeting with regards to sustainable long term solution for rota assurance and CAMHS JD work schedules. HR business partners for CAMHS are in discussion with LTHT workforce colleagues to scope out possibility for them to process and administer the works schedules, rota and to using a robust system like Rota software (Allocate). Initial meeting has been planned between LTHT workforce, LCH HR rep, CAMHS rota co-ordinator and LCH Guardian of safe working hours (GoSWH) to review this piece of work.

Rota Gaps (number of night shifts needing cover)		June 2022		July 2022		August 2022	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	17	n/a	16	n/a	19
	Internal Cover	n/a	1	n/a	8	n/a	8
	External cover	n/a	16	n/a	8	n/a	11
	Unfilled	n/a	0	n/a	0	n/a	0

3.2 **Exception reports**

No exception reports filed during this quarter.

3.3 **Fines**

No fines levied by the GSWH during this quarter.

3.4 **LNC Junior doctor representative**

Dr Baljit Karda has been appointed as the junior doctor trainee representative on the LNC from July 2022. This post has been vacant for a few months and Dr Karda's involvement will have a positive impact on LNC and GSWH's engagement with junior doctors.

3.5 **Feedback from trainees**

Junior Doctors Forum (JDF) was held on 06/07/2022. GSWH introduced the Dr Karda to the team. Medical education team introduced the Health toolbox which is a new website and application that has been introduced by LCH to cater for all Junior doctor related information. Junior doctors were shown how to use it and discussion held to include more information as suggested by the Junior doctors.

GSWH updated junior doctors about the on going work related to CAMHS ST rota.

GSWH has taken on board the feedback from the past Trust board meeting regarding capturing the voice of Junior doctors into the Trust board report. This was discussed at JDF. Further progress has been made and BMA IRO has agreed to collate information from other Trust with regards to questions to include in the feedback and GSWH will then work with communications team to set up an anonymous survey. The survey will aim to gather feedback directly from the Trainees about their issues, feedback for GSWH and JDF.

Next JDF is being planned for 06/10/22(tentative date) and GSWH has requested all Junior doctors to try and priorities it in view of potential attendance by Trust Board Chair. Junior doctors present at JDF were appreciative that the Trust Chair was keen to meet with them.

4.0 Impact

This report has been informed by discussions with Junior doctors, JNC, HR business partner, previous GSWH reports, GSWH and medical education team from LYPFT and guidance received from NHS employers and Health Education England.

4.1 CAMHS Historic ST rota issue

Issues related to possible underpayment and previous CAMHS ST rota being non-compliant remains as mentioned in previous GSWH reports. This is a big piece of work dating back to year 2016/2017 when the current Junior doctors contract was introduced. Since the last Board meeting, following progress has been made-

- BMA IRO has obtained permission to represent from four Junior doctors who have worked on this rota in the past and has officially written to LHC workforce directorate. The Trust workforce directorate have requested for further information from BMA IRO and have registered this issue under the Trust Grievance policy (underpayment of wages constituting to post employment grievance).

- GSWH has reviewed previous GSWH Board reports (between 2017 and 2021) to collating any information related to CAMHS works schedule, rota monitoring and exception reports. GSWH first report dated 22/05/2017 mentions about all junior doctors moving to the 2016 JD contract by Feb 2017 and that generic works schedule for trainees who are contracted by LCH were created by clinical/educational supervisor with support from HR.

  August 2017 board report highlights that the required mechanisms of engagement, work schedules, exception reporting, and the junior doctors' forum have been implemented within the Trust.

There is no information as to how the CAMHS ST on-call Rota was produced and if there was a HR review of the rota being compliant with regards to rest requirement between on calls.

Between 2017 and end of 2020 there have been five exception reports by CAMHS training related to working hours and the GSWH report mentions about these being resolved. There is no data in GSWH reports indicating if work schedule review or rota monitoring because of these exception reporting was needed or conducted. December 2017 board report highlight the paucity of exception reporting and that it is likely to represent an ongoing challenge for engagement rather than an absence of contractual difficulties.

- GSWH has been in touch with CAMHS HR Business partner, CAMHS consultant who was around during 2016 JD contract introduction and was actively involved in JDF working along with the GSWH during that period. This is to obtain further information to clarify if they have any information related to work schedule review that was undertaken and if there was HR involvement in development of the CAMHS on-call rota as a part of work schedule development.

- JNC has been kept informed of the progress and GSWH has highlighted to JNC the need for a named HR contact for JD contract issues, rota issues so that Junior doctors are well supported, and any contractual issues are identified and resolved promptly.

4.2 Community Paediatric Training

Community paediatric trainees are based in LTHT for all their on-calls and 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. No further progress has been made since last Board report as GSWH has not been invited to LTHT JD forum.

5.0 Recommendations

Board is recommended to:

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

- Support GSWH with the on-going work related to CAMHS ST historical rota compliance and payment issues

- To note that work has been started to look into sustainable long term solution with regards to rota assurance and JD workplans and the need for dedicated HR support for Junior doctors working in LCH

- To note that there is a risk a fine is levied (by GSWH in conjunction with the BMA) in response to compliance of CAMHS ST on call historic rota and financial impact on the trust if any underpayments identified

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (45)

Title: Safe Staffing

Category of paper: For assurance
History: Quality Committee 25 July 2022

Responsible director:
Report author:

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

The report sets out progress in relation to maintaining safe staffing over the last six months. It covers the range of services provided in the Trust. Data is contained in an appendix with the main body of the paper being used to provide assurance to the Board in relation to the effect of staffing pressures on services and how these are being mitigated.

Safe staffing has been maintained across the one inpatient unit for the time period. The usage of temporary staff is highlighted for all services within the appendices of the report. The paper sets out the mitigation in place and also triangulates elements of patient safety data to the staffing numbers where this is possible.
There continues to be an impact from the pandemic on staffing.
Work continues to look at establishing clear guidance and being able to define safe staffing across the range of LCH services, however this is complex and especially in absence of national guidance.

Recommendations
The Board is recommended to:
Note the contents of the report and the progress being made and support six monthly reviews to Quality Committee and subsequently to the public Board meeting.

1.0 Background

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

1.2 In addition to reporting on the in-patient areas, of which the Trust now only has one, the paper also provides information on all the Trusts services.

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

2.0 Safe staffing

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

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

3.0 Specialist Business Unit (SBU)

3.1 Services within SBU have continued to strive to meet the needs of service users in a safe and effective way.

3.2 The following table provides information regarding staffing levels within services in the SBU. It includes details of the budget, staff in post, number of vacancies within the service and actions which are being taken by the services to recruit to vacant positions. The data was pulled at the end of May 2022 and reviewed again at the end of June 2022. Staffing within Police custody suites continues to be an area of concern and the service has been asked to complete a trajectory to provide an update on staffing levels.

Name of service	Budget WTE	Contracted WTE May 22	Vacancy	comments
Cardiac service	33.72	32.67	1.05	Considering skill mix
CIVAS	11.85	10.61	1.24	Out to advert
Respiratory Service	26.11	22.61	3.50	Out to advert for Nursing and Physiotherapy Positions
Respiratory virtual Ward	13.76	11.70	2.06	Going out to advert shortly, considering skill mix
Long Covid Rehab service	28.57	22.96	5.61	In recruitment
Homeless Health Inclusion Team (HHIT)	7.29	6.61	0.68	Planning underway to appoint a Joint Care Navigator with lived experience -will be hosted by St Gemma's
Community Gynae	1.73	1.73		
Leeds Sexual Health (LSH)	58.58	53.11	5.47	2 of the 4 Nursing positions are now filled - commencing July 2022. Out to advert for other posts.
Police Custody Yorkshire and Humber	123.28	105.69	17.59	Police custody have13 WTEs in the recruitment process, awaiting start dates, 1 returning from mat leave and 1 returning from secondment. Remaining vacancies out to advert. Predicting 3 leavers over the next 3 months. Service to produce a workforce trajectory by area.
L and D Humber	14.86	14.86		
WYOI primary care	37.87	30.90	-6.97	Nursing vacancies 5.4 WTE. Covering through bank, agency. Band 4 substance misuse vacancy. B5 and B7 vacancy upcoming. CAMHS (SWYFT provided) continue to also suffer with recruitment issues and therefore have a number of mental health practitioner vacancies at both Adel beck and WYOI. Service to work with Head of Service to develop skill mixed workforce plan and trajectory.

Name of service	Budget WTE	Contracted WTE May 22	Vacancy	comments
Portfolio1				
Cardiac service	32.67	33.72	1.05	Within the service there are 1.89WTE vacancies. 0.2VFW monies -1WTE in recruitment. There is a skill mix plan underway for remaining WTE's
CIVAS	11.85	10.61	-1.24	
Respiratory Service	26.11	22.61	-3.50	Out to advert for Nursing and Physiotherapy Positions
Respiratory virtual Ward	13.76	11.70	-2.06	Going out to advert shortly, considering skill mix
Long Covid Rehab service	28.57	22.96	-5.61	In recruitment
Long Term condition admin	0.60	0.00	-0.60	
HHIT	7.29	6.61	-0.68	Planning underway to appoint a Joint Care Navigator with lived experience -will be hosted by St Gemma's
Community Gynae	1.73	1.721	-0.01	
LSH	58.58	53.11	-5.47	2 of the 4 Nursing positions are now filled - commencing 14/7/22. Out to advert for other posts.
Police Custody Yorkshire and Humber	123.28	105.69	17.59	Police custody Y and H 13 WTEs in the recruitment process, awaiting start dates, 1 returning from mat leave and 1 returning from secondment. Job out to advert which closes 23.6.22. Predicting 3 leavers over the next 3 months. Service to produce a workforce trajectory by area.
L and D Humber	15.86	11.64	-4.22	3WTE commenced in post W/C 21/6/22 1 post remains vacant which is admin and this is out to advert
WYOI primary care	37.87	30.90	-6.97	Nursing vacancies 5.4 WTE. Trying to cover through bank, agency (1.5 WTE agency vetted). Band 4 substance misuse vacancy. B5 and B7 vacancy upcoming. HCA vacancies. CAMHS continue to also suffer with recruitment issues and therefore have a

3.3 Services continue to record, risks and closely monitor incidents, concerns, and complaints to identify if there are any themes where reduced staffing levels have contributed to them. Following a deep dive in MSK it was clear form Datix that there where no reported patient safety incidents in relation to waiting times.

3.4 Recruiting to vacant positions in many services is difficult, leads are sharing there are many reasons for this, some are detailed here:

- Health care professionals reviewing their own work life balance and choosing to leave or alter how they work
- Shortages within the workforce and the lack of staff that have the appropriate skills to fulfil the roles which are vacant
- Competition within the system where new roles are been offered by other providers where the terms and conditions are different – ARRS roles graded at higher band levels - agencies offering higher rates of pay for similar roles etc.

3.5 Services continue to be flexible and adaptable to meet the staffing levels required in the services to meet the capacity and demands. They continue to have ongoing recruitment drives and some services (MSK and SLT) have introduced development roles into their services, whilst this is a positive step it is acknowledged that during the time of development staff in the roles need longer appointment times and more supervision which initially reduces capacity.

3.6 Services continue to offer additional hours and overtime to staff to increase capacity and absence levels and rotas are proactively monitored to try to improve situations as issues arise.

3.7 Exit interviews are monitored to explore if there are any themes emerging which need to be addressed.

4.0 Children's Business Unit (CBU)

4.1 Children's Community Nursing Service
Hannah House

4.2 Hannah House is a C1 service and has remained open throughout the pandemic to support vulnerable children and families. During the pandemic bed occupancy rates reduced. There has since been a reduction in new referrals due to a number of reasons including upskilling of Social Care Personal Assistants and more parents choosing not to send children away from home.

4.3 Unfortunately, there have been two Covid outbreaks amongst Hannah House staff in April 22 and June 22. During the latter, two children's stays had to be cancelled and rearranged to maintain safe staffing levels. Alternative arrangements were offered to one of the parents for day hours over two days, this was declined, and the child was kept at home, Hannah House staff supported in the home. There were no cancellations between January and April 2022 that were due to not being able to safely staff the unit.

4.4 A child who had been resident at Hannah House for nearly 3 years whilst waiting for foster carers and then subsequent adaptations to the house sadly died in Leeds Teaching Hospital in May 2022. Staff who wanted to attend the funeral were supported to do so and the leadership team have continued to offer support to individuals.

4.5 The Team Lead for Hannah House recently retired and an acting Team Lead is in post for Community Nursing and Hannah House, pending permanent recruitment to the role.

4.6 During this reporting period work has been actioned in Children's Community Nursing to develop mutual aid capacity with a programme called 'Ready Steady Go'. This has involved building a clinical competency and support package for those who have opted to be part of a bank for the Children's Community Nursing Service for bands 3-6. This has yielded a good level of interest and enquiries, with two staff nurses signing up to offer time. One staff nurse has commenced shadow shifts at Hannah House.

4.7 There have been no complaints relating to staffing and there have been no moderate or major harm incidents.

Inclusion Nursing

4.8 Inclusion Nursing is a C1 service to support children who attend Leeds Specialist Inclusive Learning Centres (SILCs) with complex health needs in partnership sites. Within this, there are some staffing issues which are being addressed with support from HR such as staff on long term sick and related complexities. There have been ongoing discussions with the Heads of schools regarding increasing Edu-Carer provision to support the care and provision for children within the schools.

4.9 With ongoing staffing pressures staff have been flexible in their working patterns, for example, by working additional or longer shifts. Support has also been received from Hannah House which has meant that the service has managed to ensure no child's attendance at school has needed to be cancelled due to a lack of nursing staff in the schools.

4.10 Staffing shortages have also meant that two senior staff nurses, whose posts were funded by the Clinical Commissioning Group (CCG) two years ago to take forward the nurse led clinics, have been required to cover where there has been a shortfall. This has been required to support the induction and training of several new band 5 staff nurses and cover for sick leave. The CCG are aware that the nurse led clinics have therefore not progressed at this time. The aim is to setup the nurse led clinics in Autumn term 2022.

4.11 There have been no complaints relating to staffing and there have been no moderate or major harm incidents.

Continuing Care and Health Short Breaks

4.12 This C1 service provides care to children and young people in the family home. This has been provided amid a persistent high level of both long and short-term staff sickness and staff vacancies. To mitigate this staff have worked flexibly alongside and with support from the Hannah House team, CLaSS and agency staff. Largely this has been to prioritise night cover.

Carers who access the service have reported finding this particularly helpful. A conversion of day hours to night is actioned to manage the packages as best as possible. Commissioners are aware of this prioritisation and any cancelled nights which only occur following a clinical risk assessment. Cancelled nights do unfortunately occur due to staffing levels.

4.13 Throughout January to June staff sickness has been a mixture of long- and short-term absences. The Team Lead is supporting eleven colleagues through sickness monitoring. Historically there is a pattern for sickness to spike in summer and then be followed by the usual winter pressures.

4.14 Following a cancellation, a concern was raised by a parent, this was responded to by the Team Lead and has been reported on Datix. There was learning from this incident and improvements have been made made regarding better communication and clarity regarding process and personal roles.

4.15 As previously discussed during this time 'Ready Steady Go' has been developed. One staff nurse has chosen to work a day a week with Continuing Care.

4.16 Following a CLaSS colleague working some hours in the team earlier this year, they chose to apply for and were successful in getting a permanent job as they had enjoyed the work. Three staff who had left the service to work elsewhere in LCH or the acute trust have returned in this reporting period to work for the Continuing Care service.

4.17 There was one moderate harm incident in relation to a pressure ulcer. A Rapid Review meeting concluded that there were no lapses in care and no further investigation was required

4.18 No complaints have been received.

Children's Community Nursing

4.19 The team provides a C1 service for children and young people with a wide range of nursing needs in their homes. Staffing is currently stable.

4.20 Staff have been supported following the death of a young person that they had cared for over several years.

4.21 The Team Lead retired in May and as previously stated a new acting Team Lead has been appointed to manage the Children's Community Nursing and Hannah House.

4.22 There have been no complaints relating to staffing and there have been no moderate or major harm incidents.

0-19 Public Health Integrated Nursing Service (PHINS)

4.23 Clinical staff within the 0-19 PHINS consists of Specialist Public Health Nurses (Health Visitors & School Nurses), Staff Nurses, Family Support

Workers, Health Care Support Workers and one Oral Health Promotion Practitioner.

4.24 There has been stability overall with the band 3's, 4's and 5's, however higher levels of sickness absence and Covid isolations have put additional pressures on service delivery, particularly regarding developmental reviews.

4.25 It has been very difficult to maintain safe staffing levels within the band 6 workforce over the past six months and a significant decline in Health Visitor numbers has posed a real challenge to the service due to recruitment numbers being lower than the number of practitioners leaving or reducing hours. Band 6 safe staffing levels have been monitored through a service capacity tool which has helped to determine capacity requirements for each 0-19 team.

4.26 The 0-19 PHINS is commissioned to provide 125 Whole Time Equivalent (WTE) Health Visitors and 20 WTE School Nurses. The table below shows the number of WTE band 6 practitioners working within the service from January 22 to the end of June 22. The overall vacancy factor at the end of June was 28.63 WTE Health Visitors and 6.34 WTE School Nurses.

	Jan	February	March	April	May	June
Health Visitors (WTE)	95.82	94.40	94.84	91.60	85.90	82.71
School Nurses (WTE)	13.04	12.55	13.19	13.19	13.59	13.66

4.27 Despite a rolling programme of recruitment there is a national shortage of Health Visitors and School Nurses, the service has therefore been working closely with Commissioners on a new service offer which supports a skill mixed model of care and additional recruitment of Staff Nurses and Family Health Worker posts.

4.28 The service has continued to report at Opel Level 3 due to increasing capacity pressures which have also been impacted by higher levels of sickness. The service has not been able to resume the antenatal contact because of this, but there is a plan to recommence this contact within the new service offer.

4.29 CLaSS staff have also been used to support service delivery requirements, alongside the offer of additional hours and overtime to existing band 6 staff.

4.30 The service has been successful in recruiting 8.36 WTE Health Visitor and 1.64 WTE School Nurse Specialist Community Public Health Nursing Students into band 6 posts. They will join the service in September 2022.

4.31 There have been no complaints relating to staffing and there have been no moderate or major harm incidents

School Immunisations

4.32 The School Immunisation Team provides a C2 service that is commissioned to predominantly deliver a school-based programme of diphtheria, tetanus and poliomyelitis (Td/IPV), meningococcal ACWY (MenACWY), human papillomavirus (HPV) and measles, mumps and rubella (MMR) vaccinations.

4.33 These vaccines form part of the national childhood immunisation programme, which aims to prevent school-aged children from developing vaccine preventable childhood diseases that are associated with significant mortality and morbidity. Although there is Commissioner expectation that the programme will be delivered primarily in schools, the programme must be offered to 100% of eligible school-aged children/young people, with all reasonable steps taken to engage with children and young people that are home-schooled, from groups that find it difficult to access services (e.g. Gypsy, Roma or Traveller children) or looked after children who may require special and specific arrangements.

4.34 The Covid pandemic brought many challenges for the team including high levels of pupil absenteeism that has resulted in lower uptake levels and greater numbers of young people still requiring their vaccinations. To manage these increased numbers over the past 6 months the team have facilitated fourteen Community Clinics in the evening, Saturday mornings and in school holidays, however numbers attending these have remained low and they have relied on staff volunteering to work additional hours and CLaSS staff being available.

4.35 CLaSS staff have also been used on a daily basis to supplement substantive staff in school sessions in order to be able to manage the larger cohort sizes of children requiring scheduled and missed immunisations from these past 2 years. No school sessions have been cancelled due to staffing issues.

4.36 There have been no complaints relating to staffing and there have been no moderate or major harm incidents

Child and Adolescent Mental Health Service (CAMHS)

4.37 The teams within CAMHS have continued to deliver care using a hybrid approach of face to face and virtual appointments.

4.38 There are vacancies across the whole of CAMHS and overall, we have seen an increase in referrals to all areas of the service. Diversification of some aspects of service delivery has been undertaken to meet the needs of young people and their families/carers.

4.39 CAMHS has experienced pressures with recruitment and retention and increased demands for services evidenced by a sharp increase in referral

rates. CAMHS Learning Disabilities, Eating Disorders and Mindmate SPA continue to report at OPEL level 3. There continues to be significant work around workforce planning and demand and capacity in CAMHS. There are significant waiting lists in many areas of the service. Investment from LCH continues to support outsourcing for both school age neurodevelopment assessment and therapeutic interventions for children and young people with emotional disorders. We are undertaking a pilot scheme to refine the initial routine assessment pathway into CAMHS, this is a combination of reducing the assessment length and situating it as a MindMate SPA intervention to ensure children and young people access the most appropriate service in a timely manner. Finally, the roll out of the MindMate Support Teams continues to ensure a consistent early intervention offer in the city, we expect full coverage of the city in 2025.

4.40 There have been no complaints relating to staffing and there have been no moderate or major harm incidents

5.0 Adult Business Unit (ABU)

5.1 As previously stated there are no nationally agreed staffing levels for community teams or evidence based tools. The Trust continues to develop the work to set safe staffing levels in community teams. Leeds is one of the test sites to develop a community based registered nurse safer staffing tool. The data from the national NHS England data collection process is now being used to inform work led by the Executive Director of Nursing and AHPs to develop target safe staffing levels for Neighbourhood Teams. This work includes consideration of the registered nurse establishment needed to respond to the local population health management needs and the aligned work underway to improve health equity. It also builds on work being undertaken under the Neighbourhood Model Transformation Programme (NMTP) on a predictive model for staffing availability using data from the health roster system.

5.2 The NMTP continues and is providing an opportunity to revisit and refresh the Neighbourhood Model, including a number of workstreams specifically focussed on staffing issues and informed by staff feedback. Complementing these longer-term improvements, a stabilisation plan focussed on immediate term improvements to increase capacity and manage demand for Neighbourhood Teams has also been initiated with oversight from the Executive Director of Operations and Executive Director of Nursing and AHPs. Taking account of individual patient needs, this work includes increased use of clinics, virtual consultations, increased self-management working with the Enhance Programme as well as ongoing work to increase capacity.

5.3 Information is provided in Appendix 3 in relation to staff turnover and sickness rates. Also included is the breakdown of temporary staff used through the LCH CLASS system. We continue to support staff to work from home where this is feasible for their role.

5.4 Staffing is monitored and managed on a twice daily basis through the Capacity and Demand reporting tool with senior clinical and operational oversight seven days a week. For most of this reporting period ABU and the Trust initiated a Bronze and Silver Command process to have additional oversight of capacity and demand and decision making required to inform the actions that are initiated to ensure patient and staff safety was maintained. This included mutual aid across the organisation. In June 2022 these arrangements were stepped down as available staffing improved but with an ongoing focus on the Stabilisation Plan described above. With support from QPD to maintain the focus on the safe management of daily capacity and demand a new daily capacity and demand tracker is being developed that will report out on safe staffing and capacity pressures from early Q2.

5.5 Staffing levels are monitored within the Adult Business Unit monthly performance process and any additional actions required considered by the Adult Business Unit senior leadership team. The improving availability of detailed staffing information through the e-roster system enables improved planning and reporting. In addition, a quarterly update report reviewing key indicators for Neighbourhood Team quality and workforce is provided to Quality Committee and Business Committee.

5.6 The rollout plan for the Patient Complexity Tool (PCI) which will support our understanding of the changing needs of our caseloads, is paused as result of capacity and demand pressures and other priorities e.g. triage, allocation, safe staffing workstream.

5.7 The main recruitment challenge in Neighbourhood Teams continues to be in recruitment of registered nurses reflecting the national shortfall in these roles. Recruiting sufficient advanced clinical practitioners and District Nurses continues to be difficult reflecting the national picture.
Despite an ongoing national shortfall in therapists, this has recently improved in Neighbourhood Teams. Whilst core staffing levels have improved, the next challenge for Neighbourhood Teams is to recruit in response to additional investment in community services (Physiotherapy, Occupational Therapy, Neighbourhood Nights Service, Pharmacy Technicians, Self Management Facilitators and Neighbourhood Clinical Assistants).

5.8 In addition to the ongoing recruitment issues, during this period teams are experiencing reduced capacity due to the ongoing impact of COVID, particularly the impact of self- isolation, and the Omicron Variant Close working with CLaSS ensures that available bank and agency staff are targeted at teams with the greatest staffing challenges. The Trust wide resourcing group chaired by the Executive Director of Nursing and AHPs and the Director of Workforce coordinates actions to support recruitment across the Trust including the Neighbourhood Teams. In addition, the contract with a local private sector provider continues to support capacity in a number of teams with particular staffing challenges from a combination of vacancies and sickness. During June we welcomed the first cohort of international nurses to LCH, including 5 staff who will be aligned to Neighbourhood Teams during Q2 and 4 newly qualified apprenticeship nurses.

5.9 Work is in progress reflecting on our experience of mutual aid over this winter to improve future resilience by investing in staff skills and support ahead of any future potential requirement for mutual aid.

5.10 The new District Nursing training programme is progressing. We supported 15 registered nurses to undertake the course in 2020. 14 registered nurses have places on the District Nursing training programme that commenced in September 2021. 9 nurses completed the 2020 full time course in September 2021 and have moved into District Nursing roles within the Neighbourhood Teams. During the last 6 month period the numbers of B7 District Nurses has increased to 18 now working within the Neighbourhood Teams. External recruitment to the new Band 7 District Nurse role is ongoing and, recently, increasingly successful. The Business Unit is putting forward our proposed numbers for future District Nurse training (Specialist Community Practitioner) and Community Matrons (Advanced Clinical Practitioner) training for future cohorts. Internally we have continued to support Band 5 nurses with a development programme to enable them to progress to the next steps in their careers. We are now offering this programme to ensure equality of access to this development opportunity for part time staff. The development of District Nurses and ACPs takes a minimum of 2 years and requires detailed forward planning for release and support of staff along with targeted recruitment and retention of LCH trained staff.

5.11 Staff experience and morale remains variable and is influenced by a number of factors Staff engagement is ongoing in all teams and a range of local initiatives continue to be implemented to improve staff experience and engagement and in this period, we have implemented fortnightly ABU Live Briefings via MS teams, and in May 2022 undertook a Connect and Reflect week to promote opportunities for staff in all teams to reconnect following a period of pressure.

5.12 There are a number of routes for staff to share their feedback and discuss solutions to local and citywide issues including:

- Regular team meetings
- Neighbourhood Model Transformation Programme engagement activities
- Additional staff support sessions (virtual and face to face where required)
- Executive Director of Nursing and AHPs and other Board Member visits/engagement sessions (including virtual) e.g. Team LCH meetings
- Regular time with and focussed support from ABU Leadership Team when required
- Maintaining individual staff 1:1s with their supervisor or line manager
- Appraisal and clinical supervision, recognising that work is in progress to improve clinical supervision rates, with appraisal rates improving.
- Monthly quality and performance panel
- Presentations at Quality Committee e.g. , CCSS and self-management facilitators
- Clinical drop ins
- Clinical sessions, members of the senior leadership team undertake clinical sessions alongside NT and Citywide Service colleagues
- Specific drop ins for the Community Matrons, Trainee Community Matrons and DNs / senior nurses, Leadership Team members with support from the ODI team as required.

5.13 Monitoring patient safety incidents that are related to staffing issues or concerns constitutes a key area for review. Based on learning from the last period we have maintained additional support with incident investigation and learning. We have continued to monitor ABU incident investigations, mortality reviews and any complaints raised by patients, families and staff as always and any issues related to staffing levels will be escalated to the senior management team (SMT).
There have been a total of 16 complaints, 24 concerns and 192 compliments logged in the reporting period January to June 2022 (compared to 17 complaints and 237 compliments in the previous 6 months). No new themes have emerged.

5.14 As previously reported the audit of cancelled and rescheduled visits continued to be monitored during this period, This daily review of all Neighbourhood Team rescheduled and cancelled visits showed that due to the capacity and demand imbalance, there continued to be a number of registered nurse visits that were rescheduled or undertaken by a non-registered member of staff. The senior clinical oversight of this decision making and clinical risk has been maintained and monitored by further cancelled and rescheduled visit audits along with patient safety incident reports. Business Intelligence also produce a weekly report of this data from SystmOne. A new capacity and demand management tool has been developed in conjunction with QPD to enable more effective monitoring of the daily position and decision making and is due to be implemented in Q2 2022. This data continues to be monitored closely with involvement of the Director of Nursing and AHPs, who reports to the Senior Management Team and Quality Committee regarding any areas of escalation from this audit work.

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

- Completion of essential work completed on the day and includes the oversight of mutual aid measures required to undertake this.
- Daily handovers (added in December 2021 to the essential work guidance)
- Safety huddles
- Neighbourhood Team Quality Boards - incidents, complaints, patient FFT and safe staffing returns were paused during the peak of the Pandemic. A simplified Quality Board will be reintroduced in Q2 2022.
- Caseload reviews are included within the Neighbourhood Team essential work guidance and can only be rescheduled with the oversight of the teams Clinical Pathway Lead.
- Clinical supervision and safeguarding supervision
- Review meetings post serious incidents
- Additional capacity from 3 WTE seconded clinical staff to support the timely incident investigation was introduced towards the end of this period.
- Sharing patient safety memos and learning from incident memos

5.16 Virtual Ward (frailty) Staffing levels. The Virtual Ward (frailty) operates as an enhancement to the existing Neighbourhood Team offer and implementation began in November 2020. The service provides a community based 2 hour response 0800-2000, 7 days a week for people being cared for at home, who would otherwise be supported by hospital services. It is jointly delivered by Leeds Community Healthcare, Leeds Teaching Hospitals Trust, CCG and

other partners. A positive evaluation demonstrated benefits for patient outcomes and experience, and to system flow in supporting more people in the community. Recurrent funding was secured in September 2021 and recruitment to the service is ongoing. Appendix 3 provides some detail on the number of people supported by the service to date.

5.17 From a staffing point of view there are some particular risks and issues which reflect the overall Neighbourhood Team position. These include:

- Availability of staffing across a range of nursing, AHP and non registered roles. We have implemented new roles e.g. phlebotomy to support capacity where possible
- Advanced clinical practitioners - critical to the service model- time to train (2 years lead in time for train and develop), highly competitive job market

5.18 System partners are working on expanding the virtual ward offer (in line with national guidance) which will create further demand for workforce to support this key area of work. This will continue to be monitored closely.

6.0 Conclusion

6.1 This paper presents the six-monthly review to Committee and Board in relation to safe staffing. The paper demonstrates that the Trust has maintained safe staffing in the six-month reporting period, despite many challenges.

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

6.3 Work will continue to develop safe staffing tools for all LCH services, but in the absence of national solutions this is challenging.

7.0 Recommendations

7.1 The Board is asked to receive and note this report.

Appendix 1

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

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

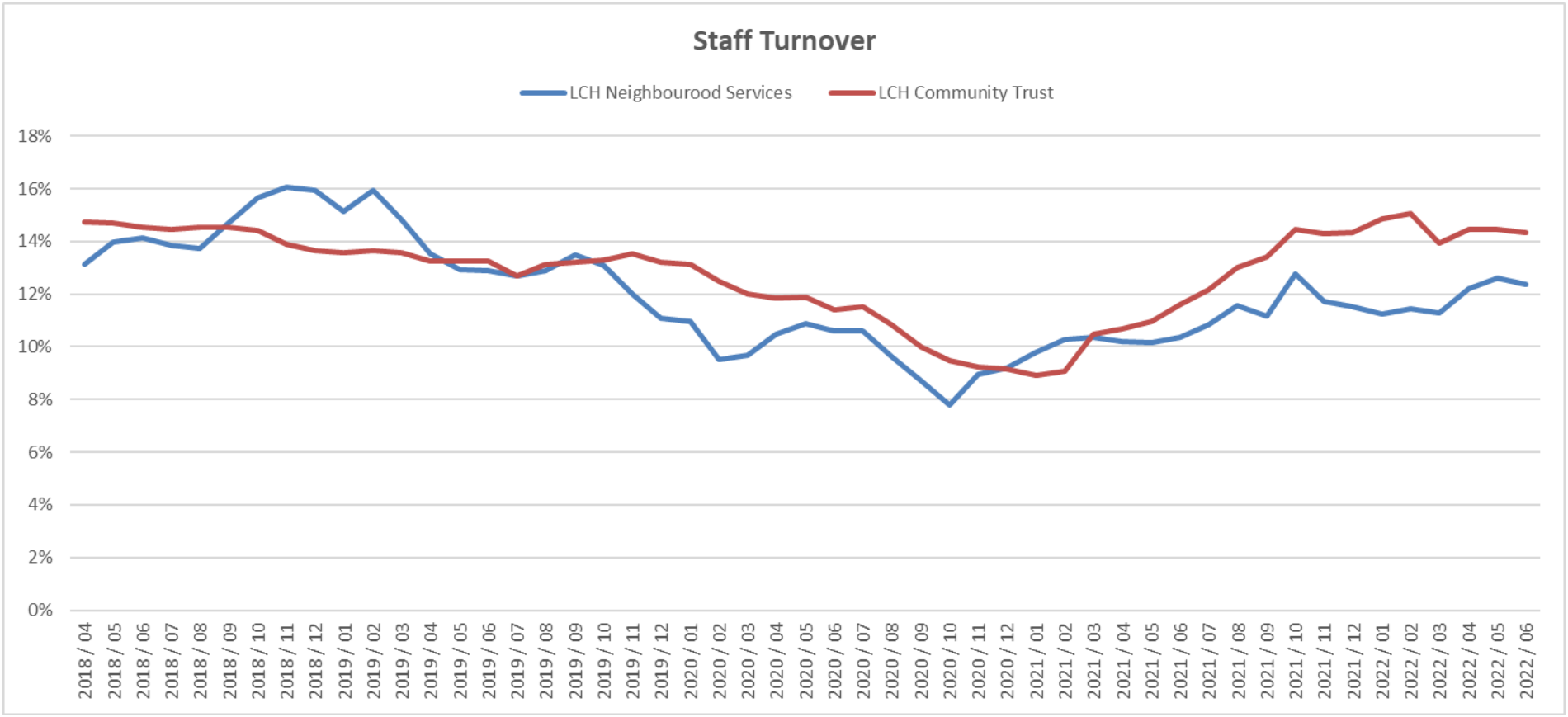
Appendix 2

National Guidance

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

Appendix 3

Neighbourhood Teams
Staff Turnover
As shown in the chart below LCH and Neighbourhood Team turnover has increased somewhat in the last 12 months in line with the LCH position overall.

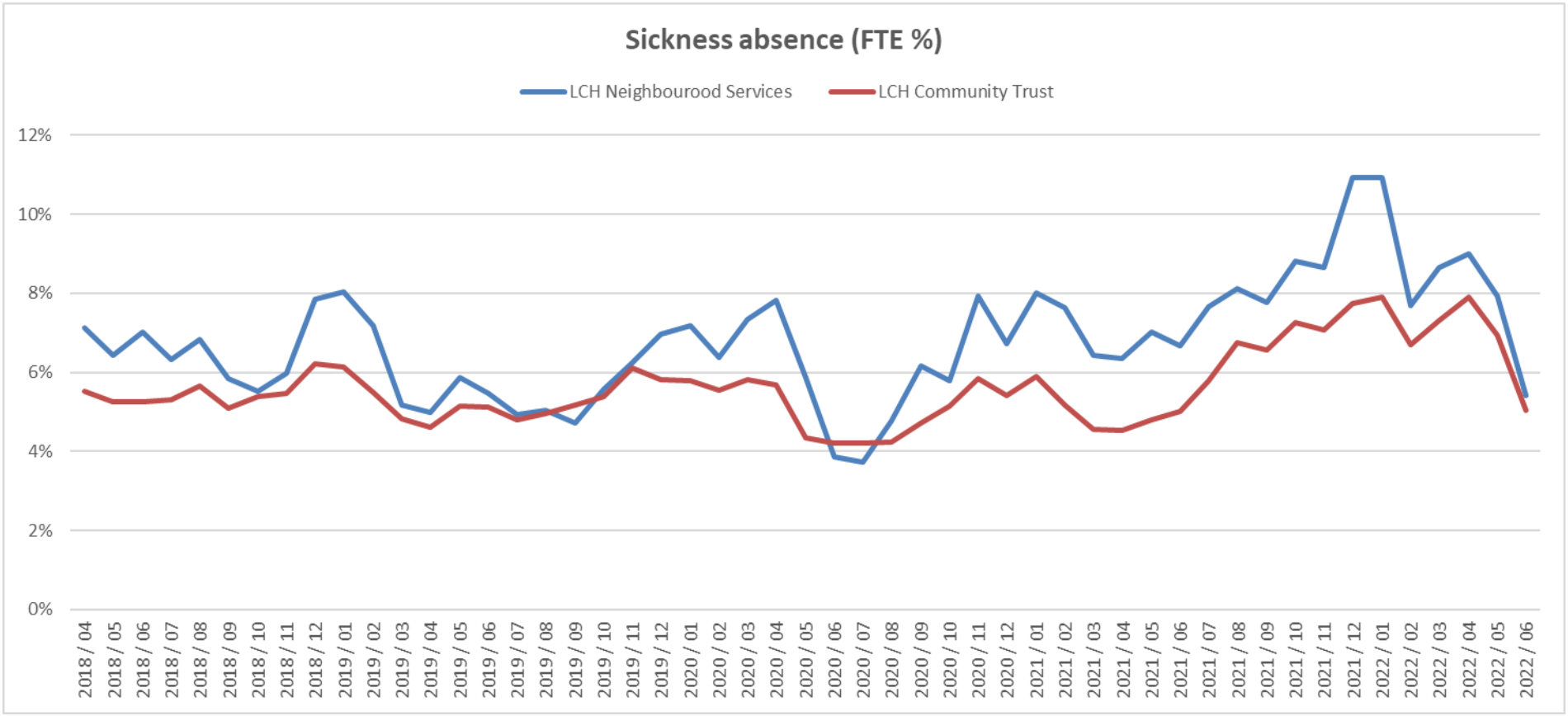


Percentage of leavers <12 months

As shown in the chart below, the percentage of leavers in their first 12 months of employment in Neighbourhood Teams is stable over the last period but then rapidly increased towards the end of the period. It should be noted that this is due to a reduction in new starters rather than an increase in leavers.

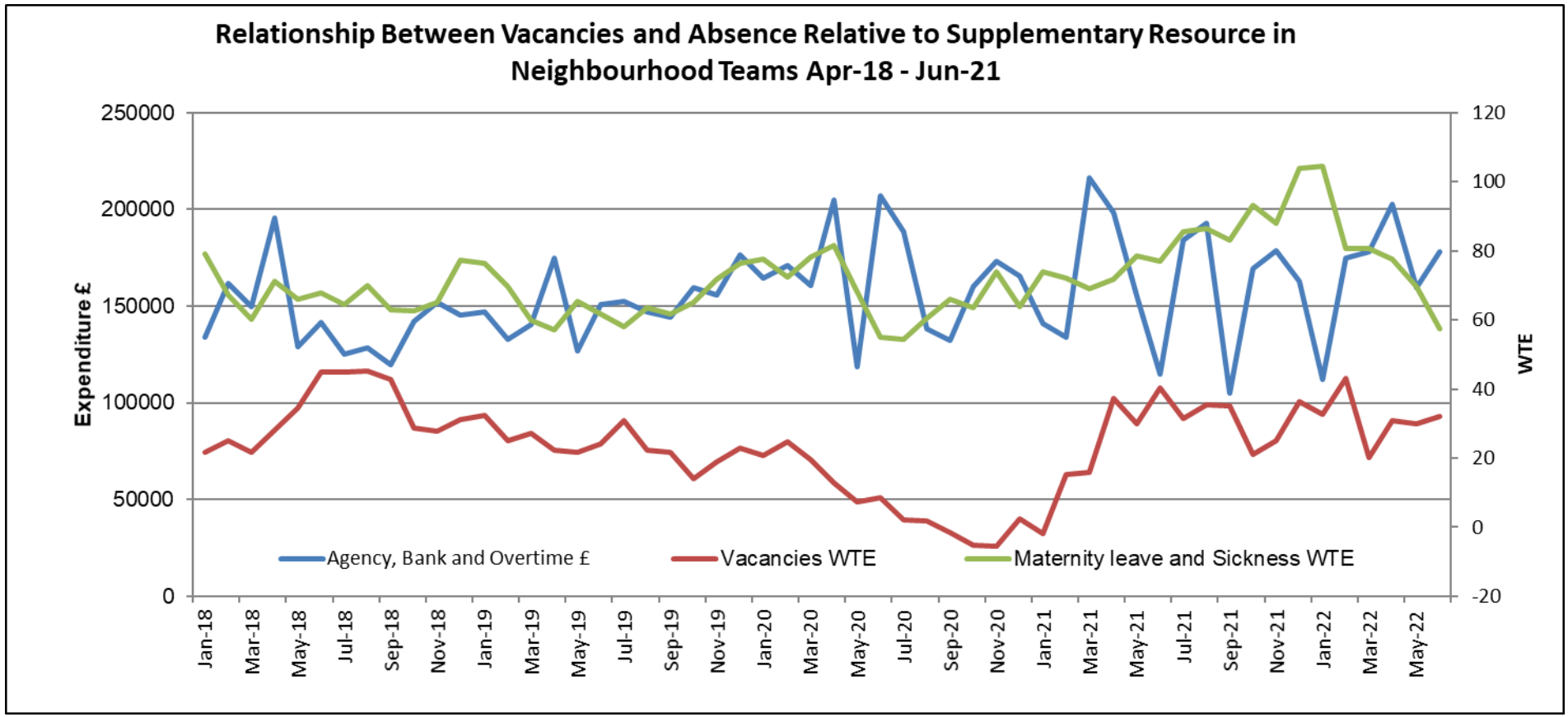
Sickness Absence

As shown in the chart below, Neighbourhood Team sickness absence increased during the early period of the COVID-19 pandemic, reducing in May and June 2020 and then returned to higher levels over the last 6 months, peaking in the Omicron period. The large drop shown in June 2022 is expected to be temporary as reporting is updated during July.



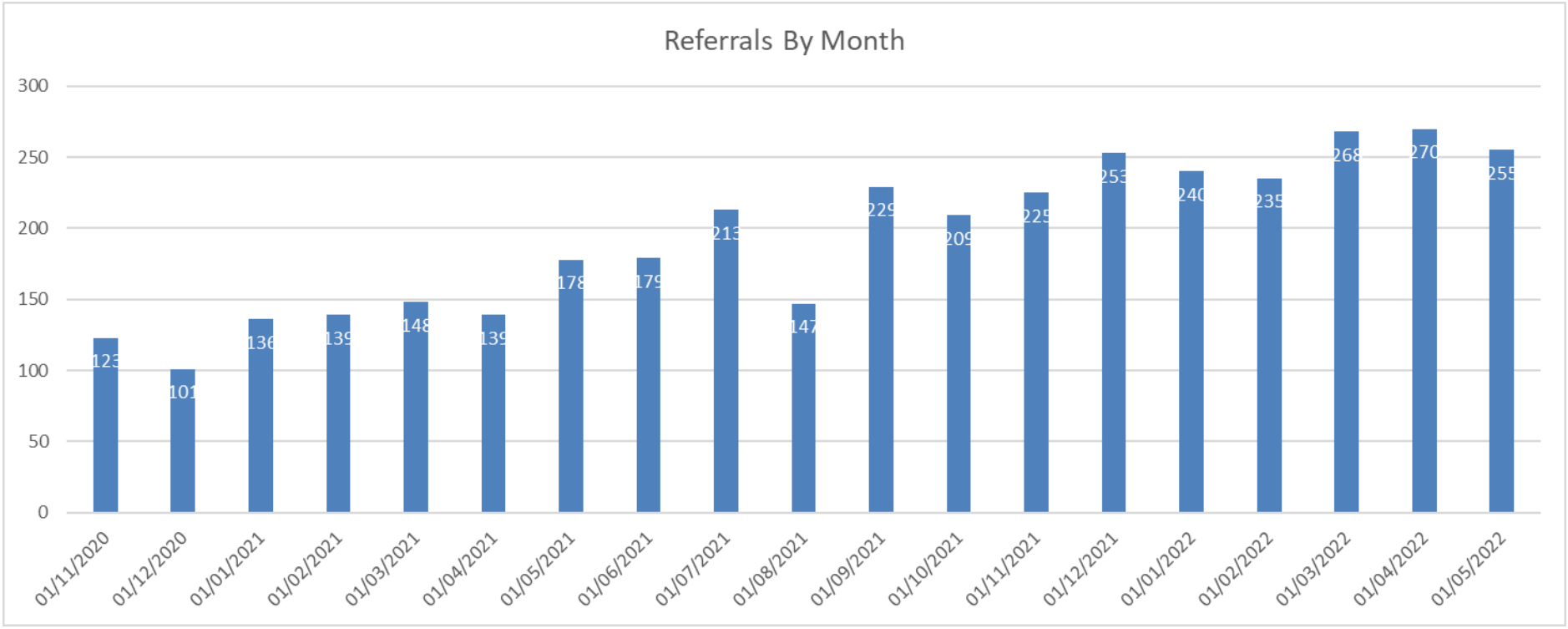
Supplementary staffing

This chart shows an increase in Neighbourhood Team vacancies over the last 12 months, whilst maternity leave and sick leave has also risen gradually in the same period. Supplementary staff via bank and agency has remained relatively consistent during the period with peaks and troughs.



Virtual Ward (Frailty) referrals by month

This chart shows the steady increase in Virtual Ward (Frailty) referrals by month since it was established.



Safe staffing report – additional page (after page 5 of report)

Portfolio 2				
Dental	40.51	30.66	-9.85	Currently out to advert for several posts which includes B2 admin and Clinical roles. Looking at workforce remodelling and the employment of trainee Nurses within the service. still unable to recruit paediatric dentist risk level raised from 6 to 15 in last 2 weeks escalated to commissioners
Diabetes counterweight	3.14	1.54	-1.60	
Diabetes service	21.35	18.87	-2.84	
Dietetics children's	7.10	6.10	-1.00	
Adult Dietetics	22.98	20.20	-2.78	
T3 Weight management	6.60	6.60		
MSK	60.34	45.16	-15.18	HoS meeting with DoW and Mo Drake to identify how service could work differently to recruit to vacant posts. This will include the use of other AHP's, and chiropractors to deliver care. Also strength condition / exercise coaches.
FCP	8.64	9.01	-0.37	
LCH Pain service	8.19	7.74	-0.45	
Podiatry	55.07	54.72	-0.35	
CNRS	44.09	33.01	-11.08	Service continues to go through redesign and is currently in the first phase of mobilisation which is impacting on vacancy rates. The mobilisation is completed by March 2023
Stroke Pathway	33.96	31.57	-2.39	
SLT (adults)	13.25	18.13	-4.88	
LMWS	87.42	78.20	-9.22	Short Term • Service Workforce Mapping – this has been drawn up to show a full and accurate live picture of vacancies and workforce across LMWS.* • Work done by HOS ops and Ops Lead to understand turnover and reasons for vacancies • Ongoing rapid recruitment for PWP and CBT roles (this is not proving fruitful) * • Use of Agency Staff in PWP roles – uptake is low but we have had some success • Review of Roles in teams to ensure we have the right mix* • Increase of Counselling For Depression Workforce (CFD) and Airelogic Algorhtymn adjusted to accommodate – this offsets CBT Vacancy at a rate of 1.8 WTE. • Ongoing review of workforce and roles to ensure we have the right mix * • Pilot online only CBT and PWP posts – uptake is poor initially • Scoping a joint venture with Northpoint to provide a hub workforce for one year to fill vacancies whilst trainees are moving through • Finance sign off to support staffing initiatives

				Medium Term • Large Scale trainee programme implemented in March this year. 12 High Intensity Trainees are in post with a further 7 starting in September. This will fill the vacant posts and provide adequate trainees to offset future turnover • Similar programme is in place for PWP Trainees and this is being looked at now to increase scale to manage the very high turnover and trainee need . In liaison with national training team and our commissioner colleagues • Wellbeing and Recruitment & retention work for current staff* • Increase workplace resilience and staff engagement * • Dynamic and responsive Training Matrix to have well skilled staff who want to stay * • Review of Recruitment across partnership • Increase online offer to potentially include permanent contracts across PWP and CBT workforce • Re - do the modelling for the service to be clear about the workforce needed s historic assumptions have changed post pandemic and do not take into account workforce or complexity challenges Long Term • Strategic oversight of turnover and patterns in staff movements to allow quick effective response • Maintenance of adequate trainee throughput to ensure that vacancies are identified in advance as much as possible and planned for using service patterns and data • Quick response to vacancies and responsive recruitment • Maintenance of effective Trainee Programme and training matrix • Work around presenting LMWS as a service people want to work in • Work with National team and training to look at the proposed expansion models and the increase in funding attached to that

Trust Board Meeting held in public: 5 August 2022

Agenda item number: 2022-23 (46)

Title: Professional registration: Nursing and Allied Health Professions

---

Category of paper: For information
History: N/A

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

Executive summary (Purpose and main points)

Purpose of the report

This report provides an update on professions regulated by Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) as a statutory requirement within the organisation considering compliance and any fitness to practice concerns.

Main points

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

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

The organisation has clear processes to ensure we are aware of all referrals concerning our staff to regulators.

Recommendations

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

Professional Registration

1 Introduction

1.1 Professional registration exists to protect the public. It is a statutory requirement for nurses practicing as a nurse to be on the Nursing and Midwifery (NMC) register and for an Allied Health Professional (AHP) using a protected title to be on the Health and Care Professions council (HCPC) register.

1.2 Some roles within the psychological professions do not currently fall within statutory registration. NHS England are leading work to revise this. The organisations revised registration policy acknowledges this and makes clear the need for voluntary registration with an accredited register. This paper summaries nursing and AHP registration compliance and concerns for the year July 2021 to June 2022.

2 Background

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

2.2 AHPs are regulated by the HCPC. HCPC protect the titles that AHPs work to meaning that it is an offence to practice under any of the titles unless you are on the register. Registrants are required to pay an annual fee and re-register every 2 years. They are required to maintain a portfolio of continuing professional development (CPD) which they may be asked to submit at the time of re registering. Staff will receive a notification from ESR four months prior to re-registration and a letter from HCPC two months prior. LCH employ 7 of the 14 professions regulated by the HCPC. (Podiatrist, Dietitians, Occupational Therapists, Paramedics, Physiotherapists, Practitioner Psychologists and Speech and Language Therapists). During the last year, Dietitians, Arts Therapists, Physiotherapists, Occupational Therapists and Speech and Language Therapists have undergone re registration. Podiatrists are currently in the process of re registration completing by the end of July 2022.

3 Current position

3.1 LCH employ 1065 staff in the staff group "nursing and midwifery" on ESR indicating that they require NMC registration for that post. ESR shows that 1027 are on the NMC register with current registration.

3.2 Thirty-eight (38) have an expired or missing registration date on ESR. Four (4) of these staff are employed to support vaccinations only and are therefore not required to be registered and nine (9) work as psychological wellbeing practitioners whose registration is still being determined by NHS

England. Two (2) are correctly registered with HCPC and on checking the NMC register further, sixteen (16) have current registration and their records need updating.

3.3 The seven (7) remaining staff whose staff group suggests they require NMC registration are employed in the following roles:

- 1 triage coordinator and registered appropriately with Social Work England as a social worker.
- 1 Community nurse who has recently retired
- 1 primary care manager in YOI who does not need to be registered to undertake their role
- 4 clinical team managers in mental health, three (3) of which are on accredited registers and one (1) in a completely operational role not requiring registration.

3.4 The Trust employs four (4) members of staff in Nursing Associates roles who are also required to register with NMC. Two (2) are currently registered. One (1) has progressed to a nursing student and is therefore no longer working as a nursing associate. The remaining staff member (1) is not working as a nursing associate and therefore does not need to be registered. There are additional staff employed within the organisation who hold NMC registration even though it is not a requirement of the role and their registration is current.

3.5 LCH employ 558 staff in the staff group "Allied Health Professional" meaning they require registration with HCPC. 505 are on the HCPC register with current registration.

3.6 Of the remaining 53, twelve (12) are duplicates leaving 41 who would be expected to have HCPC registration. On further checking 38 are on the relevant part of the register, two (2) are nurses and on the NMC register and one (1) is employed as a psychological wellbeing practitioner in Leeds Mental Well Being Service and does not currently require registration.

3.7 There are currently three (3) live investigations with NMC and two (2) with HCPC. NMC have received two referrals from Policy custody about two separate staff members employed by LCH. The Trust has conducted our own investigations into the allegations and risk assessed the continued employment of the staff. All relevant information requested has been shared with NMC.

3.8 The trust has made one (1) referral to the NMC in the last year. The member of staff is currently on maternity leave and therefore not currently suspended from practice.

3.9 There has been one (1) referral by a member of the public to HCPC in the last year relating to an MSK physiotherapist employed by the Trust. This has been risk assessed by the HCPC and they have not placed any restrictions or interim orders on the individuals while they investigate. The physiotherapist continues to practice in MSK.

3.10 There has been one (1) referral by LCH to HCPC. This was in relation to a podiatrist. We are currently taking this concern through the Trust's formal processes and we will share the outcome with HCPC once completed. On

receipt of our initial contact, the HCPC have not placed any restrictions on the podiatrist's practice. They continue to be employed in a non-patient facing role while we complete our investigation.

3.11 NHS England are still progressing their work to ensure that all staff working in low intensity psychological professions are regulated. The trust continues to work with both CAMHs and LMWS to ensure our staff meet the requirements when published.

.

4. Conclusion

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

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

4.3 The organisation is aware of referrals to regulators and the processes to manage these situations as detailed in the professional registration policy are being followed.

5.0 Recommendations

5.1 The Board is recommended to note the above position

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (47)

Title: Health Equity Strategy update

Category of paper: For assurance
History: none

Responsible director: Medical Director
Report author: Health Equity Lead and Public Health Consultant

Executive summary (Purpose and main points)

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

This paper provides:

- an update on work to deliver the health equity strategy since the last update in March 2022
- information about CQC's new approach and relationship to health equity
- update on ICB health inequalities funding for LCH projects and the new contract schedule on health inequalities
- focus on Health Equity objective 6: testing different ways of working

Recommendations

Board is recommended to receive this report and assurance within it and continue to support action to address inequity during periods of increased escalation.

Health Equity Board update, August 2022

1. Background

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

The first year of the strategy (May 2021 – April 2022) focussed on raising the profile of the organisational commitment to identifying and addressing inequity, understanding our current position, and putting into place the infrastructure and conditions for actions to flourish and become embedded.

This has included:

- First analysis of waiting list data by deprivation, ethnicity and interpreter requirement
- Establishing the new Equity and Quality Impact Assessment process and embedding this in project management approaches and tools
- Engaging with staff through training, BU leadership meetings, the virtual Health Equity community
- Engaging with and promoting the work being done in LCH with partners through the new ICB structures, THIG, Integrated Care Steering Group and Third Sector strategy group

2. National context

2.1 CQC

CQC are developing a new approach to regulation which will use a single assessment framework that is applied to providers, local authorities and integrated care systems. The four-point rating scale (outstanding, good, requires improvement and inadequate) and five key questions (safe, effective, caring, responsive, well-led) will remain central to the approach, but the Key Lines of Enquiry (KLOEs) will be replaced by quality statements that describe what good care looks like and link to the regulations. Quality statements are described by CQC as the commitments that providers, commissioners and system leaders should live up to, showing what is needed to deliver high-quality, person-centred care.

CQC's increased focus on addressing inequity specifies the need to include:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

These are supported by six types of evidence which CQC will use to understand the quality of care being delivered against a quality statement. While all evidence may be viewed with an equity lens, the two types of evidence that have a specified connection to health equity are:

- **People's experience of services**, requires evidence of feedback from people who face communication barriers and recognises that people's experiences are diverse and therefore includes data on demographics, inequalities and frequency of use for care services
- **Off-site observations,** through expert by experience support in engaging with communities whose voices are seldom heard

CQC key questions	Quality statements	Equity work in LCH
Safe	• Learning culture • Safe systems, pathways and transitions • Safeguarding • Involving people to manage risks • Safe environments • Safe and effective staffing • Infection prevention and control • Medicines optimisation	• Equity analysis in mortality reviews; development of equity analysis data for incidents • CBU using Always Event methodology in transitions from children's to adult services • Safeguarding "was not brought" approaches being incorporated into access policy and patient flow work
Effective	• Assessing needs • Delivering evidence-based care and treatment • How staff, teams and services work together • Supporting people to live healthier lives • Monitoring and improving outcomes • Consent to care and treatment	• Mandatory communication needs template in SystmOne. • Work to embed wider determinants in clinical assessments to contribute to clinical prioritisation, for example in waiting lists. • Self-management facilitators in Neighbourhood Teams supporting people, including those with additional communication or health literacy needs to maximise independence. • Equity analysis of outcomes data. Outcomes training online module includes health equity.
Caring	• Kindness, compassion and dignity • Treating people as individuals. • Independence, choice and control • Responding to people's immediate needs • Workforce wellbeing and enablement	• What Matters to Me template now available on SystmOne • Shared Decision Making NICE guidance assessment underway • Leeds Sexual Health testing new self-reported equality monitoring form, in line with NHSE/LGBT Foundation good practice guide to monitoring sexual orientation and trans status.
Responsive	• Person-centred care • Care provision, integration, and continuity • Providing information • Listening to and involving people • Equity in access • Equity in experiences and outcomes • Planning for the future	• LCH Person-centred care group now established, linking work on health equity, reasonable adjustments, shared decision making. • Review of LCH patient engagement strategy includes focus on seldom-heard voices • Equity breakdown of access and outcome data (deprivation, ethnicity, interpreter requirement) • Waiting list / patient flow programme has equity embedded within it • Access policy review to be more explicit about addressing inequity
Well-led	• Shared direction and culture • Capable, compassionate and inclusive leaders	• Links between Health Equity and EDI Forum and mutually supportive workstreams

	• Freedom to speak up • Workforce equality, diversity and inclusion • Governance, management and sustainability • Partnerships and communities • Learning, improvement and innovation • Environmental sustainability – sustainable development	• No Bystanders Summit, Sept 2022 addressing discrimination/abuse experienced by staff and patients • Financial wellbeing included in workforce strategy • EQIA includes sustainability. Increase focus on contributions to air quality in areas of high deprivation.

2.2 To note the NHS Confederation produced a board assurance tool built on the Care Quality Commission's (CQC) well led domain eight key lines of enquiry measures (KLOEs), with the overall aim of achieving **'exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes'** focussing on achieving the five national priorities for tackling health inequalities. This is being developed further by NHS Provider using the Core20plus5 framework, with a plan for producing briefings /webinars and peer learning for Boards and Executive leads for Health Inequalities from August 2022 to March 2023. We are working with NHS Providers to ensure the Trust can take maximum advantage of the offer.

3. Local context

Our work as a Trust on Health Equity is part of both the citywide work on implementing the Leeds Health Inequalities Toolkit; and also the wider transformational changes of moving to achieving population outcomes, within our available resources, focused on what matters to people by delivering person centred integrated care.

3.1 WY ICB in Leeds contract schedule 2(N)

Schedule 2(N) of the NHS Providers contract for 2022/23 focuses on the actions required in relation to providers role in addressing health inequalities. The ICB in Leeds has detailed this as focusing on implementing the actions detailed in the NHS Long Term Plan in relation to the urgent need to prevent and manage ill-health in groups that experience health inequalities.
It details that the Providers will be required to focus work on health inequalities with an aim to:

- increase their understanding of health inequalities.
- inform thinking and decision making;
- outline shared goals and themes which can be contributed to; and
- take action which can make a real difference to people who experience health inequalities.

The schedule stresses the need to refer to the Tackling Health Inequalities Toolkit for health and care partners in Leeds (Tackling Health Inequalities Toolkit April 2022 Update (adobe.com)) and use its framework for action. It has a requirement to understand and prioritise working with people at severe or higher risk of poverty and poor outcomes – ensuring that services meet those needs and services are accessible to all.

In addition, it will highlight the need to use and build on the Core20PLUS5 national approach to support the reduction of health inequalities within services at both a national and system level (https://www.england.nhs.uk/wp-content/uploads/2021/11/core20plus5-a4-infographic.pdf).

The Leeds Health and Care Partnership Population Boards will take the lead on analysing health inequalities data to inform and prioritise specific actions to address health inequalities. These actions will inform more focussed provider specific workplans which will be agreed and varied into the contract accordingly.

3.2 ICB funding

Nationally £200 million has been made available through 22/23 system allocations, targeted towards areas with the greatest health inequalities. The Leeds allocation of this funding is £3.1m. Following the meeting of the Shadow ICB in May it has been confirmed that this funding is recurrent. However, due to the uncertainty of the current financial position in the City and the medium term financial plan the intention is to maintain the approach that the 22/23 allocation is non-recurrent and needs to be spent in-year.

The aim of the funding is to support targeted reductions in Health Inequalities for specific population groups linked to the CORE20Plus5 approach, alongside inclusive recovery from the pandemic, and supported by five priority actions for addressing health inequalities as outlined in the NHS Planning Guidance for 22/23.

The following schemes to be led by LCH have been funded for the remainder of 2022/3. Nationally, it has been confirmed that funding is recurrent but, due to the uncertainty of the current financial position in the City and the medium term financial plan, the intention is to maintain the approach that the 22/23 allocation is non-recurrent and needs to be spent in-year.

NHSE Health Inequalities Non-Recurrent Funding for 2022/23 – Leeds CCG Tackling Health Inequalities Group (THIG) approved schemes. Total value £332,037

Scheme Name	£	Lead Population Board
Neuro Diversity training and information service	£71,035	Children and Young People
Culturally diverse Vaccination lead	£60,498	Healthy Adults
Long covid	£38,001	Long Term Conditions
Support workers for homeless Diabetic patients at risk of amputations / other complex LTC patients	£24,997	Long Term Conditions
Respiratory service expansion/development	£137,506	Long Term Conditions

LCH may also be involved in other funded projects, but progress on these projects where LCH is the named lead will reported through QAIG.

4. Year 2 of the Health Equity Strategy

In 2021, we committed to moving from intent to action in identifying and addressing inequity through 8 strategic objectives in the Health Equity strategy:

1. Increasing the understanding of health equity in our services
2. Working in in partnership
3. Developing tools and resources
4. Focussing on equity in quality and safety
5. Addressing inequity through person-centred care
6. Testing different ways of working

7. Sharing successes and progress
8. Understanding the difference we're making

An update on each of these since the last progress report (March 2022) is provided at Appendix 1, with planned work against each of these objectives for the next reporting period. The update below describes in more detail the learning from our first year of objective 6 (testing different ways of working) and the different approach being taken to this in year 2.

4.1 Testing different ways of working

In Year 1 of the strategy we identified 3 service areas where we would test out new ways of working: frailty, long-term-conditions and mental health. By virtue of the size of these service areas and the ongoing impact of the pandemic which was not anticipated in early 2021, these changes are necessarily long-term and required to be embedded in other service change and pathway developments. Examples of how this is being taken forward include:

- Embedding equity in frailty in the Neighbourhood Model Transformation Programme
- Long-term conditions reviewing and embedding equity in pathway changes
- LMWS focus on coproduction in addressing inequity
- CAMHS joining together the two agendas of equity in patient care

As well as embedding equity in service development, the Equity and Quality Impact Assessment (EQIA) process supports analysis and assurance of the potential impact of specific changes and action taken to mitigate those risks.

While the work in these three areas continues, we are also testing a different way of working – that of having a consistent area of focus for improvement in every service. This is based on: learning from the first year of implementing the strategy; the Board workshop and trust-wide review of equity data relating to access, including waiting lists and; change methodology from NHSE and Jönköping County in Sweden around actioning small scale changes within a large-scale framework in order to speed up transformation.

4.2 Communication has been chosen as the consistent focus on improvements in one area that impacts strongly on equity, looking at both literacy and language requirements to improve the access, experience and outcomes for:

- People with low levels of literacy
- People whose main language isn't English
- People with sensory impairments
- People with cognitive impairments
- People who are neurodiverse
- Intersectionality between these groups

Language and literacy are recognised as community/population issues that lead to the 'unfair and avoidable differences in health across the population, and between different groups within society', impacting on patient journeys throughout our services: from being referred to the service and waiting to be seen; understanding and being able to action health information; access to and during appointments; needing to get in touch with services and; wanting to give feedback.

There is a negative impact on access, experience, outcomes and also value of getting communication wrong – missed appointments, ineffective treatment and care. PEG has identified communication as key to delivering person centred integrated care and this work will also help achievement of Accessible Information Standards and respond to feedback through Healthwatch and other partners about improvements to communication for these groups.

4.3 Equity QI projects focussed on communication

Between July and February, each service will undertake a self-defined quality improvement project focussed on addressing inequity that arises through communication (literacy or language). By making a practical change in every service, we will:

- Make a difference to individual patient care
- Focus on tangible successes, linked to staff satisfaction and morale
- Test the cumulative impact of individual service changes with shared learning, spread and adoption

As system pressures increase and service capacity is reduced, we recommend that these continue to take place as they not only improve patient care, but by addressing ineffective communication we also have the ability to improve service efficiency and effectiveness.

These projects will be coordinated through LCH's Health Equity Leadership Group and into QAIG.

5 Risks

5.1 Service capacity

As the pandemic continues to impact on service capacity, and system pressures increase, there is a risk to engagement with the health equity work and action to address inequity. To mitigate this, as a trust we will need to understand and promote the value proposition around health inequalities, understanding and acting on opportunities to improve service efficiency and effectiveness by addressing inequity.

5.2 Corporate capacity

The speed and scale of progress on addressing inequity is affected by capacity within corporate resource as well as services.

5.2.1 Capacity in the BI team to support data provision and analysis with equity lenses (objective 1) is limited. The new 'PowerBI' dashboard to be developed will have equity lenses for data in each of the CQC domains, but decisions will need to be made about which of the priority data areas (eg waiting lists, communication templates, incidents, appointment outcomes) or equity lenses (deprivation, ethnicity, age, language, interpreter requirement, learning disability or autism) under or pending development are paused as bespoke reports until the new dashboard is developed, or which (if any) should be prioritised as bespoke reports until they are available through the new dashboard.

5.2.2 Equity in quality and safety (objective 4) includes action to identify and address inequity in 9 areas of work, all of which are impacted by capacity in QPD, as well as in services' capacity to engage in this. When vacant posts in QPD are filled this will provide some capacity, for example in the review of the patient engagement strategy where the voice of seldom-heard, marginalised and excluded groups is a significant area of focus, but currently business continuity measures affect when action can be taken.

5.3 Resourcing the Health Equity work

When LCH committed to taking a more coordinated, long-term approach to addressing inequity, a Band 8a Health Equity Lead was recruited to support the Medical Director as Named Executive Lead for Health Inequalities. This temporary role is currently being recruited to permanently. Additional capacity and leadership for health equity and associated person-centred care work has been provided through the temporary employment of a Public Health Consultant, working across LCH, LTHT and GP Confederation (to mid-May 2023).

As we move through the strategy from intent to action, the number of workstreams to create and maintain action in each health equity objective has increased, as well as an increased in objectives relating to health equity in other strategies and plans. Through the requirement for the Health Equity Leadership Group and QAIG to coordinate the equity QI projects and ICB funded projects, the project co-ordination / support need has also increased. LCH's health equity strategy commits to a

cultural change where tackling inequity in health is not some additional we do, but rather becomes an equity lens on everything we do. Through Board workshops when developing the strategy, it was therefore decided that it would not have a formal programme structure and would report direct to Board rather than through the Programme Board or other Committees. Project support has been sought from the Business Change and Development team, but there was insufficient capacity to meet this and other requests of a similar priority. The recommendation from Programme Board was to instead recruit directly to a post. We are currently looking at options to fund this 6-month support, including potential to utilise any underspend within the Directorate or whether it will require a bid for non-recurrent funding.

6 Next steps

- Identify project support to enable coordination of equity QI projects and ICB-funded projects
- Support roll-out and development of equity QI projects to test a different way of working to address inequity

7 Recommendations

Board is recommended to receive this report and assurance within it and continue to support action to address inequity during periods of increased escalation.

Appendix 1: progress update

		Year 2 focus	Update (July 2022)	Planned work to December 2022
	Increase understanding of health equity in our services	We will improve the recording of diversity and inclusion data, embedding agreed approaches to equity analysis across datasets. We will review data that tells us about access, experience and outcomes of Communities of Interest. We will increase access to equity data and the skills to analyse and use this intelligence in addressing inequity. We will increase the meetings and reports where equity lenses on data are used.	• Further analysis of equity breakdown of waiting lists at BU and service level undertaken • High-level analysis of equity breakdown of data re people on multiple waiting lists • Data quality checks being undertaken on first three incident reports with equity breakdown by deprivation, ethnicity, age and interpreter requirements for falls, pressure ulcers and access incidents	• Alignment of data development with implementation of BI strategy and new PowerBI dashboard developments • Further analysis of multiple waiting lists and incident data • Increase service access to communications template data and utilise in equity QI projects
	Work in partnerships	Delivering our 3rd sector strategy, including health equity priorities. Supporting delivery of LCPs health equity projects and Synergi mental health projects. Engagement with THIG and WYH health equity programmes and communities of practice. Taking part in the EDS2 partner review and achievement of Sanctuary Health award with provider partners.	3rd sector funded projects with: • BID • Basis • Enhance Integrated care (primary care) projects: • Care homes • Woundcare hubs • Acute home visiting THIG Population Health Boards ICB health inequalities and communities of practice Synergi Migrant Health Board Palliative Care and End of Life EDI group	• Exploring opportunities for coproduction with 3rd sector in NICE guidance assessments and engagement in EQIA review • Engagement in communication improvement projects with 3rd sector partners supporting - People with low levels of literacy - People whose main language isn't English - People with sensory impairments - People with cognitive impairments - People who are neurodiverse Embed connections with: • Enhance • Active waiting

	Develop tools and resources	We will develop and embed use of tools and resources to support leaders, staff, partners and communities to work together to identify and address inequity. This will include: Equity and Quality Impact Assessment process, Review Panel and EIA information sessions; Health Equity MS Team channel and intranet pages; Communities of Interest insight resources.	EQIA • Changes made following audit • Embedded in project management tools • Discussion tool to support early EIA consideration Expanding access to Basis and BID training Plenary and workshop delivered at Clinical conference; Cost of Living Crisis discussion held at Leaders' Network	• Summer of learning sessions • Roll-out THIG toolkit • EQIA review • Communication resources to support equity QI projects • No Bystanders summit
	Focus on equity in quality and safety	Analysis by ethnicity and deprivation to understand and act on inequity in mortality, pressure ulcers and other incidents, complaints and concerns. Consider equity in our proactive approaches to quality, including research, evidence-based guidance and outcomes. Develop an equity assessment process in the development of clinical policies and protocols.	• EQIA • Patient Engagement Champions • identification of Always Event methodology to address inequity • Identification of equity workstreams in each area of Clinical Governance and Patient Experience	• Incident equity breakdown (priority parameters) • EIA in policies and SOPs • Review of Engagement Strategy to include focus on seldom-heard voices • Implementation of NICE guidance • Delivery of ICB funded health inequalities projects
	Address inequity through person-centred care	Support 100% Digital inclusion projects and share learning within LCH service delivery Support delivery of self-management activity that improves health equity Develop awareness and identify actions to address inequity through shared decision-making, health literacy and personalised care planning and support.	• LCH person-centred care group established • Accessible Information Standards • Easy-read and reading ease guidance • Better Conversations training • Digital inclusion resources	• Citywide focus on communication, coordination and compassion • Self-management - Active waiting - Patient Initiated Follow Up • Person-centred care priorities (shared decision making, What Matters to Me template)

	Test different ways of working	Continue change work to address inequity in long-term conditions, mental health and frailty. Test having a consistent area of focus (communication) in QI projects across all services. Review learning from delivery to plan for year 3.	• Identification of communication as consistent focus across all services in QI projects, based on: - Feedback from Healthwatch and other partners on impact of poor communication - Analysis of waiting list data, in particular impact for people requiring an interpreter - Low completion levels of communication template, particularly language and interpreter requirement	• Submission of topic for self-defined equity QI project in every service/team focussed on addressing inequity that arises through communication (language or literacy) – September 2022 • Interim update on progress and key learning – December 2022
	Share successes and progress	Using change stories to share successes and learning and prompt further engagement with services and partners. Seeking out internal and external opportunities to share good practice and progress.	• Quality Account • Presentation of equity analysis of waiting list data at Planned Care Board • Making Stuff Better share and learn sessions with focus on addressing inequity • Sharing EQIA process and tools with LTHT	• SBU celebration event focussed on diversity and inclusion • Learning and impact of equity QI projects • EDS2/3 partnership • Making Stuff Better share and learn sessions with focus on addressing inequity
	Understand the difference we are making	Support citywide exploration of ways of measuring impact and progress on health equity, such as social value or social return on investment and population health. Use this knowledge to develop an evaluation framework which helps us to understand the impact we are having and make changes or take additional action where required.	• Developing logic model for impact of wider health equity work • Engagement with Population Health Boards to ensure organisational outcomes are aligned with place-based outcomes and not duplicative for patients to complete	• Matching measures to Population Health Board measures • Outcome or output measures • Citywide or LCH contributory measures • Social Value • Healthy Leeds measures • Understanding cumulative impact of individual service QI projects with shared learning, spread and adoption

Leeds Community Healthcare NHS Trust

Trust Board meeting: 5 August 2022

Agenda item number: 2022-23 (48)

Title: Medical Directors Annual Report (including Statement of Compliance)

Category of paper: Assurance
History: Quality Committee 25 July 2022

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

Executive summary (Purpose and main points)

Purpose of the Report:

To provide Trust Board with an update and overview regarding our responsibilities as an employer of Medical and Dental staff within the Trust, including:

- Appraisal and medical revalidation
- Managing concerns
- Pre-employment checks.

It fulfils the requirements set by NHS England in relation to:

- Designated Body Annual Board Report
- Statement of Compliance

This Executive Medical Director's report covers the period 01/04/21 to 31/03/22 and includes information and activity relating to the Trust responsibilities regarding employment of medical and dental staff; based on the four key principles identified in the handbook and guidance regarding "Effective Clinical Governance for the Medical Profession"[1] published by the GMC in 2018. It is accompanied by the recommended template for the Statement of Compliance for 21/22, encompasses elements previous included in both the Statement of Compliance and the Annual Organisational Audit (AOG). Whilst this template formally refers to our employment of medical professionals, for the purpose of the Board report it also references our employment of dentists, unless specifically noted otherwise.

The report details key areas of progress and further identified work against each of the four key principles identified in the GMC document of 2018 as those that underpin effective clinical governance in this context. These are:

- Principle 1: Organisations create an environment which delivers effective clinical governance for doctors
- Principle 2: Clinical governance processes for doctors are managed and monitored with a view to continuous improvement
- Principle 3: Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination
- Principle 4: Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice

Despite the ongoing pressures resulting from the Covid19 pandemic the Trust has continued to provide high quality appraisal, supported, and developed doctors and dentists in regards to both appraisal and their general wellbeing, and continued to further improve our systems to better support our medical and dental staff. The Trust gave flexibility in the appraisal process in 2020 and allowed consultants to have an appraisal if they desired, equally more flexibility was given in terms of timing of appraisal to take account of the pressures from COVID.

Leeds Community Healthcare NHS Trust has a robust system in place for ensuring appraisal and revalidation of doctors employed by the Trust, for the appraisal of dentists and ensuring appropriate fitness to practice and fitness for role of other

[1] Effective Clinical Governance for the Medical Profession

medical staff who work for the Trust. 35 doctors and 8 dentists have had an annual appraisal for the year April 2021 and March 2022. 10 doctors have been successfully revalidated.

Work identified in the 20/21 Medical Directors report to further strengthen our systems and processes regarding effective clinical governance of the medical profession has continued, and further steps are identified for progress during 22/23. Developments over the last year 2021/22 include:

- Dental appraisal is now aligned with guidance from NHS Employers and the British Dental Association, distinct from that of doctors.
- A new appraisal system has been procured for the Trust and was implemented in June 2022. This is the same system that used at Leeds Teaching Hospitals Trust, facilitating shared training across the Trusts.
- Work is ongoing with HR to improve the recruitment process for medical and dental staff, the market for workforce remains tight and we need to ensure that we are viewed as an attractive employer.
- Doctors working on bank alone will now be able to access LCH appraisal and revalidation systems This mostly concerns doctors who retire from LCH and return on CLASS
- Review of the appraisal process: in line with national guidance a relatively light touch to appraisal was maintained with emphasis on a supportive conversation and less emphasis on the need to deliver a set amount of CPD.

The Annual Statement of Compliance is attached to this report.

Recommendations

Board is recommended to:

- Note the contents of the 2021/22 Annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the statement of compliance and submission to NHS England
- Note that the 2021-2022 LCH Self-Assessment regarding compliance with the HEE Quality Framework option will not be presented in its entirety and the opportunity for Board members to view this online on request

1 Introduction

Leeds Community Healthcare NHS Trust is a Designated Body responsible for the appraisals of all doctors employed by the Trust. Regulations require that all Designated Bodies must nominate or appoint a Responsible Officer, who must be a licensed doctor. This post is held in LCH by the Executive Medical Director and is therefore represented on the Board.

The Responsible Officer is supported by a Deputy Medical Director (Professional Standards) and a Head of Medical Education and Revalidation. The Deputy Medical Director post has been held by an individual holding consultant status since Sept 2019. This individual has undergone NHSE approved Responsible Officer training.

This report covers the period of 01/04/21 - 31/03/22. During this period LCH had a prescribed connection with 35 doctors, and responsibilities to 8 dentists who undergo annual appraisal but whose regulatory body the General Dental Council (GDC) does not currently have a revalidation process. The Trust also has responsibilities to doctors working in LCH who are self-employed or work via an agency but conduct regular work for the Trust. LCH currently provides appraisal and revalidation services for one doctor with no other prescribed connection who works via the bank. For other doctors who work via bank or via agency LCH supports them to ensure they have appropriate alternative arrangements for appraisal and Responsible Officer alignment, as well as ensuring other employment checks have taken place.

In the last financial year LCH has appointed one new doctor, and one new dentist.

LCH had one doctor in a remediation or MHPS process during 21/22. The Trust Board have been regularly updated in private session. This is the same individual referenced in the 20/21 Medical Directors Report.

The age profile of the medical workforce as identified by workforce information is as follows

Age Band	Headcount	%	FTE
26-30	6	8.1	3
31-35	5	6.8	2.8
36-40	14	18.9	7.3
41-45	14	18.9	8.5
46-50	15	20.3	10.2
51-55	4	5.4	3.3
56-60	9	12.2	6.4
61-65	6	8.1	2.8
66-70	1	1.4	0

The number of individuals over the age of 56 (15 representing over 20% of the workforce) represents a group of staff that may consider retirement soon.

A breakdown of the medical workforce by ethnicity is in the following table. The largest group by ethnic origin is White British at 27% (20 doctors), the medical

workforce has a diverse ethnic background and data is not available for 40% of the workforce (30 doctors)

Ethnic Group	Headcount	%	FTE
A White - British	20	27.0	13.1
B White - Irish	1	1.4	0.0
C White - Any other White background	2	2.7	1.7
CF White Greek	1	1.4	0.6
CP White Polish	1	1.4	1.2
E Mixed - White & Black African	1	1.4	0.0
F Mixed - White & Asian	1	1.4	0.7
GA Mixed - Black & Asian	1	1.4	0.0
H Asian or Asian British - Indian	7	9.5	5.3
J Asian or Asian British - Pakistani	3	4.1	2.6
M Black or Black British - Caribbean	1	1.4	0.4
N Black or Black British - African	1	1.4	1.0
R Chinese	1	1.4	1.0
S Any Other Ethnic Group	3	4.1	1.5
Unspecified	13	17.6	6.3
Z Not Stated	17	23.0	9.0

Over the last year CLASS has supported services with Medical and Dental staff as follows:

Service Worked for	Total Hours worked	Staff Numbers
Community CAMHS	2280*	5
Leeds Sexual Health	18.5	2
Covid Vaccinations (Medic Duties)	469	1
ICAN Service	536	3
Clinical Services LTC'S	49.75	1
Community Diabetes Service	20	1
Community Dental Service	1220.5**	1
Total Hours	**4593.5**	**14**

*The majority of the CAMHS hours have been worked by one doctor, due to long standing gaps in the ST on-call rota. The large number of hours has been flagged by the Executive Medical Director with other Medical Directors regionally and assessed for safety. The partnership with Leeds and York Partnership Foundation Trust and the recruitment exercise for three new CAMHS doctors will address the need for Bank hours within the service.

**For Dental the majority of these hours were worked by one individual, the service has recently recruited which will reduce the reliance on the Bank service.

In the year 21/22 Leeds Community Healthcare was able to offer the following educational placements.

Medical Education Undergraduate and Postgraduate Placement Figures 2021-2022		
	21/22	
Service	**Undergraduate**	**Postgraduate**
ICAN	344	75
LSH	143	24
CAMHS/Psychiatry	-	96
Elderly Medicine/Neuro Rehabilitation	48	-
GP VTS Trainees	-	45
MSK	20	-
Total	**555**	**240**

LCH provides clinical leadership for Postgraduate and Undergraduate Medical Education working in partnership with Health Education England and the University of Leeds, to oversee clinical training for all levels of medical students and doctors in training.

The Trust has a medical education governance structure, led by the Medical Director, and supported by the Associate Director for Teaching and Student Support (ADSST - undergraduates) and Director Medical Education (DME – postgraduates), clinical staff, trainers and a dedicated administration team focussed on delivering and supporting high quality education and training.

LCH hosts over 300 Undergraduate Medical Students and 21 Postgraduate Doctors in training across 5 different services per year. Community placements provide experience of delivering care in a wide range of settings including in people's own homes as well as in clinics, community centres and schools.

Teaching and training standards, and support are reviewed annually via the HEE Self-Assessment, in which organisations carry out their own quality evaluation against the HEE Quality Framework. It is based on continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

The HEE Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The NHS Education Contract (2021-24) requests providers to fulfil the obligations of its roles and responsibilities set out in the HEE Quality Framework and to submit a return to HEE on their compliance with the contract.

A copy of the 2021-2022 LCH Self-Assessment online form is available to review on request.

2 Position statement for 21/22

Principle 1: Organisations create an environment which delivers effective clinical governance for doctors

The four Trust policies related specifically to the employment of medical and dental staff were approved by SMT in 2021 and are in place:

- Appraisal and Revalidation Policy
- Medical and Dental Job Planning Policy
- Remediation, Reskilling and Rehabilitation Policy

- Maintaining High Professional Standards (MHPS) Policy

The policies are due for review by June 2024

The Trust has robust processes in place to ensure appropriate checks are undertaken to confirm all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role.

Previous years priorities:

- Review of our recruitment processes for medical and dental staff, including consistency and quality of interview questions, patient involvement and AAC panel organisation
- Review and re-procurement of the electronic appraisal system in use within the Trust prior to the current 5-year contract with our current provider (PREP) coming to an end
- Changes to the Dental aspects of the Appraisal and Revalidation policy have been proposed in conjunction with the new Dental lead. These proposed amendments will require the policy to be reapproved by JNC and the Trust during 2021.

Comments:

- The review of the recruitment processes has been undertaken by the Trust HR team, and confirmed that the LCH process is in line with the procedures held by LTHT. An SOP is being drawn up to formalise the process.
- The Trust has recently procured a new electronic appraisal system (SARD), this followed a procurement exercise involving a number of Trust Doctors, the contract is in place until 2025.
- Dental appraisal is now aligned with guidance from NHS Employers and the British Dental Association.

Identified priorities for 22/23:

- Embed the new appraisal software system and deliver training to all doctors
- Standardise job description for Medical/Dental Lead role across LCH including emphasising the importance of Clinical Governance.

Principle 2: Clinical governance processes for doctors are managed and monitored with a view to continuous improvement

LCH has a combination of individual service and central mechanisms which hold information pertinent to effective clinical governance for medical and dental staff. Each service is responsible for meetings and discussions regarding these, and medical and dental staff of all employment status are encouraged to participate and actively contribute.

The Revalidation Teamwork with Workforce and HR colleagues to share information to provide central assurance of any issues relating to medical and dental staff.

Work is underway to embed meaningful objectives into medical and dental job plans, and to incorporate elements of Trust appraisal into the Job Planning process.

A recent audit has revealed significant improvement in the recording of objectives in job plans. This is anticipated to further strengthen the engagement of medical and dental staff to service and Trust objectives, priorities, and values. This will be facilitated by the implementation of the electronic job planning system.

Revalidation Panels were carried out as required during 21/22, linking with Trust systems to ensure that appropriate submission and reflection on incidents and complaints was included in the relevant appraisals.

Previous years priorities:

- Ongoing work in conjunction with the Trust Quality & Performance Panels and the Quality Assurance & Improvement Group (QAIG) subcommittee workstreams is planned to progress the opportunities for individual clinicians and services to routinely access data in a way that permits them to benchmark against their peers, both in service and nationally.
- A review of the feasibility of conducting an annual cross-verification of the Trust systems for recording incidents and patient feedback annually. It is currently conducted every 5 years ahead of revalidation. This is consistent with an anticipated move to Trust responsibility to provide this data for individual clinician appraisal from 21/22.

Comments:

- It has not been feasible to progress the benchmarking of individual consultants this year, due to ongoing work pressures.
- Data from complaints and incidents are currently checked prior to revalidation.
- We are exploring with BI the ability to provide individual consultant activity data to support appraisal and scope of practice. This would assist in benchmarking and would contribute to an appraisal pack for each doctor with data from complaints and incidents

Identified priorities for 22/23:

- Identify opportunities for doctors to benchmark against their peers.
- Encourage services to explore appropriate outcome measures for clinical staff.
- Pilot the introduction of an ‘Appraisal Pack’ which will allow activity data to be reviewed at annual medical appraisal.
- Roll out e-job planning and ensure appropriate objectives in place in all consultant job plans, that align with the strategic goals of the service.

Principle 3: Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination

Revalidation Panels ensure that all revalidation recommendations are supported by a thorough consideration of all aspects of the five years of appraisal preceding the recommendation. Introduction of these panels during 18/19 has strengthened the Trust processes and reduces the possibility of bias or discrimination.

The Trust has had an established Freedom to Speak Up Guardian (FTSUG) since December 2016. In 19/20 it was noted that medical and dental staff did not use this

method of raising concerns, and this route was highlighted to them. In 20/21 there were two specific concerns raised by medical and dental staff out of a total of 84 Trust cases.

During 21/22 one person from doctors, doctors in training and dentists contacted the FTSUG. No concern was raised formally but support was offered by the Guardian.

Junior medical staff can also raise issue or concern via the Guardian of Safe Working Hours (GSWH), the Guardian produces regular Board papers on issues raised.

During 21/22 there has been one grievance raised by a doctor or dentist employed by LCH, this is being formally investigated under the organisation's grievance policy and procedure.

Previous years priorities:

- Work is planned to benchmark our revalidation panel process against those from neighboring Trusts to seek areas for learning and improvement, and particularly consider how we might appropriately include patient representation.
- Plans to make Unconscious Bias training available for all appraisers during 20/21 were not feasible due to the ongoing constraints of the Covid19 pandemic and this is now planned for 21/22.

Comments:

- LCH have adopted the same revalidation panel template and process as LTHT and have approached other neighbouring trusts for information on their procedures. It has not been possible to facilitate patient representation at panels, but this will be reviewed in 22/23.
- Unconscious bias training is available to all LCH staff, this has been advertised to all appraisers.

Priorities for 22/23:

- Embed the new system of appraisal, training arranged for all doctors for July 2022.
- Recruitment of new appraisers to support the system in light of anticipated retirements.
- Reintroduction of regular face to face appraisal updates following the pandemic.
- Investigate the possibility of including patient representation at Revalidation panels.

Principle 4: Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice

LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard.

LCH adopted the recommended MAG 2020 model of appraisal and supported the implementation through regular contact with Trust doctors. Submission of relevant information in regards to fitness to practice was maintained, there was increased flexibility with regards to revalidation. The continued focus during the 21/22 cycle was on the doctor's health and wellbeing and verbal reflection during the appraisal meeting, rather than on a requirement to upload supporting evidence.

Previous years priorities:

- Due to the ongoing impact of the Covid19 pandemic it is not clear if peer review will be appropriate during 21/22 but if the opportunity is presented the Trust will actively participate.
- Clarify and establish the required support for doctors working for LCH on bank who have no other regular employment.
- Review the appraisal model in conjunction with guidance from NHSE and the GMC, continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.
- A further quality assurance exercise is planned for 20/21 adapting to the current guidance from NHSE on the focus of appraisal.

Comments:

- NHSE did not instigate Peer review of appraisal processes with another organisation in year.
- Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a "Scope of Work" letter provided by their Medical or Dental lead, detailing their work within the Trust. LCH provides appraisal and revalidation support for all doctors with a designated connection to the organisation. During 21/22 the Trust employs one doctor working exclusively via bank, the Trust agreed to act as their Designated Body.
- No new guidance has been issued by NHSE or GMC with regards to the appraisal model.
- During 21/22 a quality assurance exercise was conducted utilising the NHSE approved "Appraisal Summary and PDP Audit Tool" (ASPAT) for the 20/21 and 21/22 appraisal cycles. No significant issues were identified although areas for learning and improvement identified by the audit were fed back to both appraiser and appraisees.

Priorities for 22/23:

- Review the appraisal model in conjunction with guidance from NHSE and the GMC, continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.
- Audit information held by the Trust on doctors who have a responsible body other than LCH
- A further quality assurance exercise is planned for 22/23.

3 Recommendations

Board is recommended to:

- Note the contents of the 2021/22 Annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the statement of compliance and submission to NHS England
- Note that the 2021-2022 LCH Self-Assessment regarding compliance with the HEE Quality Framework option will not be presented in its entirety and the opportunity for Board members to view this online on request

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Leeds Community Healthcare NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Dr Ruth Burnett, Executive Medical Director has held the post of Responsible Officer since 1st August 2018 Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Continue ongoing support with attendance at relevant meetings and education opportunities. Support with reprocurement of the online appraisal system provided for doctors as the current contract is due to expire during 21/22. Comments: The Deputy Medical Director (Professional Standards) holds the post of Deputy Responsible Officer and has undergone appropriate training. The RO and Deputy RO are supported by a Medical Education and Revalidation Manager. The Trust has supported appropriate attendance for these three individuals at Responsible Officer and Medical Education meetings provided by NHSE, and the report contains evidence of reflection and learning from this attendance. A new appraisal system has been procured for the Trust and was implemented in June 2022. Action for next year: Embed the new appraisal software system and deliver training to all doctors.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Procurement required for a new electronic appraisal system ahead of the current contract ending

Comments: New appraisal system SARD procured for Trust use. Accurate records of all licenced medical practitioners with a prescribed connection to LCH are now maintained via SARD.

Action for next year: Embed the new appraisal software system and deliver training to all doctors.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Changes to the Dental aspects of the Appraisal and Revalidation policy have been proposed in conjunction with the new Dental lead. These proposed amendments will require the policy to be reapproved by JNC and the Trust during 2021.

Comments: Dental appraisal has moved away from the medical system and is now aligned with guidance from NHS Employers and the BDA on the advice of the dental lead.

All polices are in place and are next due for review in June 2024.

Action for next year: Awareness of potential changes in medical appraisal.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Due to the ongoing impact of the Covid19 pandemic it is not clear if peer review will be appropriate during 21/22 but if the opportunity is presented the Trust will actively participate.

Comments: Peer review of appraisal with another organisation has not happened and it did not seem appropriate to pursue this with cross system pressures. It is not clear if this will be restarted by NHS England prior to any review of appraisal

Action for next year: LCH will undertake a peer review exercise if notified to do so by NSE&I.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Clarify and establish the required support for doctors working for LCH on bank who have no other regular employment.

Comments: All doctors, regardless of employment status, are involved in governance processes relating to incidents and complaints. The Trust encourages them to be actively involved in any issues raised by patients, will ensure they have access to the relevant clinical record and will provide copies of documentation relating to these incidents for the purposes of appraisal.

Training and development opportunities are available and will be supported as appropriate for all doctors regardless of employment status. Every member of LCH staff has access to regular support from their clinical and operational line managers, including discussion regarding development needs and opportunities, clinical supervision and encouragement, and opportunities to be involved in local governance and service improvement processes.

During 21/22 we have noted the Trust employs one doctor working exclusively via bank, where the situation regarding their Responsible Officer is unclear, the Trust has agreed to act as their Designated Body.

Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a "Scope of Work" letter provided by their Medical Lead, detailing their work within the Trust.

Action for next year: None

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

   Action from last year: Review the appraisal model in conjunction with guidance from NHSE and the GMC, continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.

   Comments: LCH adopted the recommended MAG 2020 model of appraisal and supported the implementation through regular contact with Trust doctors. Submission of relevant information in regards to fitness to practice was maintained, there was increased flexibility with regards to revalidation. The continued focus during the 21/22 cycle was on the doctor's health and wellbeing and verbal reflection during the appraisal meeting, rather than on a requirement to upload supporting evidence.

   Action for next year: None

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

   Action from last year: None

   Comments: Yes, any doctors who have not had an appraisal have had an understandable reason for this and submitted plans to complete this within an approved timeframe.

   Action for next year: None

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Changes to the Dental aspects of the Appraisal and Revalidation policy have been proposed in conjunction with the new Dental lead. These proposed amendments will require the policy to be reapproved by JNC and the Trust during 2021.

Comments: Dental appraisal has moved away from the medical system and is now aligned with guidance from NHS Employers and the BDA on the advice of the dental lead. The Appraisal Policy will therefore be updated accordingly.

Action for next year: Update the Appraisal Policy to reflect changes in Dental Appraisal.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Review number of appraisers and the potential to recruit and train more

Comments: The Trust has a ratio of one appraiser to six appraisees, ensuring that no individual is required to conduct an excess of appraisals, but all have sufficient experience to maintain competency and confidence. This ratio is in line with NHSE guidance.

Action for next year: Recruitment of new appraisers to support the system in light of anticipated retirements.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Review feedback from appraisees once current round of appraisals has been completed. This will be fed back individually to appraisers and in a generalised manner with any relevant education required via the Appraiser Forums.

During 21/22 it is planned to review and widen the opportunity for supported learning, quality improvement and peer support in light of the increased opportunities for remote attendance provided during the Covid19 pandemic.

Comments: Appraisers are all supported to attend appraisal network/development attempts and are provided with both individual feedback and anonymised Trust feedback from the quality assurance process.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Focus during this year has included support for appraisers and appraisees, cascading of new guidance and information, continued to utilise the MAG 2020 format and ongoing work to ensure appraisal covers the full scope of a doctor's practice. It also provides an opportunity for supported peer discussion and development in the context of appraisal.

Appraisees have been reminded about the need to have a whole of practice appraisal, including leadership or education roles in addition to work in other settings.

Action for next year: Reintroduction of regular Appraisal updates following the pandemic.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: A further quality assurance exercise is planned for 20/21 adapting to the current guidance from NHSE on the focus of appraisal. Comments: During 21/22 a quality assurance exercise was conducted utilising the NHSE approved "Appraisal Summary and PDP Audit Tool" (ASPAT) for the 20/21 and 21/22 appraisal cycles. No significant issues were identified although areas for learning and improvement identified by the audit were fed back to both appraiser and appraisees as required. Action for next year: Complete the 22/23 Quality Assurance process.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	35
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	32
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	3
Total number of agreed exceptions	3

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Continue to engage with the GMC appropriately

Comments: No recommendations have been made to the GMC during 21/22 regarding the fitness to practice of any doctors with a prescribed connection to LCH as a Designated Body. Regular meetings are held with the GMC ELA and any potential concerns are discussed here and appropriately recorded.

Action for next year: Continue to engage with the GMC appropriately

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Consider implementation of a formalised process for the results of the revalidation panels to be communicated directly to the doctors in question

Comments: The Responsible Officer made 10 positive recommendations to the GMC during the period covered by the report, all in a timely manner and supported by a Revalidation Panel. This covers all doctors for who recommendations were due during this period.

All doctors received formal notification of their revalidation recommendation to the GMC.

Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: During 21/22 and integrated in the Reset & Recovery work post pandemic we plan to conduct further work regarding this, and improving the access to data that enables an individual clinician to benchmark their clinical practice.

It is also planned to continue work with the Quality and Research teams to ensure that quality improvement work undertaken by doctors and dentists is embedded within service and Trust work regarding research, audit, quality improvement and clinical outcomes.

Comments: The Revalidation Teamwork with Workforce and HR colleagues to share information to provide central assurance of any issues relating to medical and dental staff.

Work is underway to embed meaningful objectives into medical and dental job plans, and to incorporate elements of Trust appraisal into the Job Planning process. A recent audit has revealed significant improvement in the recording of objectives in job plans. This is anticipated to further strengthen the engagement of medical and dental staff to service and Trust objectives, priorities, and values. This will be facilitated by the implementation of the electronic job planning system.

Action for next year: Embed the new appraisal software system and deliver training to all doctors. Standardise job description for Medical/Dental Lead role across LCH including emphasising the importance of Clinical Governance.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: The process planned for implementation during 20/21 was further consulted on and reviewed, and has been subject to appropriate challenge from some appraisees despite this being a voluntary addition to the appraisal submission. It is now proposed to explore an organisational regular cross-verification of this data with Trust systems as is currently in place for revalidation panels. This proposal has been supported and welcomed by Medical & Dental leads, and in the Appraiser forum.

Comments: Revalidation processes include cross-verification of information submitted on Workforce and Trust systems to ensure any incidents and complaints are appropriately submitted and reflected on during a revalidation cycle. Existing routine systems to monitor the fitness to practice of all doctors include:

- Mortality reviews
- Clinical governance forums and meetings in service
- Quality improvement activity
- Freedom to speak up activity
- Never events

Revalidation Panels were carried out as required during 21/22, linking with Trust systems to ensure that appropriate submission and reflection on incidents and complaints was included in the relevant appraisals.

Action for next year: Pilot the introduction of an ‘Appraisal Pack’ which will allow activity data to be reviewed at annual medical appraisal.

Roll out e-job planning and ensure appropriate objectives in place in all consultant job plans, that align with the strategic goals of the service.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: The Maintaining High Professional Standards (MHPS) policy and the Remediation, Reskilling and Rehabilitation policy are both current.

Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Actions from last year: Explore whether it is possible to better identify medical and dental staff within the Trust systems regarding concerns, complaints and incidents in order to be able to appropriately analyse all concerns.

Comments: Revalidation Panels ensure that all revalidation recommendations are supported by a thorough consideration of all aspects of the five years of appraisal preceding the recommendation. Introduction of these panels during 18/19 has strengthened the Trust processes and reduces the possibility of bias or discrimination.

The Trust has had an established Freedom to Speak Up Guardian (FTSUG) since December 2016. In 19/20 it was noted that medical and dental staff did not use this method of raising concerns, and this route was highlighted to them. In 20/21 there were two specific concerns raised by medical and dental staff out of a total of 84 Trust cases.

During 21/22 one person from doctors, doctors in training and dentists contacted the FTSUG. No concern was raised formally but support was offered by the Guardian.

Junior medical staff can also raise issue or concern via the Guardian of Safe Working Hours (GSWH), the Guardian produces regular Board papers on issues raised.

Action for next year: None

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: It is planned during 21/22 to develop a key information source for operational, clinical and workforce colleagues containing the key aspects of the responsibilities of the Trust and the Responsible Officer, accompanied by additional education opportunities and support on request. This has been identified as particularly important for services who employ doctors but do not have a designated Medical Lead in the service.

Comments: The Trust is able to respond promptly to any request, this is signed off by the Responsible Officer prior to the transfer of information.

LCH has robust processes for requesting appropriate information from partner organisations on transfer to the Trust of new Designated Body doctors, and for providing it when doctors transfer out.

Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None

Comments: All processes are managed according to the Trust's Maintaining High Professional Standards (MHPS) policy. The policy includes the requirement to discuss any such cases with the Practitioner Performance Advice (PPA, formerly NCAS) at regular intervals.

The Trust has a designated Non-Executive Director to support processes for responding to concerns and ensure that these are fair and free from bias and discrimination.

Issues around potential bias and conflicts of interest are discussed prior to commencement of any formal process by the senior team.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

All doctors and dentists have access to the Trust Freedom to Speak Up Guardian.

Action for next year: None.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Review and improve our recruitment processes for consultant medical staff, including development of a bank of appropriate questions, review and renewal of the interview paperwork and streamlining of the AAC panel organisation process.

Comments: The Trust has robust processes in place to ensure that appropriate checks are undertaken to confirm that all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role. These processes are in line with NHS mandatory pre-employment checks.

The Workforce Directorate ensures that the processes undertaken in regards to bank and agency doctors and dentists is robust. These applications are reviewed by the Medical or Dental lead (or appropriate deputy) for fitness for role prior to any employment commencing and a new form has been developed that ensures additional checks are incorporated in line with best practice (e.g. Confirmation of Responsible Officer).

Action for next year: None

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Leeds Community Healthcare NHS Trust has a robust system in place for ensuring appraisal and revalidation of doctors employed by the Trust, for the appraisal of dentists and ensuring appropriate fitness to practice and fitness for role of other medical staff who work for the Trust. 32 doctors and 7 dentists have had an annual appraisal for the year April 2021 and March 2022. 10 doctors have been successfully revalidated.

Overall conclusion:

Despite the ongoing pressures resulting from the Covid19 pandemic the Trust has continued to provide high quality appraisal, supported and developed doctors and

dentists in regards to both appraisal and their general wellbeing, improved engagement with medical and dental staff and continued to further improve our systems to better support our medical and dental staff.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (49)

Title: Combined Safeguarding Annual Report

Category of paper: For Approval
History: Quality Committee: 27 June 2022

Responsible director: **Executive Director of Nursing and Allied Health Professionals**
Report author: Head of Service, Safeguarding

Executive summary (Purpose and main points)

This document forms the Safeguarding Annual Report for Leeds Community Healthcare NHS Trust (LCH) 2022-2023.

The purpose of the Safeguarding Annual Report is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2021 – 2022 and outline key ambitions for 2022-23.

The report covers the period 2020-2022 and provides information on:

- Safeguarding Adults
- Prevent
- Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood (SUDIC)
- Children Looked After and Care Leavers

Main issues for consideration

- Work with partners of the LSAB to develop a self-neglect strategy
- Work with partners of the LSAB to provide a citywide appreciative enquiry event focussing on one case of self-neglect.
- Continue to support LCH to work within the Prevent Duty
- Improve MCA practices in self-neglect cases.
- Facilitate MCA4 learning sessions and re-audit to evidence improvements of MCA documentation in self-neglect cases.
- Develop and launch LCH bespoke MCA e-learning package
- Working with LCH services implement any Safeguarding Learning Lessons, identified internally and externally from Leeds Safeguarding Children Partnership.

- Explore utilising Datix as a tool for holding incident information and evidencing the lessons taken forward within the trust.

- Work with LCH services and partners to establish a united Early Help registration process and explore a shared data set.

- Continue to engage in regional peer review and Named Doctor regional meetings
- Continue to learn from patient experiences – giving particular attention to the voice of the child by improving child friendly feedback collection processes
- SUDIC service review
- Further strengthen partnership working within LCH and across the Child Death Review partnership
- CLA to have a successful service review and restructure so that Leeds looked after children and care leavers can expect a similar level of care and support offered in most of our neighbouring areas and to ensure we have the best possible services we can for this extremely vulnerable group.

- To continue to work with our young people in care and care leavers to give them a voice and influence in health service provision.

Recommendations

LCH Board is recommended to note the contents of this report and approve its publication.

Leeds Community Healthcare NHS Trust

Safeguarding - combined Annual Report 2021/22 V2

Authors:
Head of Service, Safeguarding Adults, Children, Children Looked After (CLA) and Care Leavers – Lynne Chambers
Safeguarding Adults – Grace Stewart-Hanson
Prevent – Sharon Thomas
Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia – Kulvant Sandhu
Safeguarding Children – Wendy Brown
Specialist Child Protection Medical Services – Dr Anna Gregory
Sudden Unexpected Death in Infancy and Childhood (SUDIC) – Interim – Debbie Reilly
Children Looked After and Care Leavers – Angela Dillon

Contents Page:

Introduction and Executive Summary

Leeds Community Healthcare NHS Trust (LCH) places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The Safeguarding Team ensure LCH meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005.

The purpose of this suite of reports is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2021 – 2022 and outline key ambitions for 2022-23.

Team Structure
The Safeguarding Team based at Stockdale House provides both corporate and operational functions and sits within the Quality and Professional Development directorate providing safeguarding advice, guidance, support, supervision and training for all LCH employees.

The team consists of Named and Designated Professionals, Lead Professionals, Safeguarding Advisors and Specialist Practitioners with responsibility for:

- Safeguarding Adults
- Mental Capacity, Deprivation of Liberty Safeguards and Dementia
- Prevent
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood
- Children Looked After and Care Leavers

The focus for 2021/22 has been to ensure Safeguarding has remained a priority during the COVID19 pandemic, which has required us to review, develop and change the way we offer our service to keep our patients safe and free from abuse wherever possible. The team have continued to ensure high quality training,support and advice has been provided to staff and managers when required. It is imperative that we encourage our safeguarding workforce to maintain resilience throughout this challenging period of increased safeguarding activity. The team continue to work remotely with regular check ins, 1-1's and appraisals. The plan is to move to a much more hybrid approach in the coming months.

Alongside the global pandemic another motivator for change was to ensure we remain fit for purpose as we enter a time of significant change locally and nationally in response to the NHS Long Term Plan. The LCH Safeguarding Team will need to be agile in it's response as we move toward Integrated Care Systems (ICS) which will impact on how we organise and respond to safeguarding issues both within the Leeds health economy and across the West Yorkshire and Harrogate footprint; and as we work in ever closer alliance with the Leeds GP Confederation.

Partnership Working
The team works closely with the designated and named professionals within community paediatrics, the Clinical Commissioning Group (CCG) soon to be Leeds Office of the West Yorkshire ICB, and across other health care providers as well as colleagues in Social Care to ensure our work force have the skills and support they need to safeguard all those in our care.

Governance Arrangements
Safeguarding strategy up-dates are submitted twice a year to the Quality Committee who also receive the minutes of the safeguarding committee after each meeting including any escalations. In addition outcomes from the safeguarding committee are shared with Leeds Clinical Commissioning Group (CCG) through the Children's and Adults Advisory groups and with Leeds Safeguarding Children Partnership (LSCP) and Leeds Safeguarding Adults Board (LSAB) through the relevant sub-groups.

Safeguarding priorities are set down in an annual work plan which is reviewed bi-monthly and updated through the Safeguarding Committee. Our safeguarding strategy up-dates are heard at Quality Committee twice yearly.

The Safeguarding Team is continually learning, improving and disseminating best practice. Through our contributions to Leeds Safeguardign Partnership (LSCP) practice audits, the continuous cycle of preparation for Ofsted Joint Targeted Area Inspection (JTAI) and Care quality Commision (CQC), as well as through collaboration with agencies in the Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Stronger Communities (previously known as Safer Leeds), we have scrutinised, analysed and identified practice learning points as we strive to ensure the people of Leeds receive the best possible care.

Commitment
LCH has a responsibility to prevent and stop all forms of abuse or neglect happening wherever possible and to keep vulnerable adults safe, meeting statutory obligations and our duty of care.

LCH safeguarding team focuses on creating an environment where abuse is not tolerated, and safeguarding is everybody's business.

The safeguarding team offer guidance, support, and training to all staff in LCH to develop a workforce with the confidence and capability to meet our duty to safeguard; we work particularly with front line staff to ensure our patients can live free from abuse within their own homes. This level of support and guidance for staff and managers has been maintained throughout the COVID-19 pandemic.

It is acknowledged that some people require more support than others to make choices and manage risks; therefore, strong communication skills and quality mental capacity assessments remain key to ensuring a shared understanding of risk and action in the best interests of vulnerable adults.

Key achievements are set out at the head of each report

Safeguarding Adults

Key achievements 2021-2022:

- Worked in partnership with Leeds Safeguarding Adults Board (LSAB) and partners to raise awareness of the city-wide Self-Neglect policy.
- Work in partnership with the LSAB to develop and embed an exceptional risk forum for Self-Neglect (SN) which will add another layer of support for staff working with SN as well as another layer of protection for the citizens of Leeds
- Worked in partnership with LSAB and our Health Economy partners to participate in the Citizen Practice Audit.
- Worked in partnership with our Health Economy partners to raise awareness of the Domestic Abuse Bill April 2021
- Raised awareness of Safeguarding Supervision, its link to the Care Act and value within Adult Safeguarding, and its value to our practitioners.
- Launch of LCH Domestic Violence/Abuse Policy and Guidance on Supporting Affected Employees.
- Joint working within the Safeguarding Team and Safer Stronger Communities (previously known as Safer Leeds.) to obtain the Domestic Abuse Quality Mark (above policy is one aspect of the quality mark).
- Launch of Domestic Abuse Champion role within LCH (another aspect of the DV quality mark).
- Continued to provice a full safeguarding service during COVID 19 (Remotely) Prior to COVID the team provided telephone advice and support which hasn't changed. We also provided face to face training which is now accessed via MSTeams, the numbers of staff members accessing training via this method has actually increased and feedback is good.
- Successful online campaign implemented for Safeguarding Week Leeds-June 2021.
- Successful online campaign for White Ribbon Day, 16 days of action November 2021.
- Co-authored and published a paper in Journal of community nursing

Key ambitions 2022-2023:

- Work with partners of the LSAB to develop a self-neglect strategy
- Work with partners of the LSAB to provide a citywide appreciative enquiry event focussing on one case of self-neglect.
- Develop and deliver safeguarding supervision training to all LCH managers (had been paused due to COVID)
- Safeguarding Adults level 3 training currently 81%, aim to increase compliance to over 85% by Q3.
- Continue to embed 'talk to me, hear my voice' keeping the patient at the centre/focus of all safeguarding processes
- To maintain positive engagement with partners and ensure open, honest and transparent conversations, looking to address any emerging safeguarding themes.
- Participate in an LSAB sub group appreciative enquiry event (self-neglect) Oct 22

A key priority for LCH is to raise awareness and empower staff to recognise the signs and symptoms of abuse. The aim is for all staff to feel informed and confident to access the team for support and advice. The Safeguarding Adult Team does this by continuing to provide advice, training, and support to staff, in line with our statutory duties. We recognise that there are many different platforms for learning and always incorporate different techniques to help facilitate learning, there are also many different aspects of safeguarding.

Training

The team prioritised and worked hard to create and facilitate the introduction of Level 3 Safeguarding Training as per the Safeguarding Adults Intercollegiate Document, Adults Safeguarding: Roles and Competencies for HealthCare Staff (2018). The team are continuously reviewing and developing training packages in line with the changing horizon of safeguarding in Leeds and Nationwide. Despite the pressures

of the pandemic and staff capacity, Safeguarding is prioritised within LCH, and compliance currently sits at 81% with an aim to achieve over 85% by Q3.

> ***'Level 3 Safeguarding training is informative and engaging, no question too silly to ask'***
>
> Neighbourhood team community staff nurse

Multi-agency working is a crucial element of safeguarding and the safeguarding team works in partnership with colleagues in other provider organisations, Leeds CCG, Adult Social Care, West Yorkshire Police, and voluntary and private sector organisations to safeguard and protect the people of Leeds.

Multi-agency working in safeguarding is a key benefit that does dramatically reduce the risk of abuse, by enabling different services to join forces in order to prevent problems occurring in the first place. The key principles of multi-agency working are the commitment to hold each other to account, to understand interlinking risks and needs from all perspectives, and to take collective responsibility to help and protect all involved. A commitment to respecting and treating everyone justly according to their individuality in line with 'talk to me , hear my voice' ensuring the citizen/patient is involved throughout any safeguarding process Talk to me, hear my voice (leedssafeguardingadults.org.uk).

Inter-agency Policy and Procedure
In response to lessons learned from previous and current Safeguarding Adult Reviews (SAR) it was highlighted that as a city we need to do more around self-neglect. Staff questionnaires across the whole health economy, social care, police, housing and third sector, emphasised the need for more training, more time to build a relationship with the patient. Recognition that self-neglect is a complex subject which often requires a multi-agency response.

The LSAB developed a city wide, self-neglect policy LSAB Self neglect policy (v1).pdf (leedssafeguardingadults.org.uk) and is currently working on a self-neglect strategy aiming for completion in Q3. Professional curiosity is an area we always aim to develop and in response to this the LSAB has developed a suite of guides to support this, Professional curiosity for frontline practitioners, front line managers and senior managers Multi Agency Policy And Procedures | Safeguarding Adults (leedssafeguardingadults.org.uk)

A sub-group of the LSAB developed an Exceptional risk forum (ERF):

The Exceptional Risk Forum has been established by the Leeds Safeguarding Adults Board in recognition that sometimes, despite the best efforts of agencies to work together to intervene and provide support to someone, an exceptional risk to their safety can remain.

*If **after** the multi-agency safeguarding adults policy and procedures, or other multi-agency processes have been followed, the person remains at exceptional risk to themselves, it may be appropriate for the concerns to be raised with the LSAB Exceptional Risk Forum.*

The LSAB Exceptional Risk Forum can offer agencies with a fresh perspective and multi-agency advice and recommendations as to how that person's risk could be reduced. LSAB (2021).

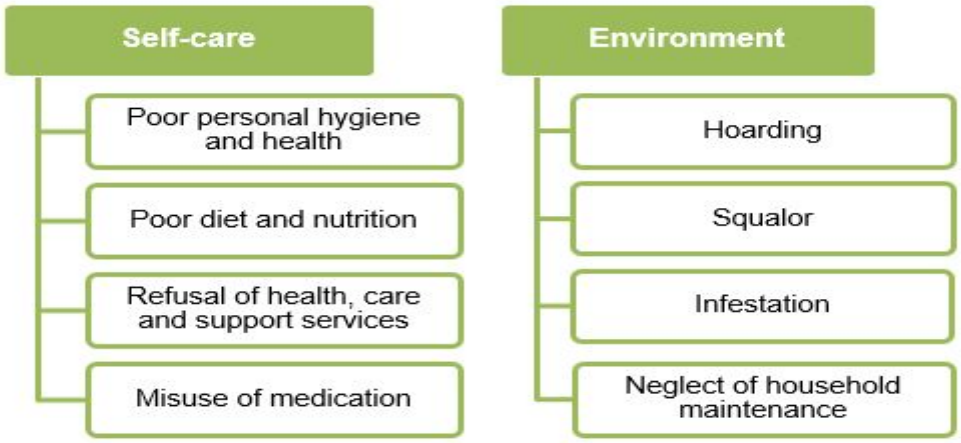
LSAB Exceptional Risk Forum (leedssafeguardingadults.org.uk) link to guidance, checklist and referral forms.

The forum panel has a core membership of Health, Social Care, Housing and Forward Leeds with the option of co-opting in any other agencies deemed relevant e.g West Yorkshire Fire Service, Police, Yorkshire Ambulance service etc. Following a recent survey, more work needs to be done to raise the profile of ERF but positives included:

- Practitioners really liked the checklist and referral form.
- The forum is valuable, needed and mostly met expectations.
- People attending felt listened to, respected, the Forum was professional.
- Forum membership to include experts relevant to the case
- Send action points sooner to the practitioner.

The Care and Support Statutory Guidance (March 2020) states that self-neglect is a form of abuse and neglect. It defines self-neglect as: "… a wide range of behaviour neglecting to care for one's personal hygiene, health or surrounding and includes behaviour such as hoarding" (Section 14.17) This may include people, either with or without mental capacity, who demonstrate: • Lack of self-care (neglect of personal hygiene, nutrition, hydration and/health, thereby endangering their safety and wellbeing) • Lack of care of one's environment (squalor and hoarding) • Refusal of services that would mitigate the risk of harm.

Self-Neglect can include:



Learning from Reviews

The Domestic Violence/Abuse agenda continues to be a priority area for Safeguarding and the Trust. The team have continued to work hard to fulfil the requirements needed to provide support and guidance to staff for their patients and also in some cases for themselves. This year we are proud to say we achieved the Domestic Violence Quality Mark awarded by Safer Stronger Communities.

Safeguarding staff members, along with other LCH staff members co-authored a paper published in the Journal of Community Nursing Journal of Community Nursing (JCN) latest issue - Journal of Community Nursing JCN 2021, Vol35, No6, titled, Domestic Violence, Our Staff and our services.*01216, Vol*

LCH continues to be an open and reflective contributor to Domestic Homicide Reviews (DHR) and Safeguarding Adults Reviews (SAR) where required. Both processes allow for analysis of findings from investigations carried out by individual agencies involved in the case, to make recommendations for improving future practice where this is necessary.

Previously DHR's highlighted the need for more knowledge and training around routine enquiry and SARs, and the need for more knowledge of self-neglect. LCH safeguarding team responded by providing Domestic abuse training which has been tailored to address specific needs arising from DHRs and non-statutory Learning Lessons Reviews, and also self-neglect training. Training packages have been reviewed and are now offered virtually. Both subjects are now also included within the Level 3 training package.

Domestic Abuse and Routine Enquiry
Continuing from the themes published within the learning from reviews the Safeguarding team has reinforced the systems for staff to identify and respond to abuse. The use of Routine Enquiry is actively encouraged following appropriate training with the aid of a domestic abuse flowchart to guide staff. We are now starting to see the effects of lockdown/COVID_19 with an increase in the number of calls for support for both staff and patients. It is imperative we are prepared to spot the signs of domestic abuse in our own relationships as well as our patients, and are equipped to ask the right questions at the right time and have the knowledge to refer to appropriate services. Domestic abuse is included in Adult and Childrens safeguarding training and staff have accessed bespoke routine enquiry training which will enable staff to ask the right questions at the right time with the knowledge of the next steps and process to begin to support the patient.

Safeguarding Champions
Safeguarding champions act as ambassadors for safeguarding in LCH, imparting their enhanced safeguarding knowledge to their teams, ensuring safeguarding is on the agenda at team meetings, managing a safeguarding information board, and encouraging staff to maintain alertness to safeguarding in all that we do. Safeguarding Adult champions can be any band, and any speciality (including childrens services)

The Safeguarding team continues to engage virtually with LCH Adult Safeguarding Champions; this is set to reach a wider audience supporting staff to learn by sharing identified cases, receiving bespoke training, and developing their knowledge and understanding of the wider safeguarding strategy and agenda. Champions feedback included that they value the meetings, gain a greater understanding of safeguarding issues, themes and trends and feel more confident sharing learning to colleagues in their own teams.

Domestic Violence/Abuse Champions
The Role of Domestic Violence/Abuse Champion is a new role that was intorduced introduced alongside the Safeguarding Adults Champion's role. It is not specific to the Adult Business Unit, instead incorporating representation from CBU, SBU and Corporate Services. The role is like that above but will focus solely on Domestic Violence/Abuse. The Domestic Violence Bill of April 2021 and the changes that will bring with it highlight the ever-increasing need for our practitioners to share knowledge and expertise to their colleagues which will be increased from undertaking this role. Domestic Violence/Abuse champions working within the trust will increase the level of advice and support to staff, assist with raising awareness of the signs of abuse and help to keep it a high priority. 2021 – 22 saw the development of this group, creating terms of reference and outlining the main aims.

PREVENT

Key achievements 2021-22:

- Development of a dedicated Prevent Web page to support staff in fulfilling their Prevent duty
- Maintained/complied with all Prevent Duty requirements throughout the year
- Maintained safe adapted services
- Continued to raise the profile of Prevent across the organisation
- Maintained training compliance.

Key ambition 2022-23:

- Continue to maintain the uptake on training
- Maintain up-to-date- information and resources on LCH dedicated webpage for Prevent.
- Continue to support LCH to work within the Prevent Duty
- Maintain safe adapted services
- Continue to raise the profile of Prevent across the organisation

Prevent is one strand of the Government's counter terrorism strategy known as CONTEST. The Prevent strategy aims to stop people becoming terrorists or supporting terrorism. Prevent addresses all forms of terrorism but prioritises these according to the threat they pose to our national security. Prevent is delivered in partnership by a wide range of organisations including Health. Together we recognise that the best long-term solution to preventing terrorism is to stop people been drawn into terrorist behaviour in the first place.

The objectives of the Government's Prevent strategy are to:

- Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
- Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.
- Enable those who have already engaged in terrorism to disengage and rehabilitate.

Safeguarding vulnerable people who may be at risk of being drawn into terrorism is an essential part of the Prevent Strategy. Terrorism is a real and serious threat to us all because terrorists actively seek to harm us, to damage community relations and to undermine the values we share. Throughout the country there is a requirement for Prevent local action plans, to be in place to support vulnerable individuals –hence the necessity for a robust training package.

Health has a key role to play. Partnership involvement ensures that those at risk have access to a wide range of support, from mainstream services, through to specialist mentoring or faith guidance and wider diversionary activities.

A joined up approach, motivation, and commitment to drive standards forward have resulted in achieving our training compliance expectations and maintain, what has been, an improving figure. Which is a testimony to staff /team's resilience and commitment.

We acknowledge that face-face training generates a conversation and would be the gold-standard in an ideal world. However, within the current climate and risks around extremism, we felt we needed to reach out to all staff, regardless of roles and responsibilities. The e-learning resource is available for all staff members; meeting the WRAP (Workshop to Raise Awareness of Prevent) training requirement for level three practitioners and counts toward the intercollegiate safeguarding competence / training requirements.

Regular meetings continue to take place across the Health Economy, where a shared learning approach and response has been adopted. This ensures continuity and reassurance around matters such as; advice, consent, confidentiality and documentation as well as support around each other's organisational practice.

LCH now has a dedicated staff intranet Prevent page, with access links to training, information, resources and contact details for concerns. Resources are regularly shared across the Health Economy to be used for staff dissemination.

It is also important to note that prevent, remains a legal duty and all NHS Trusts continue to be contractually obliged to collate and provide performance data-this is reviewed regionally before scrutiny by the National Safeguarding Steering Group.

Local Overview

The COVID-19 crisis gripped the world, and the UK remains on a variety of restricted measures. This huge change to daily life has resulted in increasing community tensions, fake news, and online usage by many.

The national safeguarding website www.actearly.uk which was launched last year, continues to encourage family and friends to act early, share concerns and seek help if they are worried that a loved one is being radicalised. The website includes case studies, signs to spot, FAQs and details of a new national advice line staffed by trained Prevent officers.

The site also provides toolkits for staff and partners to access a range of support materials, from templates to posters to business cards and tweets. https://www.counterterrorism.police.uk/actearlypartners/

Throughout the last year, prevent concerns have continued to be addressed, regular monthly Channel Panels have continued via MSTeams and the prevent team/police/chair and vice-chair continue to keep in close contact with any concerns across the city.

National support for Channel and Prevent comes through the Channel Duty guidance providing a robust framework for building on much of the good work we know is already being delivered, whilst strengthening the quality and consistency of panels and the practice of panel members across England and Wales. This enables us all t0 manage the vulnerability of individuals at risk of being drawn into terrorism more effectively.

Leeds Prevent Referrals

Referrals into the Prevent local authority and Police team come from many areas, schools, colleges, universities, healthcare professionals, social care members of the public, family members, the police themselves. The Local Authority Prevent team continue to support organisations/schools/educational settings with Prevent training and guidance.

LCH staff remain engaging and vigilant when assessing concerns and are contacting the team for discussions around potential Prevent issues. However, we mustn't become complacent, but ensure we remain professional and always work within our remit of roles and responsibilities and are constantly developing and evolving, to ensure we offer the best experience of channel/prevent for clients/families and people who come through our services.

Leeds local Issues

The impact of COVID-19 presented many issues for the people of West Yorkshire and the repercussions may be felt for many years to come.

The demographic of Leeds provides us all with lots of challenges within our practice and daily life, communities continue to be affected by some of the restrictions, still in place, which may lead to an increase in people's susceptibility to radicalisation. This is more so around the online space, people/students working from home.

Vulnerabilities have more opportunity to be preyed upon, and those using the internet for work/school/pleasure maybe taken advantage of, also, there is an increased opportunity for people to self-radicalise in the home.

This increase of online traffic to these platforms, raises concerns that the online presence may manifest into physical meetings with the easing of restrictions and the ability to travel easier now.

Local Authority/Police are working with local teams to address this change in risk and actively engage with families where young people may be exposed to negative influences online.

LCH Response

Safeguarding accessibility remains on full capacity and we will continue to offer support and advice through a range of media platforms.

LCH continues to have representation at Channel and Silver meetings, being an ideal platform for learning, reflection and ensuring that LCH continues to be compliant, effective, and efficient around the Channel Duty.

The PREVENT partners newsletter (from the local authority prevent team)continues to provide partners with a reflective, platform of information around prevent. Highlighting the shared approach to keeping the citizens of Leeds informed and as safe as possible.

Training for staff remains at a constant, which is really reassuring that we have that commitment from staff during these challenging times.

Latest quarterly training figures report:

96.6% level 3 uptake (B5 staff and above)

98% level 2 uptake (B4 staff and below)

Development of a resources page accessible for all staff is now active, information is available on the safeguarding adults intranet page, coving a wide range of topics, including, Prevent, domestic violence, cuckooing, modern slavery, with further support available from the safeguarding team.

Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Dementia

Key achievements 2021-22:

- Active membership to self-neglect task & delivery group as MCA-LIN representative
- MCA training to volunteers at Carers Leeds
- Full roll-out of dementia refresher training- continues to evaluate well
- Successful promotion of MCA sessions during June 2021 safeguarding week
- Delivery of bespoke MCA refresher sessions
- Continued growth of MCA champions forum
- Intranet pages developed and launched for MCA and dementia
- Continued support to CBU to embed consent & MCA practices
- Consent & MCA tool developed for LSH moving over to S1 alongside bespoke training
- Easy read format of advance care planning tool developed and launched
- Continued support to services with more complexity of cases involving legal interventions
- Trust wide consent policy reviewed
- Reviewed MCA training package to incorporate learning themes from incidents and SARS- improving practice around self-neglect
- MCA audit completion- key themes identified alongside learning
- First trust wide dementia audit tool developed

Key ambition 2022-23:

- Improve MCA practices in self-neglect cases. Facilitate MCA4 learning sessions and re-audit to evidence improvements of MCA documentation in self-neglect cases.
- Named Nurse's active involvement in self-neglect task & delivery group- facilitate appreciative enquiry event to further contribute to work around manging self-neglect from MCA perspective
- Support dental service review and development of their pathways involving patients who lack capacity to consent to dental interventions involving restrictive practices.
- Develop and launch LCH bespoke MCA e-learning package
- Readiness for implementation of MCA amendment bill: Liberty Protection Safeguards (LPS) legislation within LCH
- Offer regular dementia training sessions for LCH staff who are carers
- Launch LCH dementia champions model to support embedding of 3Ds clinical frameworks
- Launch dementia audit tool to improve quality in dementia care and embedding of the 3Ds frameworks across services.

The purpose of the MCA (2005) is *"to empower people to make decisions for themselves whenever possible, and protect people who lack capacity by providing a flexible framework that places them at the very heart of the decision making process".*
(Lord Falconer in the forward to the MCA 2005, Code of Practice).

Everyone working in health and social care who make decisions for people who lack capacity has a legal responsibility to know and follow the MCA (2005). LCH has a statutory duty to ensure we comply with the legislations on consent and MCA (2005), to ensure the care and treatment delivered is lawful and best practice. This is also part of CQC's Key Lines of Enquiry (KLOE) Effectiveness domain which looks for assurances in this area.

The safeguarding team support the embedment of MCA (2005) into everyday clinical practices and ensures this can be evidenced for assurance purposes. Routine work that promotes best practice for MCA and dementia includes; giving specialist MCA & dementia advice and guidance to staff, including the use of relevant legislations on consent and MCA (2005). Undertaking yearly audit to identify areas of development, facilitation of training and chairing the well-established MCA champions forum. This forum provides vital MCA clinical supervision, relevant case law updates, as well as sharing of learning from Serious Adult Reviews (SARs) where mental capacity has been a feature.

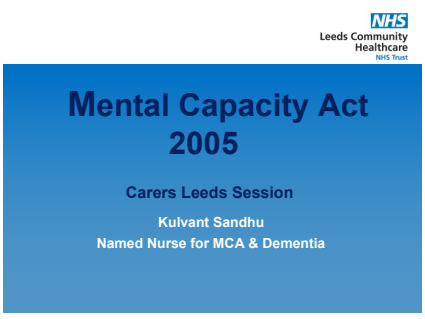
Key achievements

Collaborative working

The named nurse continues to ensure the priorities for MCA & dementia within the trust are aligned with the citywide and regional strategic groups. The named nurse continues to be an active member and deputy chair of the MCA- Local Implementation Network (MCA-LIN) which is a sub-group of the Leeds Safeguarding Adults Board (LSAB). The named nurse also continues to be an active member of the city's dementia steering group, specialist dementia & End of Life (EoL) group, and the Yorkshire and Humber clinical networks forum for dementia (led by NHS England).

The named nurse also has membership to the Self-neglect task & delivery group as MCA-LIN representative, a multi-agency working group focused on embedding learning from Serious Adult Reviews (SARs) around self-neglect including embedding of MCA (2005).

Through recognising the need to support carers of our patients, the named nurse continues to hold membership with the trust's Carer's steering group which collaborates with the 3rd sector agency Carers Leeds. This to ensure through the MCA & dementia work streams the needs of carers can be identified and met. The named nurse continues to deliver MCA training sessions for volunteers at Carers Leeds who are supporting people across the city in their caring role. This has enabled the volunteers to better understand the MCA legislation and best interests decisions when supporting the carers they are working with.



During the pandemic and throughout winter pressures, the named nurse continued to work collaboratively with the wider safeguarding team, support safeguarding adults agenda with Domestic Homicide Review (DHR) and attendance at Rapid Review meetings.

Developing the workforce

Dementia training has continued to be delivered over virtual platform with this year seeing the increased roll-out of the 3 yearly refresher training. The refresher training continues to evaluate well alongside the initial dementia training package, both delivered by highly experienced and knowledgeable dementia trainer. Practitioners report feeling more confident and knowledgeable in providing good care to those living with dementia.

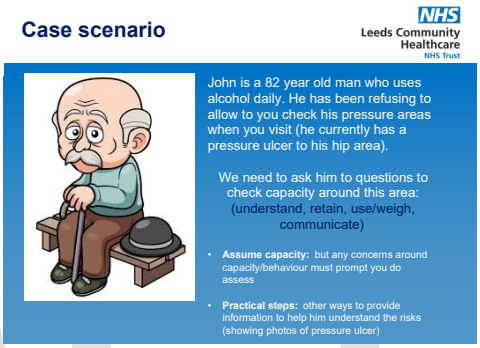
"Thank you- very useful refresher"

"Really helpful and practical refresher. I will be able to implement the advice straight away. Thank you very much."

"Refresher training very insightful and interactive. Thank you"

Evaluation comments from dementia refresher training

MCA stat/mand training continues to be offered over virtual platform with no pause in delivery during the pandemic or winter pressures. Alongside these bespoke sessions focusing on learning from Rapid Review meetings and SARs have also been held over safeguarding week as well as refresher sessions focused on good quality capacity assessments to support the development of practitioners' skills.

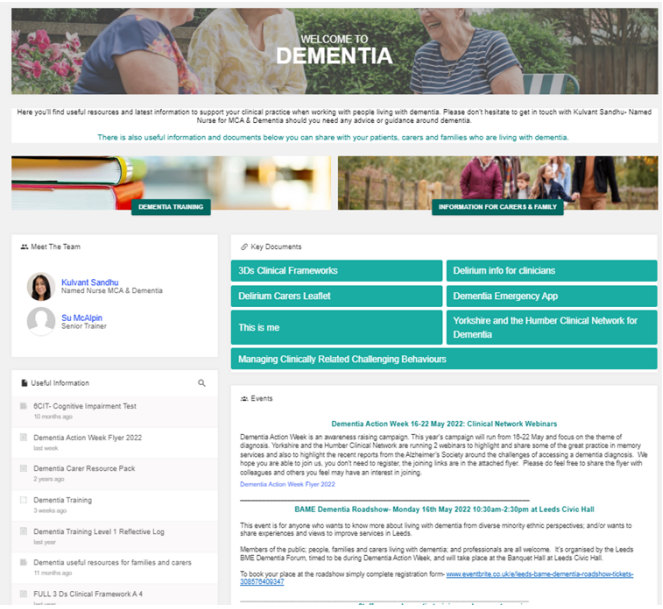


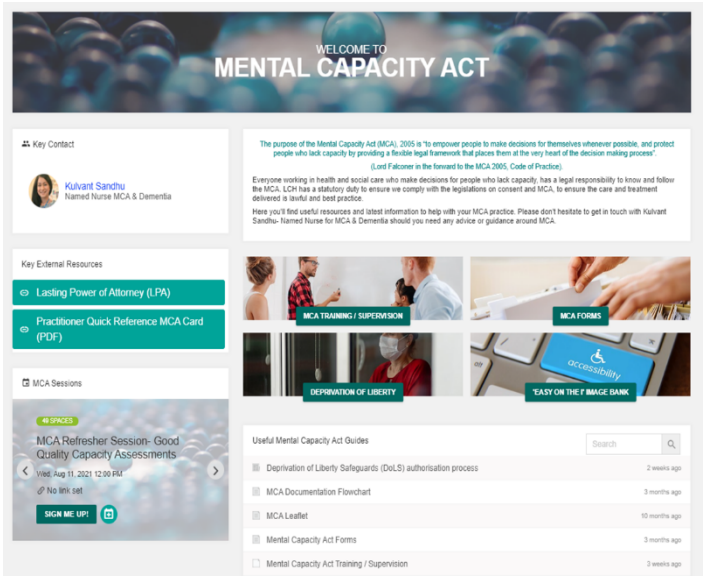
The named nurse continues to facilitate and develop the MCA champions forum with membership from over 50 practitioners trust wide. This forum supports embedding of MCA practices and learning back into the clinical teams. Members of the forum continue to value the specialist knowledge shared and development of their own understanding of the MCA legal framework.

"I want to thank you for all the MCA guidance you have shared with me to give me a better understanding. I have enjoyed being an MCA champion for the Trust".

Feedback from an MCA champion

To further support practitioners with up-to-date information, guidance and learning opportunities, the new MCA and dementia intranet pages have been developed and launched trust wide. Feedback from practitioners has been positive with easier to access material and guides to support their clinical practice.



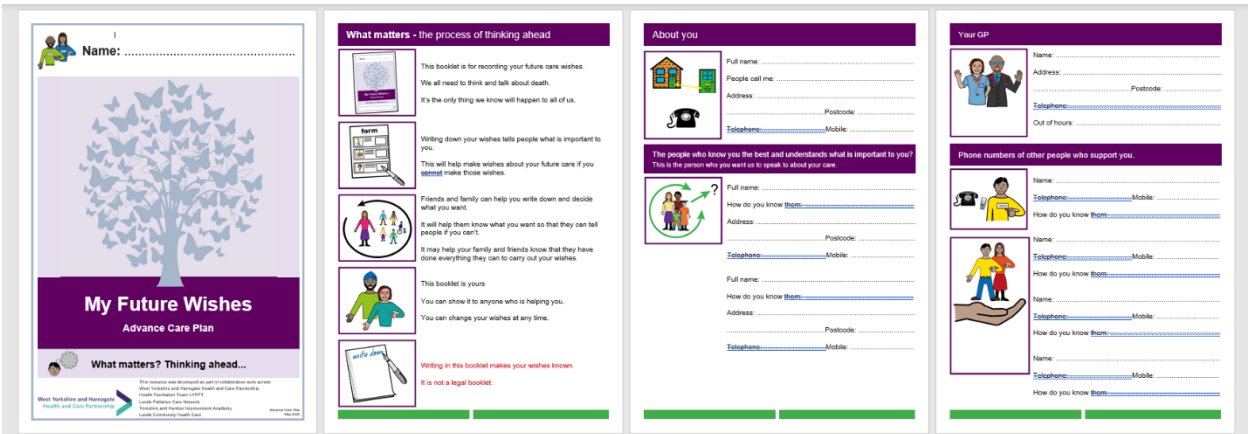


Making Safeguarding Personal

Continued support to the Children's Business Unit has remained for embedding the consent template within their electronic patient records (EPR). Evidence from MCA safeguarding calls from children's practitioners, this template is supporting improvements in their practice around seeking out the voice of the child and young person, ensuring they are involved in decisions about their care and treatment.

The named nurse provided support to the Leeds Sexual Health Service during their move over to a new EPR system, adapting the EPR consent template to better align to their requirements. This resulted in the trust wide version also being updated to ensure requirements around Fraser guidelines were being captured when services were providing sexual health or contraception advice and treatment to young people aged under 16. This work also involved providing bespoke refresher sessions on consent and MCA to support their transition.

Further multi-agency collaborative working opportunities have arisen with the named nurse being part of a city-wide working group to develop an easy-read format of an advance care planning tool. This was launched to ensure accessible information around advance care planning was available to those who require it, to enable them to actively participate in these important discussions.



The past year has also involved the named nurse providing intensive support to various teams for best interests meetings and decisions. These cases have often been complex, involved multi-agency support to manage risks, ensuring interventions are least restrictive and in line with patient's views and wishes. This

has also involved identifying the requirement of legal intervention when required and seeking this out on behalf of services, as well as support them through any legal process such as referring cases to the Court of Protection.

Quality improvement and assurance

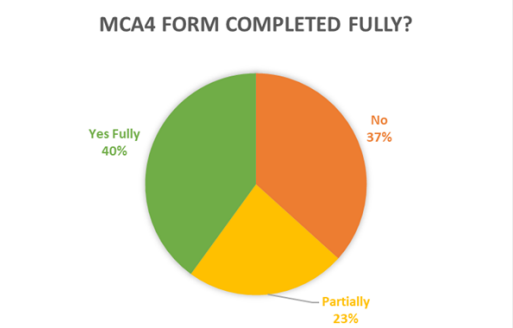
The past year has also involved the named nurse reviewing the trust wide consent to care and treatment policy, ensuring guidance for practitioners is clear and referenced to the latest case law, legislations, and best practice.

The MCA stat/mand training package has also been reviewed and updated to incorporate learning themes from incidents and SARS, to improve practice around management of self-neglect cases in the context of MCA.

This year's annual audit focused on the number of MCA4 forms (titled Unwise Decisions) that were completed in 2021, the quality of them and how they have impacted on decision-making to manage risks. The audit will be completed again 12 months post launch of the EPR SystmOne MCA4 quick link button (launched in November 2021) to compare results.
Key themes identified from the MCA audit showed:

- 2/3 of the forms were fully or partially completed, evidencing the patient's capacity for the unwise decision was considered which is good practice especially in complex self-neglect cases.
- While reviewing the patient records during the audit, the MCA4 form discussions had resulted in some patients accepting help or changing their decision of declining interventions.
- Evidence of good multi-agency working by practitioners was noted, as well as involving family and carers.
- Of those patients who had sadly died, the records showed the completed MCA4 form evidencing the patient's capacity for the unwise decision / decline of interventions prior to death.
- Training needs was identified around the completion of MCA4 forms to help improve the quality of documentation in self-neglect cases.

Following the audit, MCA4 learning sessions are being planned to share audit findings, promote the MCA4 quick link button on EPR, and expected documentation standards for capacity assessments when working with those who self-neglect. These bespoke sessions will be delivered throughout 2022-2023.



Reason for MCA4 form completion (themes):	
Declining advice around nutritional intake and diabetes management	4
Decline of advice for health/ support services (referrals to specialists, visits by service)	5
Decline of skin inspections	1
Decline of advice around equipment (using and having it)	6
Decline of hospital admission (when advised to do so)	4
Refusal of advice around repositioning / PU management	8
Decline of taking medication	1
Patient making unwise choice around environment/safety	1

Finally the trust's first dementia audit tool has been developed which aligns to the embedding of the 3Ds (dementia, delirium and depression) clinical frameworks as well as latest evidence-based practices for good standards in dementia care. It is hoped this audit tool will be implemented by clinical services in the coming year.

Key ambitions:

MCA

Over the coming year ahead the MCA and dementia workplan will focus on developing practitioner's knowledge and skills when working with people who self-neglect, in the context of using the MCA effectively to manage risks. This will involve facilitating MCA4 learning sessions and a re-audit to evidence improvements of MCA documentation around unwise decisions.

This also links in with the ambition of the Named Nurse's active involvement in the city-wide self-neglect task & delivery group, to facilitate an appreciative enquiry event to better understand the multi-agency safeguarding practices in self-neglect cases. The aim being to embrace professional curiosity and focus on what worked well in managing self-neglect, and to share that learning widely with practitioners across the city.

Targeted work has also been identified within the dental service for the named nurse to support review and development of their pathways involving patients who lack capacity to consent to dental interventions involving restrictive practices. This has arisen from recent cases involving the Court of Protection, the aim is for there to be clear guidance on restrictive practices, ensuring least restrictive interventions are promoted first, and appropriate escalation of cases to the named nurse that require legal consideration for the dental intervention.

With demand for MCA stat/mand training remaining high, a bespoke e-learning package will be developed and launched in the coming year to run alongside the offer of virtual training sessions. The newly developed e-learning package will support practitioners to access MCA training promptly, enabling a refresher for those who prefer learning in this method. The virtual sessions will continue to remain available for those practitioners who preferring learning in this format.

The MCA amendment bill (2019) along with the Liberty Protection Safeguarding (LPS) legislation has been further delayed by the government due to the pandemic. This year has seen the release of the draft code of practice which is open to consultation, it is hoped the new legislation will be implemented once the code of practice has been finalised. Focus for the year ahead will continue to ensure LCH is ready to implement the new legislation. The named nurse continues to be part of the city-wide LPS implementation group. This new legislation will replace the current arrangements under Deprivation of Liberty Safeguards (DoLS).

Dementia

Over the years ad-hoc sessions have been facilitated for LCH staff who are caring or supporting someone with dementia in a personal capacity. These have been well attended and positively evaluated, supporting staff in their caring role. In keeping with the trust's values of supporting the wellbeing of our workforce, these sessions will be facilitated regularly throughout the year to enable more staff to access them to gain information and support available for themselves and those living with dementia.

With the pause of the dementia steering group during the pandemic and winter pressures, the ambition to launch a dementia champions model will be planned for this year. This to support services to embed the dementia, delirium, and depression clinical frameworks, as well as improve standards of care delivery for those living with dementia.

Alongside this the trust's first dementia audit tool will be launched for services to complete to identify and support embedding of the 3Ds clinical frameworks and identify any areas of improvement. The audit tool will also allow for clinical services to evidence good standards of care delivery to those living with dementia who access our services.

LCH Safeguarding Children team.

During 2021/2022 LCH Safeguarding Children team continued their commitment to supporting practitioners across all LCH services. Children and young people, their welfare, protection, and the promotion of their best interests continues to be the children's team priority.
The Safeguarding Children Policy sets out how LCH fulfils its statutory duty to safeguard children and young people. This policy draws on and refers to other interlinked documents within trust and includes relevant legislations and statutory guidance such as Children Act 1989 & 2004, Working Together to Safeguard Children (2018), and the Intercollegiate document (2019). National, regional, and local policy or guidance form the core of the safeguarding children team practice.

Who are we?	What are we proud of?
Named Nurse for Safeguarding children (Full time practitioner) Senior Specialist Safeguarding Advisor – Children's & Adults (Part time) Specialist Safeguarding Nurse – Childrens (Full time) Specialist Safeguarding Nurse – Childrens (Part time) Specialist Safeguarding Nurse – Front Door (Full time)	Working together to safeguard children, we are a dedicated experienced team providing a trust wide service to all staff across LCH who manage safeguarding complexity and risk. We offer compassionate specialist guidance, advice, and direction to practitioners, escalating concerns where needed. We work closely with other parts of the health economy and multi-agency partners, attending a variety of subgroups. Our work is underpinned by statutory responsibility, evidenced based practice, reflection, peer review and supervision which assists our learning & supports consistency in decision making. Our team demonstrates resilience and is committed to supporting LCH and wider colleagues by adopting a positive approach that enables others.

The safeguarding childrens team offer responsiveness and organisational leadership on a range of current and emerging safeguarding issues, whether identified through LCH data collection, internal reviews, CQC reviews, Child Safeguarding Practice Reviews (CSPR), or case work.

This year as a team we have contributed to the Local Authority Ofsted Inspection pulling together and presenting information within a very short timeframe.
We hosted an internal multi-disciplinary "Supervision Event" to promote learning and support practitioners managing a distressing episode of care.
We continue to offer LCH staff training, briefings and 60-minute update sessions, covering current issues including "Trauma Informed Practice" and the use of "DASH" risk assessments.
We recruited an additional Safeguarding practitioner with a specific focus on working with the Front Door Safeguarding Hub (FDSH) . In doing this the team has led LCH services with the management of statutory strategy discussion requests. The response by LCH children's services has been exceptional at a time when capacity is extremely tight, and demand for discussions has been high. Strategy discussion requests have increased significantly over 2021/22 showing a 76.4 % comparative increase during March 2021 & March 2022, higher in other months during this timeframe.

Leeds Safeguarding Children Partnership

Alongside other members of the Health Economy, LCH is a strong and active partner of the Leeds Safeguarding Children Partnership (LSCP). Contributing to city wide multi-agency strategies, reviews, and developments in practice. LCH safeguarding childrens team ensure appropriate representation within the LSCP subgroups, presenting and obtaining information that informs how LCH services continue to support multi agency working. The team also represent the trust in other multi agency arenas ensuring they are mindful of all LCH services, and the impact city wide changes can have, before taking any changes forward.

Evidence from 2021/2022 that highlights some of the safeguarding childrens teamwork and how they demonstrate leadership, service development and support in practice is offered below.

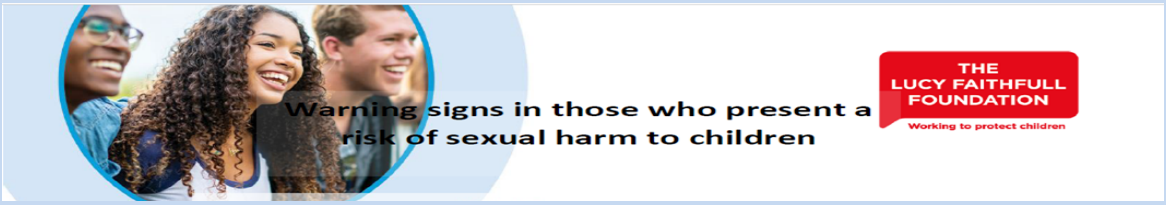
Key achievements: 2021-2022

- In May 2021 the Trust commissioned an **Assurance Review of Children Safeguarding,** the review concluded, LCH has Substantial Assurance (There is a robust system of internal controls operating effectively ensure that risks are managed, and process objectives achieved) in effect, "top marks" and an achievement team are very proud of and keen to continue.

to the

Safeguarding Week takes place simultaneously across all West Yorkshire. It's an opportunity to celebrate and share good practice & upskill knowledge on a variety of safeguarding issues. In June 2021 LCH safeguarding team & Children Looked After team offered LCH practitioners a week of time tabled briefing sessions. This included the team inviting the Gang culture and Senior A&E Navigator to speak. Assisting our practitioners understanding of how gang culture is changing in the city and how our practitioners can support preventative work being undertaken.

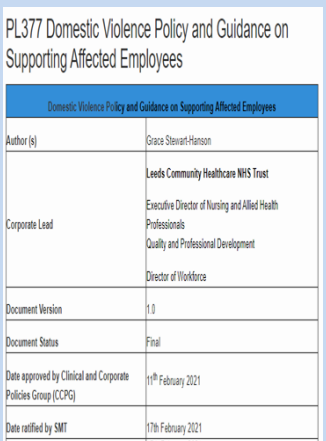
Throughout the week LCH Safeguarding team were active on social media and invited practitioners to share useful resources for staff to access, such as informative YouTube videos and links to materials available internally. They also directed practitioners to the LSCP and other external resources.



- In Aug 2021 LCH safeguarding team launched the Domestic Violence Policy and Guidance on Supporting Affected Employees.

The Policy development was a crucial piece of work for the trust, given that LCH is a large employer, and that Domestic Violence or Abuse is estimated to affect 1 in 4 women and 1 in 6 men in their lifetime.
Developing the Policy also helped the safeguarding team achieve the **Leeds Quality Mark for Domestic Violence** for LCH. We collected substantial evidence from LCH services to present to Safer Leeds (now Safer Stronger Communities) in our efforts to secure the credit and we were successful.

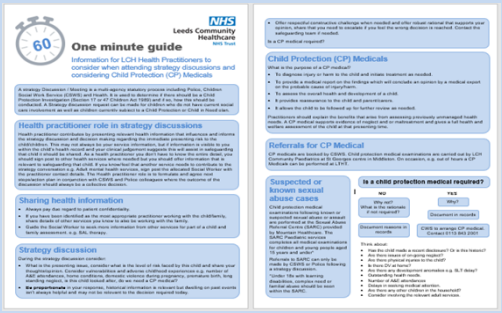
Alongside this work and to ensure a sustainable approach to keeping Domestic Violence and Abuse high on the LCH agenda, the Safeguarding team created a group of staff across the trust to be Champions. This was done with commitment from the Senior Management Team. The Champions have additional training and guidance to ensure LCH has a skilled staff group to support all employee's, disseminate current information and signpost where needed. The group is facilitated by a Specialist Safeguarding Nurse for Children.

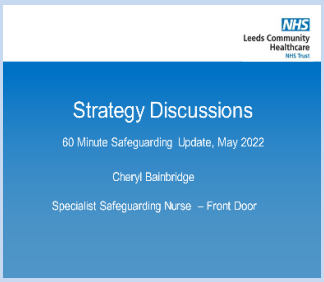


PL377 Domestic Violence Policy and Guidance on Supporting Affected Employees

Domestic Violence Policy and Guidance on Supporting Affected Employees	
Author (s)	Grace Stewart-Hanson
Corporate Lead	Leeds Community Healthcare NHS Trust Executive Director of Nursing and Allied Health Professionals Quality and Professional Development Director of Workforce
Document Version	1.0
Document Status	Final
Date approved by Clinical and Corporate Policies Group (CCPG)	11th February 2021
Date ratified by SMT	17th February 2021

- As mentioned, the Safeguarding team have expanded support to the Front Door Safeguarding Hub (FDSH) by:
  - Successfully recruiting a full-time Specialist Safeguarding Nurse for FDSH.
  - Working with CSWS and West Yorkshire Police to facilitate timely strategy discussions.
  - Collecting data to support the work LCH services undertake, recognising emerging themes & trends.
  - Sharing the data internally to support some service commissioning arrangements.
  - Facilitating briefing sessions to support and assist LCH practitioners who undertake strategy discussions.
  - Developing templates to aid practitioner documentation and the gathering of data.
  - Offering safeguarding supervision, ensuring good practice, & positive learning whilst valuing practitioner emotional health and wellbeing.
  - Contributing to a "Project Improvement Plan" taken forward by the CCG.





- The Children's Safeguarding team has also maintained ongoing support of the Sudden Unexpected Death in Childhood (SUDIC) process. Supporting families, identifying modifiable factors, and picking up emerging themes from these tragic events, taking work forward to ultimately raise public awareness.

- Capturing the "Voice of the Child" is essential, especially when safeguarding them. Working with other LCH services the safeguarding team have ensured that the "Voice of the Child" is established within the trust Record Keeping Audit tool. Going forward we will establish how this is evidenced by services and respond accordingly.

Key ambitions 2022-2023:

- Working with LCH services implement any Safeguarding Learning Lessons, identified internally and externally from Leeds Safeguarding Children Partnership. Explore utilising Datix as a tool for holding incident information and evidencing the lessons taken forward within the trust.
- Continue the support of the FDSH and LCH statutory strategy discussions. Ensure accurate data collection and sharing.
- Explore how current MARAC information is received and new arrangements are embedded.
- Work with LCH services and partners to establish a united Early Help registration process and explore a shared data set.
- Develop an LCH Routine Enquiry training package to deliver internally whilst also remaining part of the multi-agency arrangements for Routine Enquiry training.
- As the IICAS enquiry concludes consider how we support practitioners working with disclosures of historical Child Sexual Abuse.
- Explore alternative Level 3 childrens safeguarding training arrangements to accommodate the diverse practitioners joining the trust.
- Continue collaboration within LSCP subgroups offering an LCH perspective and utilising information gathered to support the work the Childrens team undertake.

The "day job" for the Childrens Safeguarding Team includes:

- Offering daily availability, via telephone of a specialist safeguarding nurse, for all LCH practitioners with safeguarding enquiries.
- Maintain awareness of current issues occurring in Leeds and using them to facilitate "60 minute" briefing/training sessions. This includes exploring issues such as Neglect, Harmful Sexual Behaviours, Child Exploitation, as well as recommendations from Learning Lessons Reviews and Safeguarding Practice Reviews.
- Training of the LCH Safeguarding Supervision model to ensure supervision that supports reflective practice and promotes staff resilience and wellbeing. Practitioners who become supervisors are asked for their experience of supervision annually via Survey Monkey to highlight good practice and offer opportunity for improvements.
- Data collection for attendance at Initial Child Protection Conferences (ICPC) and Review Child Protection Conferences (RCPC). This figure has remained consistently high over several years as is a credit to LCH services.
- Data collection regarding Strategy Discussions and using it to make improvements across the trust and across the city.
- Updates of the trust intranet page, advertising training, signposting to resources, and sharing good practice.
- Supporting LCH practitioners with statement writing and court appearances.

Safeguarding Children quality assurance processes:

- LCH safeguarding Children team attend a review process in relation to Record of Contacts (referrals) with the Front Door Safeguarding Hub (FDSH). A member of the safeguarding team attends a monthly audit meeting, feeding back where needed.
- We consider data regarding strategy discussions from the FDSH exploring anomalies and supporting practice.

- We attend and contribute to Sexual Health Safeguarding Multi-Disciplinary Team meetings, Community Paediatric & CAMHS Governance meetings and LTHT Emergency Department Safeguarding Review meeting.
- We offer group supervision sessions in line with the Child Protection Supervision Policy. Assisting practitioners with significant incident occurrences, and more regularly with some services across the trust for example at Weatherby Young Offenders Institute, Speech and Language Therapy, & Senior Management Teams.
- We are specialist reviewers for Datix and contribute to internal Review & Serious Incident Investigations.
- Working with services we develop our Annual Work Plan in line with the LCH Safeguarding Strategy, LCH Children's Strategy and LSCP strategies.
- We offer updates/share information and escalate concerns within LCH Safeguarding Committee.

The LCH safeguarding children team are a small service that accommodates the whole trust, we strive to support LCH front line practitioners who seek to do the best they can for the children and families they work with. Safeguarding is everybody's responsibility and LCH children's safeguarding team will continue to endorse this to the best of our ability during the following year.

Specialist Child Protection Medical Services (SCPMS) June 2022

Key achievements 2021-22:

- Submitted an expression of interest in being commissioned to provide the Sexual assault referral centre (SARC)- primarily paediatric but adult too.
- Continued to develop the working relationships with acute paediatricians in Leeds Teaching Hospitals Trust (LTHT)
- Now having commissioning conversations about change to the routine admission of Child Protection cases to the wards when no acute medical need - ongoing still
- Increasing engagement in strategy meetings and case conferences where child abuse or neglect is suspected – many by remote access eg skype.
- Continued to foster strong working relationships with colleagues at the paediatric Sexual Assault Referral Centre including handover of patients
- Strengthened relationships with sexual health and Genito-Urinary medicine doctors
- Involvement with the Risk and Vulnerability Subgroup of Leeds Safeguarding Children Partnership regarding child victims of Female Genital Mutilation (FGM). We also provide an FGM assessment to several other authorities.
- Attendance at Multi-agency Safeguarding Operational Group (MASOG) by Named doctor to look at operational processes for community paediatrics, police and social care
- Several team members train on ALSG Child Protection Recognition and Response course
- New named doctor is increasing networking between the Named and Designated doctors for other areas and across Leeds.
- Named dr joined a national named dr group set up during lockdown. This continues to run but less frequently- attended irregularly
- Named dr – continued to deliver training to a range of professionals – sw, education, police and health incl GPs, also front door team.
- New psychologist supervision for the SCMPS and SUDIC- this is going well and well engaged with.
- Royal College of Paediatrics and Child Health (RCPCH) key standards for CP medicals published and we meet all standards apart from one, suggestion to provide paperwork to sws at time of medicals to aid communication- we have actioned this and now provide paperwork to sws at end of CP medical..
- Despite significant staffing issues with less staff, covid infections in staff – we have managed to have cover for all CP clinics except one. This was covered for urgent cases by LGI, no cases needed to be seen that day.
- ESREP student study showed a reduction in referrals during Covid, change in mean age of children being referred, change in referrals – less by schools and more children with a history of domestic violence. This study accepted at RCPCH conference as a poster.

Key ambitions 2022-23:

- Continue to ensure the rota means that children are seen in a timely way and there is no delay. We are in discussion with senior managers about the staffing of the rota and the prospective

cover complication ie we have to swap to have annual leave. All other clinics are cancelled with leave. – this is still being explored, currently we are cancelling a clinic from another setting.
- Continue to work with the LTHT and deliver child Protection Medical Services (CPMS) from an appropriate venue and all children who are medically well do not get admitted and are seen for CP medicals by us.
- Continue to improve our interaction around strategy discussions and Child Protection.
- Develop and implement clinical pathways in partnership with MHL for children with Sexually Transmitted Infections including e.g. ano-genital warts
- Continue to engage in regional peer review and Named Doctor regional meetings
- Continue to learn from patient experiences – giving particular attention to the voice of the child by improving child friendly feedback collection processes, this is being explored but no decision as yet.
- Produce training that can be accessed remotely, some of the training I deliver has photos in and I need to obtain appropriate images to add to the presentation. – this has not been progressed due to issues with images.
- Maintain strong links with the LCH Children Looked After and Safeguarding team
- Submit a high quality bid for the SARC when more details are provided.

Who are we?	What are we proud of?
10 community paediatricians, 2 band 5 nurses, 1 play therapist, 2.8 admin staff and 1 clinical services manager Part of ICAN (Integrated Children with Additional Needs) services; commissioned by Leeds CCG	Providing a daily **senior doctor led** clinic to see children (0-18)referred for all forms of child abuse **Trained and skilled administrative staff** to take referrals from 09:00-17:00 on weekdays **Compassionate, highly skilled nursing staff** to chaperone and support families & medical staff in clinic Clinical work underpinned by **peer review and supervision** to challenge practice & offer support **Dedicated team**, who show great strength and resilience to rise to the many changes this year Continuing to provide **medical training** in child protection **information sharing** and working together to safeguard children **Monthly governance programme** for continuing professional development and links with the regional peer review programme.

What we did in 2021/22

- Saw 436 children (411 acute, 25 follow up) between April 2021-March 2022. This is a significant rise of 96 acute medical referrals. We continue to see cases that would have been seen by LGI, but were redirected to us on the new SOP.

- 64% physical abuse; 11% neglect; 4% anogenital examination for medical issues, no sexual abuse; 29% siblings of index children

- We aim to provide child protection medical reports to Social Care in 4 working days. Performance has dropped in the last year , 52.8% (previously 70%)reports sent within 4 days to social care; 75% (previously 93%) within 7 days. This is likely due to our significant increase in referrals and also the sudden death of one of the secretaries leading to a delay in typing etc.

- Clinical governance sessions have been well attended remotely and covered topics including – journal article reviews; review of RCPCH standards for CP medicals- and the audit of our extra tool for social workers; child to parent abuse; burns talk; notes audit etc.

Held 51 peer review or colposcopy meetings last year.

Sudden Unexpected Death in Infancy and Childhood (SUDIC)
(Abridged from the report produced for the Local Safeguarding Children Partnership)

Key achievements 2021-22:

- To maintenance of high standards of facilitating the SUDIC process in Leeds by despite to ongoing impact of the COVID-19 pandemic.
- Continual review of systems and processes to support practice
- SUDIC Strategic Reference Group partners delivery of a West Yorkshire wide SUDIC conference
- Development of a SUDIC briefing package for quarterly delivery via the LSCP training
- programme
- Sharing of SUDIC practice with teams across boundaries via the Child Death Peer
- Network
- Team members had access to regular psychological support to assist with maintenance of their mental wellbeing.

Key ambitions 2022-23:

- Maintain the high standards of service delivery achieved in previous years and continue to develop practice
- Stabilise the team following periods of long term absence and staff changes
- SUDIC service review
- Consider the extent to which service delivery changes required in response to the COVID-19 should be retained former practices reverted to
- Further strengthen partnership working within LCH and across the Child Death Review partnership

'The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths' **(Chapter 5, Working Together (WT), 2018)**

SUDIC Activity 2021-22

Between April 2021 to March 2022 there were 12 deaths of children normally resident in Leeds which met the SUDIC criteria. However one additional death occurred in the previous year (2020-2021) out of the country and was notified to the team in 2021-22. Some comparative data is set out in the tables below:

Table 1

	Under 1year	Under 5years	5-12 years	Teenage	Number
2019-20	5	3	3	1	12
2020-21	4 (+1)	5	1	2	13
2021-22	5	2	2	3	12
Total	15	10	6	6	37

Table 2

	Male	Female	Number
2019-20	5	7	12
2020-21	8	4 (+1)	12 (+1)
2021-22	8	4	12
Total	21	16	37

Thankfully, the number or sudden or unexplained deaths of children in Leeds remains a small subset of the child population; with children under 1year tending to be the most vulnerable and boys being more susceptible than girls. No single cause of death predominates, but safe sleeping and road traffic collisions are recurrent themes; this is borne out in the 2021-22 data.

The SUDIC process has been completed for 4 children who died during 2021-22. Post-mortem reports, Final Meetings or Child Death Overview Panel (CDOP) meetings remain outstanding for the other 9 children.

Where appropriate, home or scene of death visits were carried out by the team for all of the children who died during 2021-22. Ideally these occur within 24-48 hours of the child's death; this is not always achievable due to the work pattern of the SUDIC team (Monday – Friday, 08:30 – 17:00), the need to be guided by any police investigative parameters and the wishes of the child's parents.

All contacts were made in line with COVID-19 guidance. The response timeframe for the visits carried out is set out below:

SUDIC Visits to Family 2021-22				
24-48 hours	**48-72 hours**	**over 72 hours**	**No visit**	**Total**
7	2	3	1	**13**

Initial SUDIC Meetings

This meeting seeks to; understand the circumstances of and, if possible, the reasons for the child's death, consider the immediate needs of all family members, and to contribute to the process of identifying any lessons to be learned about how best to safeguard and promote children's welfare in the future.

Initial multi-agency meetings were held for all 12 of the Leeds childhood unexpected deaths occurring during 2021-22. This is consistent with performance over the preceding two years. The normal SUDIC meeting process was not deemed appropriate for the child death which occurred in the previous reporting year but notified to the team in 2021-22.

During 2021-22, 28 Day Reports to HM Coroner have been provided by the SUDIC Consultant for 12 of the deceased children, one SUDIC process was led by an out of area team.

SUDIC Final Case Discussion Meetings & Final Reports

Due to the ongoing pandemic all meetings were held online. Final meetings have been held for 5 of the 12 children who died during the 2021-22 period and reports have been provided to HM Coroner and the Child Death Overview Panel (CDOP).
The SUDIC Team are awaiting the Post Mortem Reports for 7 of the children who died during 2021-22. Final Case Discussion meetings will be convened once the PM Reports are available.

Governance

The SUDIC Team are members of the Leeds Safeguarding Children Partnership (LSCP) Child Death Overview Panel (CDOP) which is a statutory group.

The LCH SUDIC Team is responsible for providing the SUDIC reports for each child to the Leeds CDOP and ensuring that any relevant recommendations made by the panel are fed back to LCH Child Death Review Group.

LCH Child Death Review Group

The SUDIC Team are members of the LCH Child Death Review Group.
All SUDIC deaths are reported into the LCH Child Death Review Group along with the expected deaths of children under the care of LCH services.

The deaths are reviewed with the aim of ensuring that a critical appraisal of LCH input is carried out and where necessary, action is taken, and lessons learned. CDOP recommendations relevant to LCH services are communicated through this group.

Information from this group is reported to the LCH Mortality Review Group which provides assurance to the LCH Trust Board.

The SUDIC Strategic Reference Group (SSRG)

The SUDIC Strategic Reference Group is a sub-group of the Leeds Safeguarding Children Partnership (LSCP) and chaired by the Business Manager of the LSCP. The SUDIC Consultant and the Lead Professional have membership of the SSRG.

Group membership consists of partner agencies in the Joint Agency Response and provides an opportunity to reflect on and address issues raised in the SUDIC process. Actions are agreed and monitored in the meetings in relation to the following four broad headings:

1. **Process & Performance**

Throughout 2021-22 the SUDIC process has been impacted by the ongoing COVID-19 pandemic with meetings taking place online. A "health warning" has been added to the invitation e-mail to practitioners advising they consider their own mental wellbeing due to the emotive nature of the meetings and in response to practitioner feedback on the distress of attending a SUDIC meeting while at home.

Performance has been less effected as, with the use of appropriate Personal Protective Equipment (PPE), the team has been able to continue to deliver the rapid response element of the role in person.

2. **SUDIC Process Awareness Raising**

An online event on the "National and Regional Impact of Covid-19 on Child Deaths" was developed and delivered by the SUDIC Consultants; offering an opportunity for ongoing professional development within the team and across the SUDIC network.

A 'Light Bite Session' on Child Death Review Processes in Leeds has been developed for delivery via the Leeds LSCP training programme offering practitioners across the multi-agency partnership an opportunity to gain some basic understanding of the SUDIC process.

3. **Family Engagement**

A leaflet is given to grieving families which sets out brief details of the SUDIC process in accessible language, contact details for the team, information on how to give feedback and how we use and look after personal information.

Families are also given leaflets detailing a range of bereavement support groups including the Community Bereavement Service offered by Martin House.

Use of Personal Protective Equipment in response to the COVID-19 pandemic has minimised the impact on service delivery for grieving families.

4. **Review of Links with Partners**

The SUDIC Team has maintained links with the Child Death Peer Network, formed from teams across England. The virtual meetings give participants an opportunity to share practice, discuss common issues and creates the potential to influence local and national practice.

Partnership working and actions related to identified modifiable factors

One SUDIC case has been taken forward by the LSCP as a Child Safeguarding Practice Review (CSPR) resulting in a reflective discussion with the LCH staff concerned facilitated by the Safeguarding Team.

A second case will be considered for CSPR by the LSCP Review Advisory Group (RAG).

In response to further case LCH 0-19 PHINS have been asked to reinforce the already clear and strong message about safe sleeping with a reminder to parents to continue safe practice while away from home.

Conclusion

2022-23 will see the SUDIC team experience staff changes which offers the opportunity to reflect on the success of the past few years while planning to continually develop practice within the team and across the multi-agency Child Death Review partnership.

The SUDIC Team would be unable to carry out their work without the support of colleagues within LCH and across a wide variety of partner agencies; we are grateful for their professional and caring support of bereaved families as well as their co-operation with, and their contributions to this important work.

Children Looked After (CLA) and Care Leavers

Key Achievements 2021/22

- Dr Alison share, Designated Doctor, received a well-deserved award in the category of 'making stuff better' in this year's thank you event.
- RHNA delivery continues to meet KPI's and National performance targets, with audit indicating high standard of health assessments. This is in spite of every service delivering RHNA's being under tremendous capacity pressure.
- Maintaining the delivery of training to those supporting Looked After Children at level three standard, Intercollegiate Document 2020. Feedback from training is very good/excellent.
- All RHNA's completed within LCH include all recommendations from CQC with regards to quality of analysis.
- IHNA's for UASC's amended to ensure meeting NICE Guidance 2021
- UASC health needs training package developed and delivered to primary care
- UASC health needs information developed for primary care, social care, and carers.
- Development of West Yorkshire Health and Care Partnership CLA subgroup, chaired by Angela Dillon, Designated Nurse, with a remit to share good practice and reduce variance.
- Establishment of the North, Northeast and Yorkshire Regional Looked After Children's Subgroup. West Yorkshire ICS is represented by Angela Dillon Designated Nurse.
- The Designated Nurse has met with the Looked After Children's and Care Leaver Council to gain their input into a number of initiatives including reviewing the final health assessment to include the health leaving summary. This will increase the quality of information care leavers receive and reduce duplication of work for the nurses. The council have also contributed their thoughts to develop a WhatsApp follow up for when young people are finding it difficult to meet for health assessments, which the specialist nursing team hope to have in place this summer.
- Systems are now in place to share information within LCH to the relevant team when a looked after child of young person attend A&E.
- Leeds Children's Social Work Service now shares information with the Specialist Nurses Team when a looked after child or young person has been reported as missing.
- Reporting has been reviewed and streamlined to reduce admin duplicating information collected from read codes within templates of system one. A PIP report is being developed to support service improvement and development.
- A bid for service review/restructuring has been completed, examining how the Looked After Health Team can meet the Service Specification, National guidance and Statutory duties. It includes population data and projections, a service position statement, a benchmarking exercise of provider services for looked after children across West Yorkshire Health and Care Partnership. It looks at different models of service delivery and, risk and benefits of each and highlights areas that are of concern with current service delivery.

Key Ambitions 2022-23

- To have a successful service review and restructure so that Leeds looked after children and care leavers can expect a similar level of care and support offered in most of our neighbouring areas and to ensure we have the best possible services we can for this extremely vulnerable group.
- To continue to work with our social care colleagues to improve LCH's ability to provide the Initial Health Needs Assessment to inform the planning at the first childcare review, in line with statutory requirements.
- To work with PHIN's. SILC nurses and ICAN services to develop a shared understanding of the NICE baseline assessment and develop an action plan to deliver the recommendations outlined in the NICE Guidance for looked after children 2021,

- To continue to work with our young people in care and care leavers to give them a voice and influence in health service provision.
- To move foetal alcohol spectrum disorder service forward for Looked After Children.
- To ensure statutory training from level one to five, Intercollegiate Document 2020, is in place for all staff needing this.

Leeds Community Healthcare Children Looked After and Care Leavers

Introduction
This is the annual looked after children and care leavers report 2021-22 for Leeds Community Healthcare (LCH), covering the period form 1st June 2021 to 31st May 2022. It forms part of Leeds assurance arrangements in relation to services delivered to Leeds children placed in and out of Leeds and children placed in Leeds by other local authorities. It reflects the priorities set out in the Looked After Health Team Service Level Agreement, "A child of Leeds" Leeds Corporate Parenting Board Strategy 2021- 2024, and the Looked After Children and Care Leavers Health Improvement Plan. The primary objective is to ensure that all looked after children and Leeds care leavers are supported to improve their health outcomes.

Definition of Children Looked After:
A child is legally defined as looked after by a local authority if he or she:
- is accommodated by the local authority for a continuous period of more than 24 hours,
- is subject to a Care Order to put the child into the care of the local authority (including secure settings),
- is subject to a Placement Order (child placed for adoption)
- is an unaccompanied asylum seeker and under the age of 18.

Definition of a care leaver:
A care leaver is a young person aged 16-25 years old who has been 'looked after' at some point since they were 14 years old and were in care on or after their 16th birthday. Care leavers are entitled to some ongoing help and support from Children's Services after they leave care.

Health needs of Looked After Children and care leavers
Most children and young people come into care having experienced neglect and or abuse, usually from their primary care givers. Children who experience adverse childhood experiences, especially in the early part of their life, have significant risks of health inequalities with increased risk of suffering long term effects to both their emotional and their physical health, including higher risk of cancer, strokes and heart disease as adults. The Care Leaver's Association document "45 Care Leaver Friendly Ways" 2017 identified that care leavers were seven times more likely to die before the age of 25 than the general population, four times more likely to have a special educational need compared to the overall population, 50% will become pregnant or a parent within 2 years of leaving care and 40% will develop long term mental health conditions. The effect of health inequalities impacts throughout care leavers lives and is strongly linked to their ability to achieve and attain within education, their employment opportunities, earning potential and life chances. The importance of promoting and developing good physical health and mental resilience must have a high priority throughout their time in care and beyond to help mitigate these risks.

Leeds Looked After population:
The looked after children population who live in Leeds are a mix of those who are under the care of Leeds City Council and those who are under the care of other local authorities and placed in Leeds. A proportion of children and young people who are looked after by Leeds City Council are placed out of area in other authorities.

In May 2022, the number of children in care of Leeds Local Authority was 1362 and a further 259 were placed in Leeds by other authorities. Nationally and locally the numbers of children being taken into care has continued to increase.
Leeds looked after children's population demographics has changed significantly over the past 5 years and is predicted to continue to change over the coming years. 50 more children were placed out of area in the past year compared to previous years and a significant increase in the number of UASCs (unaccompanied asylum-seeking children) 80, have arrived in Leeds over the past 6 months. This is in on top of the 100 additional 15–18-year-olds coming into care and staying in care between 2017 and 2021. The demographics of children in Leeds coming into care continues to show an increase in teenagers, who have experienced

long term neglect and abuse and are extremely complex. All of these changes have impacted on the caseload complexity and numbers of the Specialist Nursing team.

All looked after children living in Leeds have the right to use universal health services regardless of the placing authority. NHS Leeds Clinical Commissioning Group (CCG) retains the statutory responsibility to ensure that all Leeds CLA, including those placed in other authorities, have their health needs met. A key role of the Designated Dr and Nurse for Looked After Children is to understand the health needs of the looked after and care leaver population, to ensure services are meeting these needs and to assure the services in line with National Guidance.

Looked After Children Health team

- 1 Designated Dr 2 sessions a week.
- 1 WTE Designated Nurse
- 1 WTE band 7 Professional Lead
- 3.9 WTE band 6 Specialist Nurses.

To meet the health needs of looked after children and care leavers the Looked After Children Health Team collaborate with LCH specialist and universal services; Public Health Integrated Nursing Service (PHIN's), Specialist Inclusive Learning Centre (SILC) nurses, Integrated Children Additional Needs (ICAN) services, sexual health teams, secure setting health teams and services across the health economies and partner agencies; Leeds Teaching Hospital Trust (LTHT), Therapeutic Social Work Team, Children's Social Work Service (CSWS) and Corporate Parenting Board.

Initial Health Needs Assessments (IHNAs) are completed by community paediatricians in the ICAN service.

Implementation and monitoring of health plans and completion of Review Health Needs Assessments (RHNAs) is the responsibility of three services: Specialist CLA Nursing Team, PHIN's and SILC nurses. Current provision for looked after children within LCH across all services is meeting statutory elements, health needs assessments and statutory safeguarding meetings. No other work is being completed due to capacity issues, which means that many areas of the Service Level Agreement and NICE guidance are not being implemented. A bid for service restructure, to enable health to meet National Guidance, Statutory targets and Service Specification has been completed and is awaiting consideration.

NB. LCH is commissioned to provide 2 sessions a week of Designated Dr time by the CCG. For some time only 1 session a week has been provided and it is proposed to reduce this further. This is concerning as the role cannot be performed in the time currently being provided.

Performance V KPI's and National objectives:

Table one IHNA performance

	Apr-21	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Number children	10	31	19	27	17	33	14	17	37	32	24	33
HNA completed in statutory timeframe	2	8	4	11	1	3	0	2	8	11	6	6
Percentage	**20.0 %**	**25.8 %**	**21.1 %**	**40.7 %**	**5.9%**	**9.1%**	**0.0%**	**11.8 %**	**21.6 %**	**34.4 %**	**25.0 %**	**18.2 %**
HNA completedwithin KPI	9	13	8	19	10	13	2	4	10	21	14	17
Percentage	**90.0 %**	**41.9 %**	**42.1 %**	**70.4 %**	**58.8 %**	**39.4 %**	**14.3 %**	**23.5 %**	**27.0 %**	**65.6 %**	**58.3 %**	**51.5 %**

LCH has not been able to deliver high proportions of IHNA's in statutory time frames for a number of years. This is primarily due to late requests for the assessments. There is the requirement that social care should request the health assessment by working day four of a child coming into care and that the assessment should be complete and returned to social care by day twenty. Less than half of the requests are received by LCH by day ten, which makes it extremely challenging to meet statutory guidance. As a result of this

LCH's KPI's are - those requests received by day ten should be completed by day twenty and those received after day ten should be completed twenty days after receipt of request. Over previous years LCH has averaged 85%-95% completion of IHNA within KPI timeframes, Table one shows that this has fallen significantly this year. A risk assessment was completed and IHNA's placed on LCH's risk register. There is a robust plan in place with increased clinic capacity to enable timely assessments.

The issue of Late notification for RHNA by social care has been escalated to Director level and Corporate Parenting Board within the Local Authority. A task and finish group has been established to examine barriers within Children's Social Work Services systems to timely request with a view of improving the process and meet statutory guidance.

Table two RHNA performance

Cohort	Measure	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
0-18	% achieved **KPI 90%**	**93.5%**	**94.0%**	**94.6%**	**93.0%**	**94.0%**	**93.7%**	**93.4 %**	**93.6 %**	**94.4%**	**93.4%**	**93.2%**	**91.3%**

The rate of completion of review health assessments within statutory time frames continues to meet National Guidance and KPI's however there is a downward trend from 93.5% in April 2021 to 91.3% in March 2022, rolling annual completion rates, and it is expected that the rate will fall further due to capacity issues impacting on the delivery of timely assessments. The audit of quality of health assessments continues to show a high standard. This is both for those completed in Leeds and those completed by other authorities.

Table three percentage compliance with key health indicators; Immunisations, Dental and emotional health and wellbeing (SDQ.)

Key indicators	April 2021	March 2022
Immunisations up to date Target 85%	81%	77.6%
Dental checks up to date	69%	87.8%
SDQ	53.5%	45%

- LCH has a target of 85% of looked after children's immunisations being in line with the national schedule. 81% met this target in April 2021, 77.6% in April 2022. The reduction could partly be as a result of catch up programmes due to covid of school immunisations, which are yet to be completed. These should be completed by July 2022. The significant increase in UASC's over the past 6 months will also have affected immunisation statistics. There is no current capacity for the Specialist Nurses to offer catch up immunisations.
- In April 2021, 69% of children in care in Leeds had an up-to-date dental check (one completed in the previous 12 months). In April 2022 this had increase to 87.8%, due in part to the opening up of services post covid and partly as a result of variable commissioning of dental service by NHS England for vulnerable groups, which started in Summer 2021.
- The Strength and Difficulty Questionnaire (SDQ) is an evidence-based tool used to assess children and young people's emotional and mental health. National guidance is that all looked after children and young people over the age of 4 have SDQ assessments, which should inform the health assessment. Nurses completing RHNAs are required to facilitate the completion of SDQ for all looked after children between the ages of 11 and 16. Social workers are responsible to ensure the carer SDQ is completed for 4- to 16-year-olds. In April 2021, 53.5% of RHNA's requiring the nurse facilitated SDQ score had this included in the assessment. In April 2022, this had reduced to 45%. Record reviews show that not all SDQ' scores are captured in the correct template for use of data reporting. Training for nurses has been revised to ensure that templates are completed correctly, so that data can be captured. However, there are a significant number of assessments where the SDQ is not being completed which needs to be addressed.

Quality Assurance.

- Monthly reports are produced showing performance against Key Performance Indicators.

- Health Needs Assessments (HNA's) completed out of area are audited for quality against national standards.
- HNA's completed by LCH practitioners are audited every month, with all services audited at least twice a year. This allows any issues around slip in standards to be addressed quickly. Individual practitioners are given feedback for exemplary HNA's and when the standard needs to be improved. If there is a broader issue within a service, training updates are offered, and the service is re audited in the coming months.
- An audit was completed to look at the implementation of health plan actions.
- An audit was completed to look at the record reviews and implementation of health plans for Leeds children placed in other authorities beyond 20 miles of Leeds.

Audit outcomes:
The audit which examined the implementation of health plans following IHNA indicated that one third of health actions were not monitored or implemented.

The Audit looking at children placed beyond 20 miles of Leeds showed that half had not had timely record reviews and late health assessments had not been followed up.

Health Improvement Plan update:
FASD
Audits estimate that 35-40% of looked after children and care leavers and up to 70% of adopted children will have experienced alcohol in utero. There is an increasing knowledge base of the impact this can have on individuals' development and ability. Many care leavers fall through a gap when they transition out of care. They have difficulties with executive functioning and struggle to care for themselves, yet do not meet the criteria for either social care or health transition to specialist services as they have an IQ over 60 and do not have a learning disability or Autism diagnosis. Social care record review suggests that many of these individuals would meet the criteria for FASD assessment (NICE QS204 2022).

The West Yorkshire FASD Diagnostic Pathway Group has not met since July 2021. A subgroup of Leeds practitioners from the Therapeutic Social work team, Adel Beck, One adoption West Yorkshire and representation from LCH (Angela Dillon and Anna Gregory) continued to meet with the remit to look at bidding for a pilot FASD service for looked after children and adopted children. There are plans to reconvene West Yorkshire Pathway Group in light of the recent NICE FASD publication.

UASC's
The plan to develop and deliver a training package for primary care looking at the health and safeguarding needs of UASC's has been completed. The training was well received by those who attended and will be offered again 2022-23. It has also been offered to LTHT and will be included in the Registrars and junior Dr training offer 2022-23. A guide has been developed for GP's to aid their understanding of UASC and young asylum seeker health needs.

Care Leavers
Care leavers are one of two safeguarding priorities for NHSE 2022/23. There are plans to develop a national flag for care leavers which will make mapping health needs easier and ensure health professionals have access to vital childhood information to inform their practice. Work is taking place at a regional level to examine early deaths of care leavers. Leeds social care have identified UASC's as a vulnerable group for early death, as four have completed suicide in the past 5 years. At the moment there is no process for formal review and learning from these deaths.

Care leaver health remains a priority in the health Improvement Plan with an objective to Work towards a specialist sexual health offer for care leavers, including specific perinatal and post-natal support and parenting support (across the whole pathway). Leeds Maternity Strategy has an agreed priority around improving care for young parents as part of the reducing health inequalities theme. Work on this has recommenced after a pause due to covid and the looked after children and care leavers will be represented by the Angela Dillon, Designated Nurse.
The care Leaver Hub at Archway, Roundhay road is due to open this summer. There has been a great deal of discussion about health's offer to this project, with no firm commitments given. The Looked After Health Team do not currently have any capacity to support this project.
Care leaver training sessions have been given to GP safeguarding practice leads in Leeds, focussing on the impact of trauma on their lives and safeguarding needs.

Safeguarding Annual Report Conclusion

2021-22 has been another busy and productive year for the safeguarding team with the additional challenges brought by the COVID 19 Pandemic.

key themes emerging from this report point to the priorities for the team being:

- The setting and maintaining of quality standards across all safeguarding
- Fast effective responses to emerging safeguarding themes
- Development of EPR templates to support best safeguarding practice (including the new routine enquiry template which is near completion.
- The essential development and maintenance of internal and multi-agency relationships and networks to ensure high quality service delivery with safeguarding of vulnerable children and adults remaining at the core of all we do.

2022-23 will see the Safeguarding Team:

- Continue to provide an excellent service across all areas of safeguarding
- Continued evaluation of training and support needs of LCH staff
- Continue to work with the Safeguarding Boards to review and develop Safeguarding in Leeds in line with the changing horizon across the coutry.
- Maintain excellent working relationships with partners
- A move towards virtual supervision sessions
- Ensure LCH practice in Children Looked After and Safeguarding is of a high standard and responsive to the needs of the people of Leeds.

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (50)

Title: Risk Management Policy and Procedure (review)

Category of paper: for approval
History: Clinical and Corporate Policy Group

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

Executive summary (Purpose and main points)

The Risk Management Policy and Procedure is reviewed on a 3-yearly basis. The Policy has been reviewed by the Risk and Safety Manager, consulting with managers within the Trust, and then presented to the Clinical and Corporate Policies Group for further review and comment. The revised policy is now presented to the Board for approval.

Amendments include:

Section	Detail of each change made
Policy	
Section 3	• Risk owner definition amended
Section 4	• Committee subgroups and risk owner responsibilities now added. • Risk review group has been altered to risk review groups within each business unit
Section 5	• Additional comments included into the security consequence descriptors
Section 6	• Minor changes made to job titles • Revision to monitoring arrangements (reference to KPMG removed)
Procedure	
Section 6	• Clarification of the risk management process for ensuring risks are reviewed by senior management prior to being added to the risk register
Appendix Two	• Additional paragraph added to section three of the risk appetite statement (statement has already been approved by the Board in March 2022).
Section 4	• Updated roles and responsibilities
Appendix 4	• Board Assurance Framework process added to this document

Recommendations

- Approve the revised Risk Management Policy and Procedure

Leeds Community Healthcare NHS Trust

Risk Management Policy and Procedure	
Author (s)	Cara McQuire, Risk and Safety Manager
Corporate Lead	**Leeds Community Healthcare NHS Trust** Thea Stein, Chief Executive
Document Version	5
Document Status	Draft
Date reviewed and agreed by Clinical and Corporate Policies Group (CCP)	June 10th 2022
Date approved by Trust Board	August 2022 – to confirm
Date issued	
Review date	
Policy Number	PL354

Changes made to this version:

Section	Detail of each change made
Policy	
Section 4.6	• Risk review group has been altered to risk review groups within each business unit
Section 5.2	• Additional comments included into the security consequence descriptors
Section 6	• Minor changes made to job titles • Revision to monitoring arrangements (reference to KPMG removed)
Procedure	
Section 6	• Clarification of the risk management process for ensuring risks are reviewed by senior management prior to being added to the risk register
Appendix Two	• Additional paragraph added to section three of the risk appetite statement (statement has already been approved by the Board in March 2022).
Section 4	• Updated roles and responsibilities
Appendix 4	• Board Assurance Framework process added to this document

Executive summary

This policy and appended procedure define the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation, ensuring that sound risk management principles are an integral part of its governance structure and processes.

It details the respective responsibilities for corporate and operational risk management throughout the Trust.

The appended risk management procedure provides guidance for assessing, scoring and recording risks and assists with the development of mitigating action plans.

The appended risk appetite statement provides clarification for identifying target scores, ensuring that risks are adequately controlled.

The appended Board Assurance Framework procedure informs the Board, committees, senior management team and company secretary of their roles in ensuring the strategic risks to the Trust's objectives are being managed effectively.

This policy applies to all employees, locum and agency staff and non-executive directors and, where appropriate, independent contractors.

Equality Analysis

Leeds Community Healthcare NHS Trust's vision is to provide the best possible care to every community. In support of the vision, with due regard to the Equality Act 2010 General Duty aims, Equality Analysis has been undertaken on this policy and any outcomes have been considered in the development of this policy.

Contents

1. Introduction

Leeds Community Healthcare NHS Trust's Board is committed to leading the organisation in delivering safe and effective services and achieving excellent results, thereby ensuring that the organisation makes the very best possible use of public funds.

Risk management is the recognition and effective management of all threats and opportunities that may have an impact on the Trust's reputation, its ability to deliver its statutory responsibilities and the achievement of its strategic goals.

The purpose of this policy and procedure is to establish risk management as an integral part of Leeds Community Healthcare NHS Trust's culture where there is effective management of risk and appropriate escalation through the Trust's governance structure.

In adopting and implementing this policy and procedure, the Trust will protect its patients, staff, contractors, visitors, business interests, reputation and partnership organisations.

This policy defines the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation ensuring that sound risk management principles are an integral part of its governance structure and processes. It also sets out the respective responsibilities for corporate and operational risk management throughout the Trust.

The appended risk management procedure supports staff to identify, assess, manage, and monitor the risks that threaten the organisation's ability to achieve its objectives. The aim of the risk management procedure is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the identified risk.

The appended risk appetite statement documents the amount of risk the Trust is willing to accept in the pursuit of its strategic goals.

2. Aims and Objectives

The risk management policy has been produced within the context of the Trust's vision, values and strategic goals.

In terms of risk management, the Trust Board is committed to:

- Adopting best practice in the identification, evaluation and effective control of risks to ensure that they are reduced to an acceptable level or eliminated as far as is reasonably practicable
- Maximising opportunities to achieve the Trust's objectives and deliver core service provision

The Trust however acknowledges that some risks will always exist and never be eliminated and accepts responsibility for risk when this occurs.

The overall strategic aim is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system in place.

The Trust takes a holistic approach to risk management, incorporating both clinical and non-clinical risks. The Trust has the following risk management objectives:

- To minimise the potential for harm to patients, staff and visitors
- To protect everything of value (standards of patient care, staff safety, reputation , assets, and funding)
- To have an integrated and consistent approach to risk management
- To maximise opportunity by adapting and responding to changing risk factors
- To be compliant with statutory and regulatory requirements

These objectives will be achieved by:

- Embedding the risk management framework across all levels of the organisation, which will provide assurances to the Board that appropriate processes are in place to manage corporate and operational risks effectively (see appendix 1)

- Facilitating and promoting an open and just culture in which staff are held to account, are supported, understand their role and responsibilities, feel able to identify risks and communicate them effectively, report adverse events and learn from experiences.

- Maintaining a comprehensive register of risks.

- Ensuring the application of a consistent approach to the risk management process, which allows risks to be ranked and graded by severity in order that they are prioritised effectively.

- Enabling staff to take action to minimise risk and maximise opportunities as far as possible, systematically addressing any gaps in control and reducing the impact and/or likelihood of risks to individuals and to the organisation, in line with the Trust's risk appetite (see appendix 2).

- Ensuring risks are managed to agreed, acceptable levels and these levels are sustained by effective monitoring and review processes.

- Ensuring compliance with current and future risk management related standards and legislation.

3. Definitions

Risk	The chance that something will happen that will have an impact on the achievement of the Trust's objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).
Risk management	The systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk. Within the Trust, risk management encompasses all clinical and non-clinical risks.
Risk assessment	The process used to evaluate the risk and to determine whether precautions are adequate or more should be done.
Risk appetite	The amount and type of risk that an organisation is willing to pursue or retain. The Trust's risk appetite statement is appended to this policy.
Risk tolerance	The Trust's readiness to bear the risk after risk mitigation in order to achieve its objectives. Tolerance relates to specific or individual risks, rather than the more general approach represented by risk appetite.
Risk tolerance threshold	The threshold levels of risk exposure that, with appropriate approvals, can be exceeded, but which will trigger some form of further response i.e. escalation and monitoring. The Trust's risk tolerance threshold applied to all risks is '8'. Any risk which has a current risk score of 8 or more will be reported to the appropriate Board subcommittee. Risks currently scoring 15 or more will also be scrutinised by the senior management team (SMT) and the Board.
Board Assurance Framework (BAF)	The BAF provides the Board with a register of significant risks that have the potential to impact on the achievement of the Trust's strategic objectives and gives assurances that the risks are being managed effectively.

4. Responsibilities

All staff employed by Leeds Community Healthcare NHS Trust must work in concordance with the Leeds Safeguarding Multi-agency Policies and Procedures and local guidelines in relation to any safeguarding concerns they have for service users and the public with whom they are in contact.

The Trust has a system and processes (governance framework) within which risk is addressed and managed. This system ensures that controls are in place so that the organisation can achieve its policies, aims and objectives and safeguard public funds and assets. Board subcommittees provide assurance to the Board that risk is being managed.

4.1 The Trust Board

The Trust Board of Directors is responsible for the organisation's overall governance.

The Trust Board will:

- Review and maintain an effective system of internal control, including systems and resources for managing all types of risk.
- Gain assurance about the implementation of this policy from a number of sources; e.g. the Trust risk register and assurance reports; individual Board members intelligence from front line and service contact; external regulatory reports; internal governance policies, systems, processes and Board subcommittee minutes.
- Determine and monitor strategic risks on the board assurance framework
- Approve the risk management policy through which it ensures that the control of risks is approached in a strategic and organised manner.
- Approve the risk appetite statement, which is reviewed annually by the responsible directors

4.2 Audit Committee

The Audit Committee provides an overarching governance role and reviews the work of other Board subcommittees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work.

The Audit Committee will:

- Ensure that a robust risk management process is in place and test this through internal audit reports.

- Receive and recommend the annual governance statement, which includes assurances about the Trust's risk and control framework, to the Board for approval.
- Monitor the effectiveness of the Board Assurance Framework process,
- Act with delegated responsibility from the Board,

4.3 Quality Committee

The Quality Committee has delegated responsibility for assurance of clinical risk.

The Quality Committee will:

- Oversee the detailed analysis and performance management and correlation of clinical risks, clinical impact of non-clinical risks, complaints, incidents and clinical audit to provide evidence of effective clinical risk management to the Board.
- Scrutinise clinical risks that have a current risk score of eight or more as reported by the Risk Manager to the Quality Committee every other meeting and where relevant, propose further risk reduction treatment.
- Provide the Board with assurance against the strategic risks assigned to the Committee

4.4 Business Committee

The Business Committee has delegated responsibility for assurance of non-clinical risks, largely related to corporate services including workforce, information and financial functions.

The Business Committee will:

- Scrutinise non-clinical risks that have a current risk score of eight as reported by the Risk Manager to the Business Committee at each meeting and where relevant, propose further risk reduction treatment.
- Provide the Board with assurance against the strategic risks assigned to the Committee

4.5 Committee Subgroups

The Committee Subgroups have delegated responsibility for identifying, reviewing and escalating risk to the relevant subcommittee.

4.6 Senior Management Team

The Senior Management Team (SMT) has delegated responsibility to oversee and review the contents of the Trust risk register

The Senior Management Team will:

- Review the contents of the Trust risk register on a monthly basis, facilitating critical challenge of the content
- Promote a proactive risk management culture
- Provide assurance of risk management to the Trust Board.
- Agree and approve the appropriate closure of risks on the risk register if, following all possible mitigation, the residual risk remains at (current risk score) above the Trust risk appetite score (see Trust Risk Appetite, Appendix 2).

4.7 Chief Executive

The Chief Executive has overall accountability and responsibility for risk management supporting the achievement of the organisation's policies, aims and objectives. The Chief Executive is a member of the Board, Quality Committee, Business Committee and SMT.

The Chief Executive will

- Ensure that the Trust's principal objectives are agreed
- Ensure that there are sound systems of internal control based on an ongoing management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically
- Ensure plans are in place to review the effectiveness of the system of internal control
- Prepare and sign the annual governance statement on behalf of the Board, after reviewing the effectiveness of the system of internal control.

4.8 Directors

On behalf of the Chief Executive, directors are collectively and corporately responsible and accountable for the management of all risks in the organisation whether in their own area or risks across the organisation.

Directors will:

- Ensure the risk management policy and procedure is consistently applied within their respective area of responsibility.
- Define the Trust's current risk appetite and articulate it in the form of a dynamic risk appetite statement.
- Review the risk appetite statement at least annually.
- Review high/extreme level risks (scored at 8 or above) assigned to them, on a monthly basis prior to Business and Quality Committees and SMT.
- Assign themselves direct ownership of extreme risks if they feel this is appropriate.
- Approve the closure of risks on the risk register that are within their field of responsibility.
- Nominate a senior manager to be responsible for maintaining an overview, including monitoring and coordinating the management and quality of the risk registers within their directorate.
- Ensures that there is a robust process for populating the risk register with identified risks in all directorates and departments and a process for monitoring the progress and treatments of those risks.
- Maintain a review of the controls for BAF risks assigned to them

4.9 Non-Executive Directors

Non-Executive Directors provide independent scrutiny and judgement in relation to the working of the Trust's risk management processes.

4.10 Company Secretary

The Company Secretary will:

- Ensure that the Trust operates in accordance with statutory regulations and that there is appropriate stewardship and corporate governance of the business of the Trust.
- Facilitate the smooth operation of the Trust's formal decision and reporting processes, ensures that the Board and its committees are properly constituted with clear enforceable terms of reference and that they are observed and reviewed at least annually.
- Ensure that there are effective information flows across the Board and its committees, including the reporting and monitoring of risk.
- Hold responsibility for the risk management processes.
- Be responsible for the development of the board assurance framework (BAF) ensuring that the work programmes of the Board and its subcommittees are aligned to the risks identified within the BAF and support the assurance requirements.

4.11 Risk and Safety Manager

The Risk and Safety Manager will:

- Work with the SMT to co-ordinate and implement this policy.
- Ensure the safe storage and update of the risk register, the day-to-day collation of data, analysis of risks and provision of reports to the Board and committees.
- Support services through the provision of expert advice and guidance in implementing the risk management procedure.

4.12 Senior Managers / Service Leads

Senior Managers and Service Leads within the Trust are responsible and accountable for

- The day-to-day effective management of risks of all types within their areas of responsibility.
- The ongoing maintenance and review of the service's risks and should ensure that they and their staff are working in accordance with the risk management procedure detailed in appendix 1.

Senior Managers must ensure that:

- Risks are identified, proactively and reactively
- Risk assessments are undertaken
- Appropriate documentation of the risk assessment is produced in accordance with the risk management procedure
- Risk assessments and action plans are agreed and verified
- Risks are entered onto the risk register at the appropriate level and a target risk score is set, in line with the Trusts risk appetite statement
- New risks and updated information about risks are introduced and discussed at relevant forums and performance meetings
- The risk register and associated action plans are actively reviewed on a monthly basis to ensure maintenance of an up-to-date risk register
- All reasonably practicable measures have been taken to reduce the risk, recognising resource and financial restrictions, in line with the Trust's risk appetite
- If it is considered that the risks are 'extreme' (have a current risk score of 15 or above), the risk assessments must be discussed with the relevant director
- There are mechanisms in place to keep local staff and managers informed of risks in their area and this will usually be through their team briefings, email, meetings
- There is a culture of learning from risk management

4.13 Business Unit Risk Review

Each business unit will ensure there is a forum established to:

- Review new risks (those above the risk appetite statement) that have been added to the risk register.
- Review escalated and deescalated risks and risks that have recently been closed.
- Acts as a moderator for risk grading, ensuring appropriate ownership of the risk and ensuring that effective management of the risk is being recorded.
- Maintain an oversight of the practical application of the risk management procedure.
- Discussions about risk must be captured in the meeting minutes
-

4.14 Risk Owner

The risk owner (as identified on the risk register entry) must ensure that

- Their allocated risks on the risk register (regardless of score) and associated action plans are actively reviewed on a monthly basis to ensure maintenance of an up-to-date risk register
- All reasonably practicable measures have been taken to reduce the risk, recognising resource and financial restrictions, in line with the Trust's risk appetite
- There is appropriate liaison with risk specialists (i.e. risk manager, fire safety adviser, health and safety officer, fraud specialist etc.) for the management of the risks in services

4.15 All Staff

Managing risk is the responsibility of every employee within the Trust. Action must be taken as soon as possible at the lowest possible level to eliminate, transfer or reduce the risk.

All employees are responsible for their own working practices and are required to assist with the risk management procedure.

All staff will:

- Report incidents and near misses using the organisation's incident reporting system (Datix©), learn from safety alerts and incident reports
- Fulfil their duty under legislation to take reasonable care for their own safety and the safety of others by complying with policies, training requirements and safety procedures
- Ensure they report all concerns and risks about safety, security, the quality of care and risks linked to the use of the Trust's assets and resources, to their line managers.
- Communicate risk assessments in which risks have been assessed as being all high or extreme (scoring 8 or above = amber or red) to an appropriate manager for review
- Maintain competence in the use and maintenance of equipment
- Be familiar with all applicable Trust policies and procedures and working in accordance with these requirements
- Be familiar with emergency procedures e.g. evacuation and fire procedures
- Escalate their concerns if they feel they have not been acted upon.

5. Training

The Trust Implements a structured programme of training based on a training needs analysis.

The Company Secretary will ensure that the Board are aware of their risk management responsibilities and that training is provided as appropriate. New Board members, all directors, senior and middle managers will also attend risk management training. All new employees will receive risk management awareness training at induction.

Bespoke risk management training will be available to all teams and services tailored to their specific needs. This could include advice and guidance on the management of risk in their area, risk recording and peer reviews.

All training is recorded and monitored through the workforce development department, which reports non-attendance to line managers and ensures alternative risk management training is offered to staff.

The Statutory and Mandatory Training Policy including training needs analysis provides greater detail.

6. Monitoring Compliance and Effectiveness

Minimum requirement to be monitored / audited	Process for monitoring / audit	Lead for the monitoring / audit process	Frequency of monitoring / auditing	Lead for reviewing results	Lead for developing / reviewing action plan	Lead for monitoring action plan
Risk Management training attendance	Annual report and accounts provided to the Audit Committee. Report to include bespoke, individual and leaders training	Risk and Safety Manager	12 Monthly	Audit Committee Chair	Risk and Safety Manager	Risk and Safety Manager
Subcommittees review BAF risks	Report to Board Subcommittees	Company Secretary	6 Monthly	Company Secretary	Company Secretary	Company Secretary
Risk Management system and organisational performance	Audit Committee to review audit findings on risk management system	Audit Committee Chair	As per audit plan	Audit Committee Chair	Risk and Safety Manager	Risk and Safety Manager

7. Approval and Ratification Process

The policy has been approved by the appropriate body and ratified by SMT on behalf of the Board.

8. Dissemination and implementation

The Clinical Audit & Effectiveness Team will support the dissemination of this policy by ensuring it is sent to the Quality Leads via email, uploaded to the LCH Intranet and shared via the Trust's weekly newsletter or the Trust's approved briefing.

Implementation will require:

- Operational Directors/ Heads of Service/General Managers to ensure staff have access to this policy and understand their responsibilities for implementing it into practice.

- The Quality and Professional Development and Workforce Department will provide appropriate support and advice to staff on the implementation of this policy.

The Risk Management policy and procedure is included in the induction sessions.

There is also a training session available for managers to understand their roles and responsibilities regarding this policy and procedure.

9. Review arrangements

This policy will be reviewed in three years following ratification by the author or sooner if there is a local or national requirement.

10. Associated documents

- PL276 Counter Fraud and Anti-Bribery Policy
- PL268 Incident and Serious Incident Policy
- PL282 Health, Safety and Welfare Policy
- PL333 Security Policy and Strategy
- PL381 The Prevention and Control of Violence, Aggression and Lone Working
- PL304 Fire Safety Policy
- PL340 Management of Slips, Trips and Falls
- PL322 Management of Body Fluid Exposure Incidents Policy

- PL297 Driving at Work Policy
- PL247 Safer Moving and Handling Policy
- PL305 Infection Prevention Control Overarching Policy
- PL300 Display Screen Equipment (DSE) Policy
- PL298 Control of Substances Hazardous to Health (COSHH) Policy
- RSP004 Risk Assessment Procedure

11. References

- Good Governance Institute (2012) Risk Appetite for NHS Organisations: A Matrix to support better risk sensitivity in decision taking

Appendix 1 – Risk Management Procedure

Leeds Community Healthcare NHS Trust

RISK MANAGEMENT PROCEDURE

1. Purpose

The purpose of this process guide is to provide clear instructions on the identification of risks and the process and management of those risks. This will enable the Trust to actively monitor, manage, and prioritise all risk. It will ensure that:

- There is a consistent approach to the management of all risks: clinical, financial, reputational, staff safety and wellbeing, environmental and organisational, and to the actions necessary to control and reduce each risk
- There is a robust mechanism for the prioritisation and escalation of all risks
- Staff are aware of their roles and responsibilities within the risk assessment process
- The Trust's Board is fully aware of the risks that face the organisation, the services it provides, to organisational sustainability, and that may affect its key stakeholders e.g. patients, families, and commissioners

2. Risk Management Process

The risk process seeks to answer four simple, related questions:

- What can go wrong?
- How bad could it be?
- How likely/ how often could it happen?
- Is there a need for action?

The risk process is the same, whether carrying out a risk assessment or including risks on a risk register. It is important that risk assessments are carried out systematically and all foreseeable risks are considered. Please refer to page 29 for the template to be used when completing a risk assessment.

There are five stages to the risk management process, demonstrated in the diagram overleaf and described in more detail in sections 2.1-2.5.

2.1 Identify Risks

The Trust has systems in place that contribute to the identification of risk from a number of sources; the following are examples:

- Risk assessments
- Review of performance and working practice
- Clinical practice
- Legislation, national policy and guidance
- Incident reports
- Complaints
- Claims
- Audit and workplace surveys
- Patient satisfaction surveys
- External/internal audits
- Regulators' inspections and reports

Any of the above can inform the risk assessment process and therefore the population of the Trust's risk register. Ideally, risk identification should happen in a proactive way, for example: changes or introduction of new processes, new equipment, different ways of working etc. may initiate a risk assessment. In addition, individual staff may identify risks whilst carrying out their duties or risks may be identified through discussions in team meetings etc.

The first stage 'Identify' includes identifying the hazards; identifying who could be harmed by those hazards and in what way; identifying if and how the risks are managed at present. These are control measures – things that are already in place to remove the hazard, reduce the likelihood of the risk occurring or reduce the impact of the risk should it occur).

When identifying a risk, consideration should be given to what poses a potential threat (or opportunity) to the achievement of objectives within the context of the organisation. The organisation's objectives should be kept in mind whilst identifying risks as it helps to stay focussed on the risks that are relevant to the organisation.

Each activity should be looked at as critically as possible, observing how it is carried out, and checking existing guidelines and information.

When identifying risk it is important to note that risks and issues often get confused with each other:

- *Risks are things that **might happen** and if they did, would affect the organisation's ability to achieve its objectives and / or the success of the organisation.*

- *Issues are things that **have happened,** were not planned and require management action.*

Once identified, risks need to be clearly described to ensure there is common understanding by all stakeholders (see section 3.1 'Effectively describing risks').

2.2 Risk Assess and Score

Each risk should be assessed (measured) in terms of consequence (how bad could it be) and likelihood (how likely is it to happen). To maintain an objective and consistent approach across the organisation, the Trust's risk assessment matrix must be used to 'score' each risk – see page 31 for the Trust's risk assessment matrix and guidance on how to use it effectively.

The purpose of consistently assessing (scoring) risks is to ensure that each risk is afforded the priority, scrutiny and risk treatment (action) it deserves.

When assessing how likely it is that a risk will occur, consideration must be given to:

- The current working environment
- The adequacy and effectiveness of the controls already in place
- Historical information that can be relied upon to give an indication of the likelihood of occurrence e.g. incident reports, audits etc.

When assessing what the consequence/impact of the risk could be, consideration must be given to:

- What the impact of the risk would be in most circumstances within the Trust's environment
- What is reasonably foreseeable

2.3 Plan Action

Controls already in place have been recorded at the 'Identify' stage. Consideration should now be given to whether each control is robust and adequate. If for example, there is a local procedure in place, which is not documented, not clearly understood or not followed, then this control would be considered inadequate (described on Datix as limited or poor). In addition to any other actions required to reduce or remove the risk, an action should be to make this control more robust if possible.

As well as considering what is already in place, consideration should be given to other actions which might be required that will minimise the likelihood and/or impact of a threat or maximise the likelihood of opportunities. For each risk, an action plan is required.

Planned actions should be 'SMART':

S	Specific	Specify exactly what needs to be achieved (tasks); this should be clearly communicated
M	Measurable	There should be a defined outcome and this needs to be able to be measured – so that there is assurance that it works.? This will help indicate when the task has been accomplished
A	Achievable	Is the task achievable? What are the resources and actions required to achieve the task? Stretch goals can be set but should be attainable.
R	Realistic	The action must be possible taking account of time, ability and resources.
T	Time Restricted	How long will the task take? An achievable timescale should be set with defined milestones to check progress.

Action plans should identify the action required, the person who will be responsible for ensuring the action is implemented, and the timescales involved.

A list of proposed actions should be added to the risk assessment/ risk register (Datix) but for complex risks where there are numerous actions, it is recommended that a separate action plan is created so that each action can be effectively carried out.

Some risk actions may require a business case as a cost benefit analysis will aid justification.

2.4 Implement

At this stage, the risk should be sufficiently documented; however, the implementation step is crucial to avoid the risk from materialising, or at least reduce the impact should it occur. This step is about 'doing the doing'. Actions that have

been identified and planned should be implemented with a view to reducing or removing the risk. To this purpose, actions must be assigned by the risk owner to people who can carry them out effectively although the risk owner will remain accountable.

Risk assessments and action plans must be shared with those who could potentially be affected by the hazard in order that they can be aware of the risk, know about the controls in place and be assured that action is being taken to control the risk. Risk should be a standing agenda item at team meetings.

2.5 Measure, Control and Monitor

Risk assessments must be reviewed on a regular basis, e.g. if the staff, the activity, or the equipment used or other circumstances have changed. It is recommended that all risk assessments are reviewed at least annually to ensure they are relevant and that the controls remain effective. Risk should be a standing agenda item at team meetings.

3. Trust risk register

The risk register is a record of all the risks that may affect the Trust's ability to achieve its strategic, project or operational objectives. The electronic risk management system used by this Trust to record and monitor risks is 'Datix'. The risk register contains in summary: a description of the risk, the risk owner, any controls in currently in place, actions to be completed, and the initial, current and target risk scores. Risk register extracts from Datix are frequently drawn to allow for scrutiny of risk by appropriate managers, committees and the Board. A flowchart demonstrating the process for managing individual risks on Datix is found in section 6, page 38.

3.1 Effectively describing risks

The risk description must clearly and concisely articulate the hazard, the risk and the effect the risk would have, should it happen. There should be appropriate use of language, suitable for the public domain with acronyms spelt out in the first instance.

When describing a risk, there are three parts:

Part 1	**As a result of …**	Describe the hazard / the cause – something that is known
Part 2	**There is a risk that …**	Describe the uncertain event might happen if it's not managed
Part 3	**Which would lead to …**	Describe the effect / impact

3.2 Risk types

In formulating the risk register, consideration must be given to all types of risks, e.g.

- Clinical
- Financial
- Reputational
- Staff safety and wellbeing
- Security
- Organisational
- Working environment
- Information governance

3.3 Risk scores

There are three scores to consider when completing the risk register:

Initial risk score	• The risk rating score without any controls in place. This score should remain the same throughout the lifetime of the risk and is used as a benchmark to measure the effectiveness of controls.
Current (residual) risk score	• The risk rating score with existing controls in place. As part of the ongoing review process, the score may change until it reaches an acceptable level. • The current risk score identifies the level at which the risk will be managed and scrutinised. • The current risk score will determine whether the risk threshold level has been met, as this will trigger the escalation procedure described in the Risk Management Policy (section 3 definitions: Risk tolerance threshold).
Target risk score	• The expected risk rating score after all action and mitigation is complete. • When setting the target score, risk owners should refer to the Trust risk appetite statement (see appendix two) to determine an acceptable risk level. Having said that, all risks must ideally be mitigated to their lowest possible level, which could be below the risk appetite level.

3.4 Risk ownership

The most appropriate risk owner for a risk is determined by the manager of the affected service (where the risk may have its impact) and is the manager who has the ability to affect the risk outcome i.e. take or delegate actions.

The risk owner will retain the management of individual risks, irrespective of the risk score. Within each risk, actions can be assigned to other staff. Directors may assign themselves the ownership of extreme/high risks if they feel this is appropriate and then delegate actions to appropriate staff.

Risk owners have the responsibility of reviewing and updating individual risks that have been assigned to them. Once a risk has been mitigated as far as possible, risk owners should close the risk in a timely manner. See section 3.7 'Closing risks'.

3.5 Managing and escalating risks (thresholds)

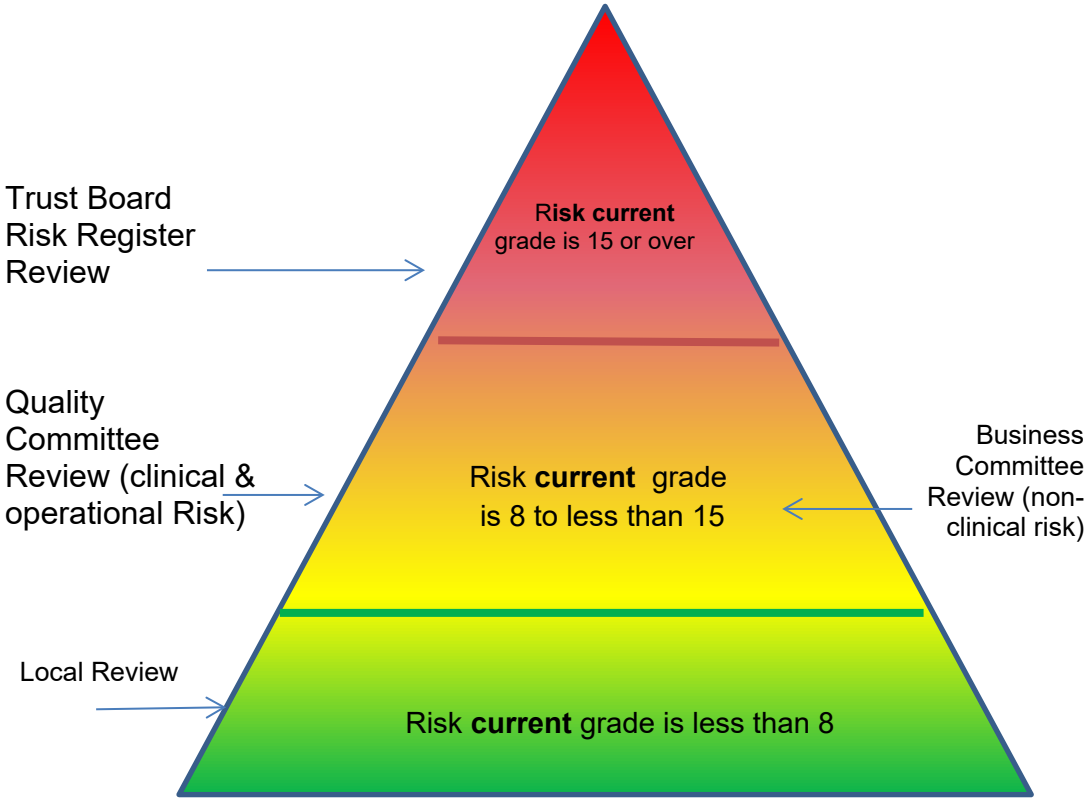
Extreme risks (risk score 15-25)	• Risks with a current score of 15-25 are categorised as 'extreme' risks. • An appropriate risk owner is a director or a senior manager reporting directly to the responsible director. • Extreme risks will be scrutinised at the monthly SMT meetings and potentially moderated.
High level risks (risk score 8-12)	• Risks currently scoring 8-12 will be reviewed by the risk owner as appropriate but at least quarterly. • These risks are monitored at monthly performance meetings. • An appropriate risk owner for high level risks is a senior manager e.g. general managers, clinical leads, heads of service etc). • These risks (currently scoring 8 or above) will be provided to the Quality Committee (clinical and operational risks) or Business Committee (operational, project and strategical risks) for consideration and potential moderation
Low/medium level risks (risk score 1-6)	• Any risks currently scoring 1-6 will be reviewed by the risk owner as appropriate but at least twice per year. • An appropriate risk owner for low level risks is a service manager

If SMT is assured that the residual risk cannot be reduced, it will then have the responsibility of authorising further action to reduce the risk and agreeing acceptance onto the Trust risk register of the risk on behalf of the Trust Board.

Any identifiable themes arising from the risk register (including lower scoring risks) may be aggregated and escalated to the Trust risk register by SMT.

In exceptional cases, any director can inform the Company Secretary of a potential risk from any source, for consideration and inclusion on to the Trust risk register.

The risk threshold levels are demonstrated in the diagram below.



3.6 Monitoring the risk register

Realistic review dates should be set by the risk owner, which should be adhered to. Risk owners should systematically review their risks and take responsibility for updating risks; however, reminders will be sent to risk owners when high and extreme level risks (scored at 8 or above) review dates have lapsed. The implementation of the action plan and the level of the risk must also be kept under review. Where implementation of an action plan has not produced the anticipated results, the risk should be reassessed and a revised action plan agreed as necessary.

3.7 Closing Risks

Once all possible actions have been completed or the hazard has passed, the risk should be closed, Datix should be updated with a risk closure date, the status should be changed to ‘closed’, and a final update should be provided.

Some risks will be routinely closed at year-end and a new risk raised from the 1st of April, e.g. the risk to achieving the financial control total in any specific year.

It is not always possible to identify and then fully implement actions that eliminate or minimise a risk. Where this is the case, it is essential that the significance of the risk that remains is understood and the Trust confirms that it is prepared to accept that level of residual risk. Following the completion of all actions, if a risk cannot be reduced to a risk score in line with, or less than the current risk appetite, the risk will require SMT approval for acceptance and closure. The director who has been assigned oversight of the risk should bring it to the attention of SMT in the monthly meeting and seek acceptance for the risk to be closed.

3.8 Data quality

For quality assurance purposes, all risk registers and supporting documentation are subject to inspection and review, without notice, by the Risk Manager or internal audit. All changes to risk registers must be recorded onto the Datix system. Datix has in integral audit trail function therefore any changes made to the risk register are recorded.

4. Risk Assessment Template

Risk Assessment Title		Team	Date Completed	Review Date
Venue (if applicable)	**Directorate / Portfolio**	**Issue**		
Reviewer Name	**Reviewer Job Title**	**Manager of Service:**		

Hazard What problem exists?	**Risk Description:** What could go wrong and how bad could it be? Refer to Trust Risk Assessment Matrix	**Initial Risk Score** Likelihood X Consequence =risk score	**Existing Controls** Measures already in place to mitigate / reduce the risk	**Current Risk Score** Likelihood X Consequence = risk score WITH existing controls	**Actions** What needs doing to, what extra controls need to be put into place?	**Action by** Who is responsible for the actions?	**Due Date** When should the actions be completed by?

5. Trust Risk Assessment Matrix

Risks are first assessed on likelihood (probability of the risk happening) and secondly on consequence (what would happen should the risk occur).

The assessment is completed by scoring the likelihood and the consequence. Tables 1 and 2 set out the scoring, which is based on a scale of 1-5. Table 3 is the matrix to which these scores are then applied. This gives the scoring a Red/Amber/Yellow/Green status which indicates the size of the risk.

5.1 Table 1: Likelihood score – time-framed and probability descriptors

When deciding the likelihood score, always remember to consider the risk controls that are already in place.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	<0.1 per cent	0.1 – 1 percent	1 -10 percent	10 – 50 percent	> 50 percent

5.2 Table 2: Consequence Score

Choose the most appropriate descriptor for the identified risk from the left hand side of the table then work along the columns in the same row to determine the consequence score (1-5), which is the number given at the top of the column.

When deciding the consequence score, always remember to consider the risk controls that are already in place. Where more than one descriptor is applicable, the highest score should be used. Please note – this is for guidance only and a holistic picture is required

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Injuries / harm - Patient **(Physical / Psychological)**	**>Impact prevented –** any patient safety incident that had the potential to cause harm, but it was prevented. >**Impact not prevented** – any patient safety incident that ran to completion but no harm occurred >Incorrect medication dispensed but not taken >Incident resulting in a bruise / graze	>Minor Injury or illness – first aid treatment needed >Health associated infection which may result in permanent harm >Any patient safety incident that required extra observation or minor treatment and caused minimal harm to one or more persons >Wrong drug or dosage administered, with no adverse effects >Self-harm resulting in minor injuries Category 2 pressure ulcer	RIDDOR /Agency reportable incident >Moderate injury or illness requiring professional intervention >Adverse event which impacts on a small number of patients >Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but no permanent harm to one or more persons >Wrong drug or dosage administered with potential adverse effects >Self-harm requiring medical attention >Category 3 pressure ulcer >Incorrect or inadequate information / communication on transfer care	>Major Injury/ long term incapacity / disability (e.g. loss of limb) >Incident leading to death >Any patient safety incident that appears to have resulted in permanent harm to one or more persons >Wrong drug or dosage administered with clinically significant adverse effects as a result of this. >Category 4 pressure ulcer >Retained instruments/ material after surgery requiring further intervention >Slip, trip or fall resulting in injury such as dislocation / fracture such as neck of femur, multiple fractures/ blows to head	>Multiple permanent injuries or irreversible health effects >Any patient safety incident that directly resulted in death of one of more persons >Unexpected death >Suicide of a patient known to the service in the last 12 months > Homicide committed by a mental health patient

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
				>Failure to follow up and administer vaccine to baby born to a mother with hepatitis	
Injury - Staff / Agency / Student (carrying out nursing duties) **(Physical / Psychological)**	>Adverse event requiring no / minimal intervention or treatment. >Incident resulting in a bruise / graze **>Impact prevented –** any safety incident that had the potential to cause harm, but it was prevented. >**Impact not prevented** – any safety incident that ran to completion but no harm occurred	>Minor Injury or illness – first aid treatment needed >Health associated infection which may result in permanent harm e.g. needle stick injury	>RIIDDOR /Agency reportable incident >Requiring time off work for over seven days >Healthcare associated infection e.g. Clostridium difficile (C Dif), Methicillin-resistant Staphylococcus aureus (MRSA)	>Major Injury/ long term incapacity / disability (e.g. loss of limb) >Over 14 days off work >Slip, trip or fall resulting in injury such as dislocation / fracture/ blow to head >Physical attack resulting in serious injury >Long term healthcare associated infection >6 months >Post-traumatic stress disorder as diagnosed by a healthcare professional	>Multiple permanent injuries or irreversible health effects >Incident leading to paralysis >Incident leading to long term mental health problems as diagnosed by a healthcare professional >Any staff safety incident that directly resulted in death of one of more persons
Personal Security	Verbal abuse	>Physical attack such as pushing, shoving or pinching causing minor injury such as laceration, sprain, or anxiety resulting in occupational health counselling (no time spent off work required)	>Physical attack causing moderate injury >Threats to use a weapon to attack any person (not limited to staff) where no such weapon is confirmed to exist >Discovery of weapons such as a knife or gun in a patient home, grounds or premise	>Use or threat of use of a weapon on staff or any person for who the Trust has a duty of care, where the presence of a weapon is known or reasonably suspected >Staff reported missing during working hours >Staff attacked	>Rape / serious sexual assault >Use of weapon leading life changing injury, death or long-term injury.

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
General Security	>Security incident with no adverse outcome >actual attempted arson attack prevented >Prevention of a suspected or likely arson attack where no actual attempt has yet been made	>Security incident managed locally (e.g. rang police) >A person behaving suspiciously or apparently attempting to conceal their activities in any part of the premises or surrounding grounds. >Controlled drug discrepancy – accounted for	>Security incident leading to compromised staff / patient safety >Breach of security – unauthorised person enters premise/restricted area >Loss of belongings through theft at building	>Breach of security leading to a serious compromise of staff / patient safety >Suspicious package left / received >Bomb discovery	>Any suspicious package or potential Improvised explosive device opened, moved or interfered with by an unqualified person (Ammunition Technical Officer/ Explosive Ordinance Disposal technician) >Bomb detonated >Chemical weapons released
Fire Safety	>Minor short term (<1 day) shortfall in fire safety system	>Temporary (<1 month) shortfall in fire safety system / single detector etc. (non-patient area)	>Fire code non- compliance / lack of single detector - patient area etc.	>Significant failure of critical component of fire safety system (patient area)	>Failure of multiple critical components of fire safety system (high risk patient area)

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Patient Experience	>Reduced level of patient experience which is not due to delivery of clinical care	>Unsatisfactory patient experience directly due to clinical care – readily resolvable	>Unsatisfactory management of patient care – local resolution (with potential to go to independent review)	>Unsatisfactory management of patient care with long term effects >Significant result of misdiagnoses	>Incident leading to death
Staffing & Competence	>Short Term low staffing level (<1 day) >temporary disruption to patient care >minor competency related failure reduced service quality, 1 day >low staff morale affecting one person	>On going low staff level – minor reduction in quality of patient care >75%-95% staff attendance at mandatory / key training >Unresolved trend relating to competence reducing service quality >low staff morale (1%-25% staff)	>Unsafe staffing level >Late delivery of key objectives / service due to lack of staff >50% - 75% staff attendance at mandatory / key training >Error due to ineffective training / competency >low staff morale (25%-50% of staff)	>Unsafe staffing level >5 days >Uncertain delivery of key objective/service due to lack of staff >25% - 50% staff attendance at mandatory / key training >Serious error due to ineffective training and /or low morale (50%-75% of staff)	>On going unsafe staffing levels >Non-delivery of key objective / service due to lack of staff >Less than 25% attendance at mandatory / key training on an ongoing basis >Loss of several key staff >Clinical error due to lack of staff or insufficient training and/or competency >Very low staff morale (>75 % of staff)

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Statutory duty/ Inspection	>Small number of recommendations which focus on minor quality improvement issues >No or minimal impact or breach of guidance / statutory duty >Minor non-compliance with standards	>Minor recommendations which can be implemented by low level of management action >Breach of statutory legislation >No audit trail to demonstrate that objectives are being met (NICE, HSE etc)	>Challenging recommendations which can be addressed with the appropriate action plans >Single breach of statutory duty >Non-compliance with core standards <50% of objectives within standards met	>Enforcement action >Multiple breaches of statutory duty >Improvement notice >Critical report >Low Performance rating >Major non-conformance with core standards	>Multiple breaches of statutory duty >Prosecution >Severely critical report >Zero performance rating >Complete systems change required >No objectives / standards being met
Adverse Publicity / Reputation	>Rumours >Potential for public concern	>Local Media – short term – minor effect on public attitudes / staff morale >Elements of public expectation not being met	> Local media – long term – Moderate effect – impact on public perception of Trust and staff morale	>National media <3 days – public confidence in organisation undermined – use of services affected	>National / International adverse publicity >3 days >National / International adverse publicity >3 days >MP concerned (questions in the House) >Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Minor schedule slippage	5–10 per cent over project budget Schedule slippage with moderate impact	Non-compliance with national 10–25 per cent over project budget Schedule slippage with major impact Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage with catastrophic impact Key objectives not met

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Business / Service Interruption	>Loss/ Interruption of >1 hour, no impact on delivery of patient care / ability to provide services	>Short term disruption of >8 hours with minor impact	>Loss / interruption of >1 day >Disruption causes unacceptable impact on patient care >Non-permanent loss ability to provide service	>Loss / interruption of >1 week >Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked >Temporary service closure	>Permanent loss of core service/facility >Disruption to facility leading to significant 'knock on' effect across local health economy >Extended service closure
Natural Environmental Impact	>Minor onsite release of substances >Not directly coming into contact with patients, staff or members of the public	> Onsite release of substances contained >Minor damage to Trust property – easily remedied <10K	>On site release no detrimental effect >Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K	>Off site release with no detrimental effect / on-site release with potential for detrimental effect >Major damage to Trust property – external organisations required to remedy – associated costs >50K	>Onsite./ Off site release with realised detrimental / catastrophic effects >Loss of building / major piece of equipment vital to the Trusts business continuity

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Information Governance	There is absolute certainty that no adverse effect can arise from the breach Files were encrypted Personal data is recovered from a 'trusted' partner organisation	Potentially some minor adverse effect. Cancellation of a procedure but does not involve any additional suffering Inconvenience to staff who need the data to do their job.	Potentially some adverse effect. A release of confidential information to the public domain leading to embarrassment Prevention of staff doing their job e.g. a cancelled procedure that has the potential of prolonging suffering but does not lead to a health decline Any incident involving vulnerable groups even if no adverse effect occurred. • Vulnerable children or adults • Criminal convictions / prisoner information • Special characteristics • Communicable diseases • Sexual health • Mental health	Potentially pain and suffering / financial loss There has been reported suffering and decline in health arising from the breach Some financial detriment occurred. Loss of bank details leading to loss of funds Loss of employment	A person dies or suffers a catastrophic occurrence.

5.3 Table 3: Risk Scoring = likelihood x consequence

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

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

6. Process for Managing Service Concerns and Risks (green text refers to Business Unit processes)

6.1 Issue/ Concerns or Risks

All staff should be encouraged to discuss and raise all issues/concerns and risks to their line manager or appropriate leader within their service. Any that are worrying, complex and seem difficult to address should be considered for a risk assessment, completed by the manager for the area concerned (risk assessment template on Risk and Safety Management page on intranet (OAK)). (See *'Clinical & Operational Risk Escalation Process'* for further guidance re management of individual clinical risks)

6.2. Adding a Risk to the Risk Register

For any risks that score above the Trust's risk appetite (see Risk Management Policy) the risk assessment should be sent by the relevant manager to the corporate senior manager or Business Unit leadership team for consideration for the risk register (via senioropsteam@nhs.net). Risks that score below the risk appetite don't need to be added if they are assessed as relatively straight forward to manage/resolve. Risks that are sent to the senior manager/ Business Unit leadership team will be reviewed (Clinical Leads to review the clinical risks and General Managers to review the non-clinical risks) and feedback given to the manager who submitted the risk information at the earliest opportunity. This may include adding or not adding the risk to the register or further enquiries. Potential new risks and updated information about risks are to be introduced and discussed at relevant forums and performance meetings.

If it is agreed that the risk should be added to the risk register, the Business Unit leadership team will nominate a Risk Owner (person best placed to manage the risk) and the corporate senior team manager / Business Unit leadership team will provide support to the Risk Owner to describe the risk register entry in terms of hazard, risk(s) and impact(s) and agree what the overall risk score should be. The Risk Owner will add the risk to the risk register on Datix, upload the risk assessment document onto Datix and complete the Datix actions field.

6.3. In Holding Area, Awaiting Review

Once a risk has been recorded on the risk register (on Datix), it is automatically given the status 'In Holding Area, Awaiting Review'. The **Risk and Safety Manager** reviews the proposed risk, evaluates whether it is appropriate for it to be on the risk register and that the most appropriate person is allocated as 'risk owner' (this will be the person who can be responsible for actions that will reduce or remove the risk). The **Risk and Safety Manager** will edit the risk information if necessary and then change the status to 'Being reviewed'.

The **Risk and Safety Manager** will check that the most appropriate director / directorate has been assigned the risk. The Director is automatically notified of the risk via the Directorate field. If the correct director has not been notified, the Risk and Safety Manager will send a communication through Datix to manually notify the correct Director. Once notified, the **Director** can also access and if necessary, amend the risk.

6.5 Rejected

If the **Risk and Safety Manager** and **Director** do not agree that the recorded risk is a risk, the **Risk and Safety Manager** will change the status to 'Rejected'. Good practice would be to put a note in the 'Progress Notes' field to say why it is being rejected and advise the **Risk Owner**.

6.6. Being Reviewed (to be changed to 'Open')

At the 'Being reviewed' status, the **Risk Owner** will be actively managing the risk down to an acceptable level (down to at least the target level ideally) through their proposed actions and should regularly review and update the risk on Datix.

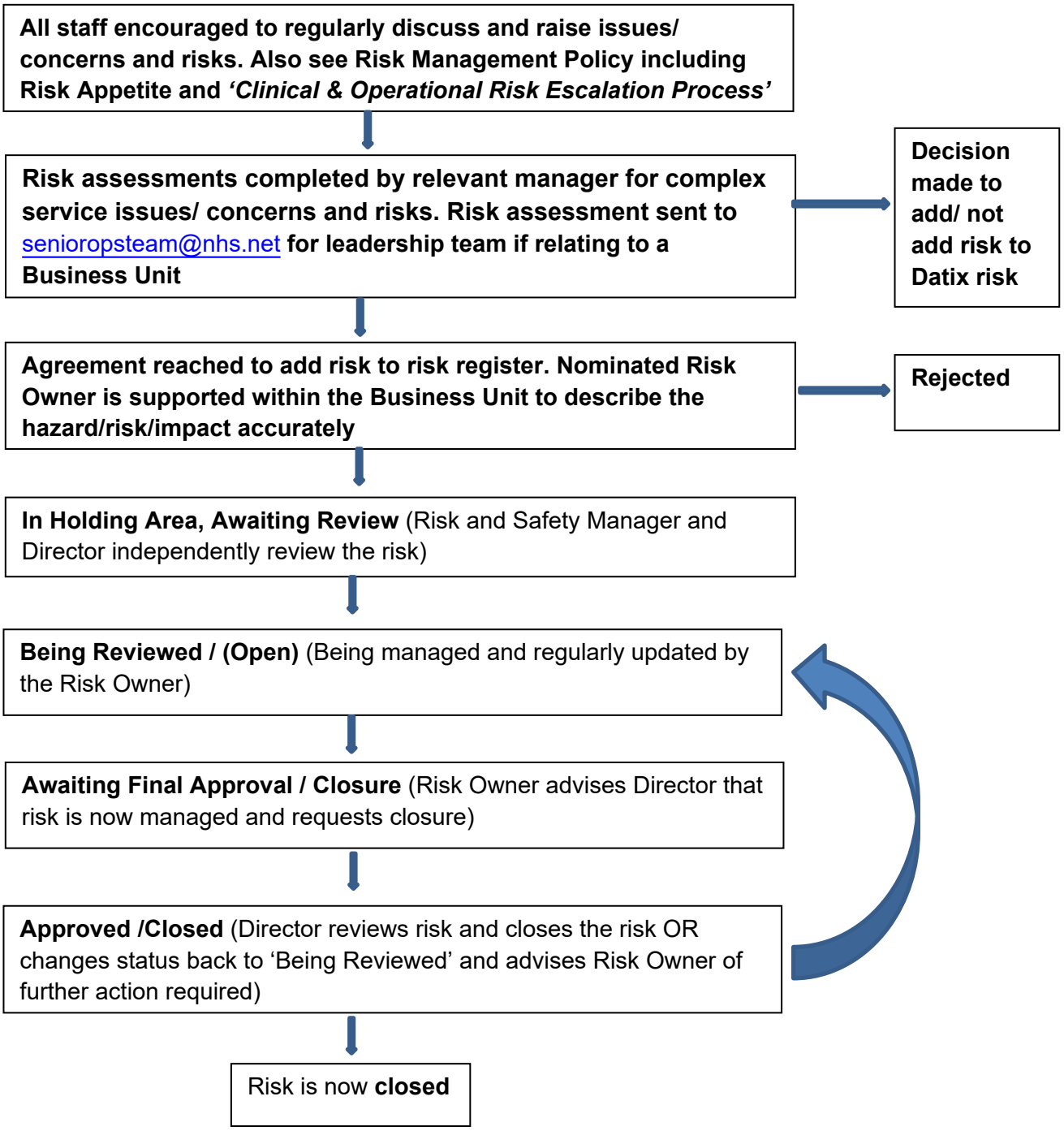
6.7 Awaiting Final Approval / Closure

Once the **Risk Owner** has completed all actions and managed the risk to the target level, they should change the status to 'Awaiting Final Approval / Closure' and the **Risk Owner** should notify the **Director** by email that the **Director** needs to again review the risk and agree that it can be closed.

6.8 Finally Approved / Closed

The **Director** will change the status to Finally Approved / Closed and put the date of closure in the 'Closed Date' field, then click 'Save' at the bottom of the risk form.
If the **Director** doesn't agree that the risk should be closed, they would return it to the 'Being Reviewed' status and advise the **Risk Owner** that it needs further management.

6.7 Process flowchart: managing individual risks



7 Glossary of Terms

Hazard	Anything/situations with the potential to cause harm, damage or loss.
Risk	A risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives. A risk can be a threat or an opportunity.
At Risk	Possibility of exposure to the hazard and therefore the chance of injury, ill health, harm, damage, loss or service disruption. It may include substances, equipment, a work practice or proposed business plan.
Consequence	The result (the impact) of a particular threat or opportunity should it actually occur.
Likelihood	The measure of the probability that the threat or opportunity will happen, including a consideration of the frequency with which this may arise.
Controls	The existing systems and processes, which help minimise the risk.
Risk Score	A means of prioritising risks by measuring each risk in terms of consequence x likelihood.
Assurance	Confidence, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved.
Residual Risk Rating	The amount of risk that remains following implementation of all actions designed to reduce the risk.
Risk Assessment	The process used to evaluate a risk and to determine whether controls are adequate or more should be done to mitigate the risk.
Risk Tolerance / Threshold	The risk tolerance is amount of risk the Trust is prepared to accept, tolerate or be exposed to at any point in time. The risk tolerance threshold is a pre-set level, which if breached triggers a further response i.e. escalation and monitoring.

Risk Register	A record of the risks faced by the Trust that could affect the delivery of objectives.
Board Assurance Framework	A high-level management assessment process and record of the strategic risks relating to the delivery of the key objectives and the governance processes required to prevent these risks occurring.
Risk Owner	The person allocated the responsibility of ensuring that actions to control the risk are implemented.

Appendix 2 – Risk Appetite Statement

Leeds Community Healthcare NHS Trust

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**

Appendix 3

Risk register update process: standard operating procedure

1. **Introduction**

This statement sets out the Risk Management procedure to ensure that the risk register is maintained effectively.

2. **Risk Management: policy requirements**

The Risk Management Policy defines the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation ensuring that sound risk management principles are an integral part of its governance structure and processes. It also sets out the respective responsibilities for corporate and operational risk management throughout the Trust.

The Risk Management Policy and Procedure states:

- The Risk and Safety Manager will ensure the safe storage and update of the risk register
- Senior Managers / Service Leads The ongoing maintenance and review of the service's risks. The risk register and associated action plans are actively reviewed on a monthly basis to ensure maintenance of an up-to-date risk register
- Risk owners have the responsibility of reviewing and updating individual risks that have been assigned to them.
- Realistic review dates should be set by the risk owner, which should be adhered to.

3. **Implementation of policy requirements**

Risk owners must proactively review their assigned risks in advance or on the date of the review date and update their risks accordingly.

The risk register will be reviewed at least monthly by Risk and Safety Manager to ensure that risks are being updated appropriately. This includes reviewing all risks, regardless of score, to ensure the update date is appropriate to the level of risk and is in date, the controls and actions are maintained, the scores reflect the level of risk described and the current controls which are mitigating the risk. The Risk and Safety Manager will also review whether risks have reached an acceptable risk score, in line with the Risk Appetite, and will recommend and follow up closure.

All risk register entries that requiring updating will be reviewed by the Risk and Safety Manager at least monthly. Risks that are about to reach, have reached or have surpassed their update date, an initial reminder is to be sent via Datix email to remind Risk Owners that the risk is out of date. For risks that are overdue by two weeks or more, a personal email must be sent by the Risk and Safety Manager via Outlook to the respective Risk Owner (and the reminder

documented on Datix notepad). For risks that are more than one month overdue, the relevant director must be notified by the Risk and Safety Manager.

SMT will receive a monthly report from the Risk and Safety Manager concerning any risks, regardless of current risk score, that have surpassed their update date by more than one month.

4. **Review**

The contents and operation of this procedure will be reviewed from time to time in response to the issue of new or amended guidance and/or as a result of practical implementation of this procedure.

Version: 1

Author: Company Secretary

Date: 6 June 2019

Appendix 4

Board Assurance Framework (BAF) process

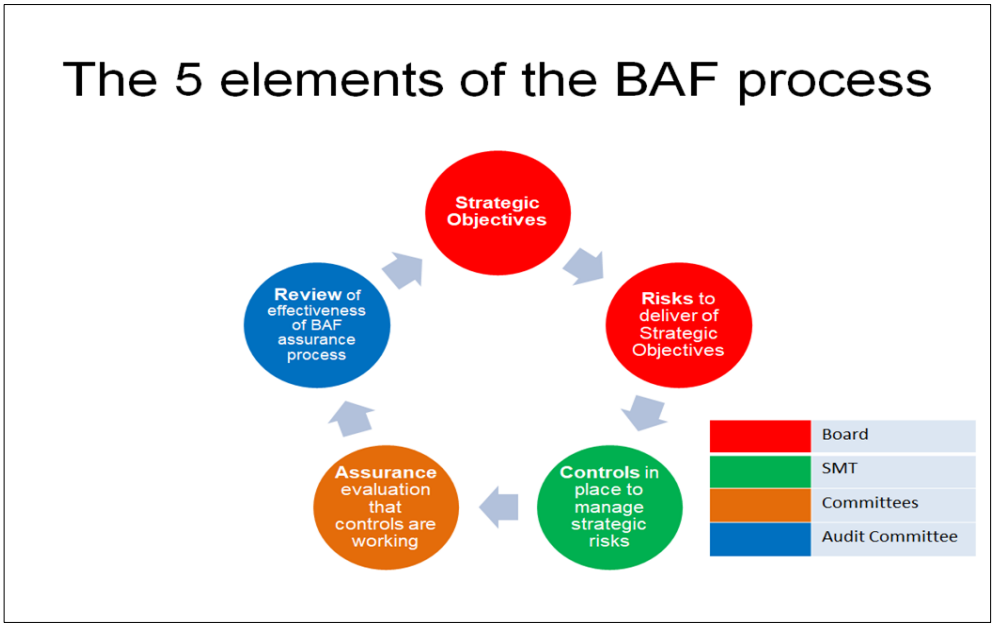
1. Purpose of the Board Assurance Framework (BAF)

"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.

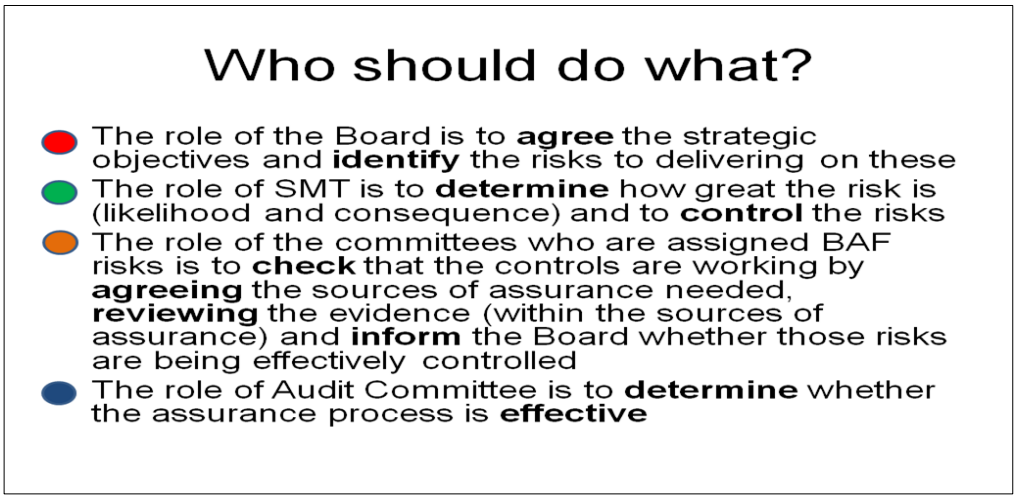
The Board Assurance Framework (BAF) is a live document that should capture the Board's thinking around the management of strategic risks. The BAF documents risks to the Trust's strategic goals and corporate objectives, controls and sources of assurance

- A control is an activity that eliminates, prevents, or reduces the risk.
- Sources of assurance are reliable sources of information informing the Committee / Board that the risk is being mitigated ie success is been realised (or not).

The Board, SMT and the governance committees each have a unique function when reviewing the BAF. The following diagrams describes the BAF process which allocates a unique role to each group – the Board, SMT, the 'assurance committees' (ie Business, Audit and Quality Committees who have been assigned strategic risks) and the Audit Committee.



2. Roles and responsibilities



Strategic risks can be retained by the Board or delegated to one of its assurance committees (Business, Audit, or Quality Committee) 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.

3. Committee Chairs assurance reports to Board

The role of the committees that are assigned strategic risks is to determine whether the controls are working by agreeing the sources of assurance needed, reviewing the evidence (sources of assurance) and indicating to the Board whether those risks are being effectively controlled (assurance level: none, limited, reasonable, substantial).

The Audit, Quality and Business Committees review the sources of assurance presented to them and provide the Board with positive or negative assurance. The Committee Chair's Assurance Report relays assurance levels to the Board, the report can also be used to advise the Board of any key issues discussed at the Committee. This is so that the Board is informed as to whether that risks to the success of its strategic goals (objectives) are being managed effectively.

4. Risk register and Board Assurance reports to Board

4.1 Risk and BAF summary reports

The BAF summary reports, as well as each committee's assurance reports, are provided to Trust Board at each meeting give an overall picture of the assurance levels provided by the Committees to the Board over recent months.

4.2 Risk themed reports

The risk themed reports that are produced on a 6-monthly basis for the Board connect the strategic risks with current and emerging risk themes.

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 type of report, each risk has been aligned with the one strategic objective it most directly affects. 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.

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. In this event, the Board and appropriate committees should seek additional assurance against these BAF strategic risks

5. BAF review process

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.

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 are presented at the March Board meeting for approval, so this provides an ideal opportunity to review the BAF at the same time.

The Senior Management Team (SMT) reviews the BAF strategic risks at its meeting in March each year. The risk scores for each of the BAF strategic risks are also reviewed to ensure the score reflects the current level of risk. SMT propose any changes to the Board.

The Board is asked to review the BAF strategic risks, consider the recommendations made by SMT and agreed any changes required for the coming year. When reviewing the proposed changes to 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

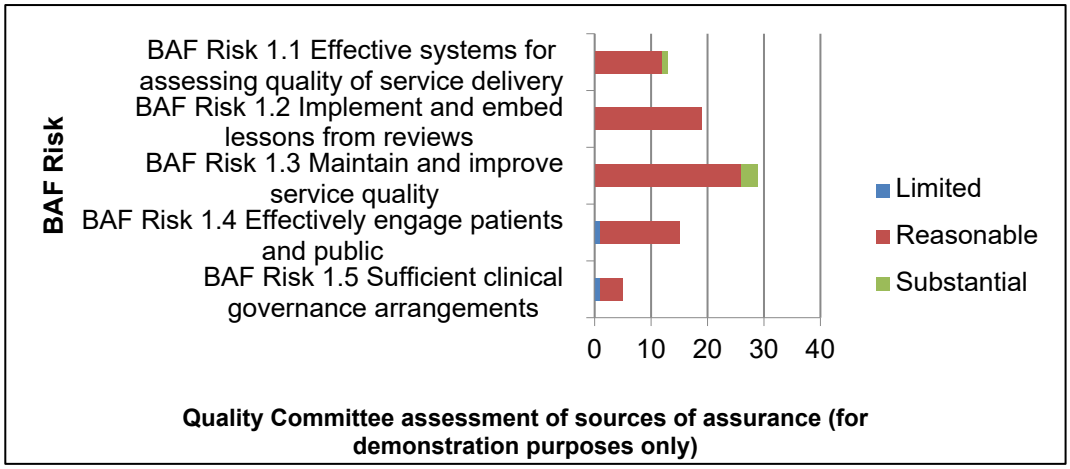
Once revisions are agreed at Trust Board, new strategic risks will be assigned to an executive director and to a committee or to the Board for oversight. Committees are provided with details of the strategic risks assigned to them for oversight. Controls to manage the new strategic risks and the required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

6. Committees review of sources of assurance

Each Committee is asked to review on at least an annual basis, the sources of assurance provided against the strategic risks to ensure that the sources are of sufficient variety, focus, depth and frequency to enable the Committee to have an informed opinion when providing assurance to the Board.

In addition, each assurance committee is provided with 6-monthly reports that demonstrates which of the strategic risks have been assessed by the committee at its meetings within the last 6 months and the levels of assurance provided. The report also highlights where, during the same period the committee received insufficient sources of assurance at its meetings for any strategic risks on the BAF to be able to evaluate whether those strategic risks were being managed. The Committees are recommended to review those strategic risks and where there are insufficient sources of assurance presented at committee meetings, this should be remedied.

Example report:



7. Levels of assurance

Assurance is when information and the discussion at committee meetings provides reliable information (evidence) for the committee members and attendees to collectively judge whether all is well and if the strategic risks associated with the information being reviewed are being effectively managed (or not).

The last item on assurance committees' agendas at each meeting is a template that requires completing by the Committee Chair. This template lists the strategic risks that are assigned to that committee and the information that the committee has received during the meeting. Committee members and attendees should be invited to conclude the assurance level after due consideration and discussion.

Meetings' chairs will need to record the level of assurance agreed. Operating in this way evidence positive (or negative) assurances for including in the Board Assurance Framework summary report and Chair's assurance reports to the Board.

In order to harmonise terminology, the statements of levels of assurance to be used are: *substantial, reasonable, limited* and *no.*

- **Substantial assurance** based on a conclusion that there is a robust system of internal control and governance in place which will deliver the Trust's corporate objectives (clinical, quality or business) and that controls and management actions are consistently applied

- **Reasonable assurance** based on a conclusion that there is a generally sound system of internal control and governance to deliver the clinical, quality or business objectives and that controls and management actions are generally being applied. Some weakness in the design and/or application of controls and management actions put the achievement of particular objectives at risk. Improvements are required to enhance the controls to mitigate these risks.

- **Limited assurance** based on a conclusion that the design and/or application of controls and management actions are insufficient and the weaknesses put the achievement of clinical, quality or business objectives at risk. Significant improvements are required to improve the adequacy and effectiveness of the controls to mitigate these risks.

- **No assurance** based on a conclusion that there is a fundamental breakdown in or absence of controls and management actions which could result (or have resulted) in failure to achieve the clinical, quality or business objectives. Immediate action is required to improve the controls to mitigate these risks.

8. Types of assurance

There are three types of assurance (sometimes referred to as 'three lines of defence'). Committees should seek to have all three types for each strategic risk if possible:

1. Service delivery and day to day management (eg information provided by a service)
2. Specialist support, oversight responsibility (eg information provided by corporate support functions)
3. Independent challenge (eg information provided by internal or external audit, CQC, patient feedback)

Policy Consultation Responses

Complete this template when receiving comments at various draft stages of the Policy.

Responder (Including job titles and organisation)	Version, Comment and Date	Response from Author
Diane Allision, Head of Corporate Governance, Safety and Risk (Company Secretary)	V4.1 I'm just thinking about how we describe the Risk Review Groups in the RM policy – as we should say that the function is part of whatever larger group the RRG is performed at. This is what the revised policy currently says – but it makes it sound like we have distinct RRGs, which we don't: **Risk Review Group** The Risk Review Groups within each business unit will: • Review new risks (graded 8 and above) that have been added to the risk register. • Review escalated and deescalated risks and risks that have recently been closed. • Acts as a moderator for risk grading, ensuring appropriate ownership of the	That sounds better, because the discussion is much more likely to be added into an existing meeting. Accepted

	risk and ensuring that effective management of the risk is being recorded. • Maintain an oversight of the practical application of the risk management procedure. How about we say instead: **Business Unit Risk Review** Each business unit will ensure there is a forum established to: • Review new risks (above the risk appetite statement) that have been added to the risk register. • Review escalated and deescalated risks and risks that have recently been closed. • Acts as a moderator for risk grading, ensuring appropriate ownership of the risk and ensuring that effective management of the risk is being recorded.	

	• Maintain an oversight of the practical application of the risk management procedure.	
Keziah Prince, Incident and Risk Assurance Manager	V4.2 Thanks for sharing the Risk management policy, I have reviewed and agree with its entirety.	Excellent
Sheila Sorby, Assistant Director of Nursing & Clinical Governance	Section 4: Is there a way of describing this paragraph in more simple terms that all our staff will understand? It feels very corporate jargon but we need all of our staff to understand and adhere to this	Actioned by Cara McQuire
Sheila Sorby, Assistant Director of Nursing & Clinical Governance	Section 1: Does this need to make explicit it is clinical and non-clinical risks as that appears to be what the policy is saying? May help staff think of risk in these 2 ways too!	Actioned by Cara McQuire
Ram Krishnamurthy, Quality Lead for Specialist Business Unit	Do we need to say who is part of this board committee?	Board of directors added to provide clarity
Sheila Sorby, Assistant Director of Nursing & Clinical Governance	Section 4 : What about corporate risks? Have leads for all these areas contributed to policy and are they aware of this responsibility? Names are listed as being involved in consultation but only evidence of 2 respondents	Committee subgroups and risk owner responsibilities now added. Also sent out to all three business unit leads for consultation

	Who is responsible for reviewing risks of below 8? All the responsibilities refer to those above 8. The flow chart suggests the decision to add or not to Datix is made at BU level so presumably there should be an auditable trail of such decisions and the rationale, is that in place?	
Sheila Sorby, Assistant Director of Nursing & Clinical Governance	Section 7: I think hereon needs the new template formatting / wording	Updated wording and template
Helen Swales	Section 11: Add hyperlink	Updated
Sheila Sorby, Assistant Director of Nursing & Clinical Governance	Section 3.5: Not covered in roles and responsibilities and I think it should be	Now addressed in Risk owner definition
Ram Krishnamurthy, Quality Lead for Specialist Business Unit	Section 3.5: Do we have a system to record this or should have one for audit trail?	Now addressed in roles and responsibilities

Policy Consultation Process

Title of Document	Risk Management Policy and Procedure
Author (s)	Cara McQuire, Risk and Safety Manager
New / Revised Document	Revised
Lists of persons involved in developing the policy	N/A
List of persons involved in the consultation process	• Diane Allison, Company Secretary • Rebecca Mazur, Senior Health and Safety Advisor • Andrew Stephenson, Security and Safety Lead • Paul Howarth, Fire Safety Advisor • Marc Wilson, Health of IG and Data Protection Officer • Claire Grey-Sharpe, Head of Clinical Governance • Keziah Prince, Incident and Risk Assurance Manager • Cherrine Hawkins, Deputy Director of Finance and Resources • Mandy Young, Clinical Lead, Specialist Business Unit • Andrea North, General Manager, Specialist Business Unit • Caroline McNamara, Clinical Lead, Adult Business Unit • Megan Rowlands, General Manager, Adult Business Unit • Janet Addison, General Manager, Children's Business Unit • Hannah Beal, Clinical Lead, Children's Business Unit

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (51)

Title: Register of sealings June to July 2022

Category of paper: for approval
History: N/A

Responsible director: Chief Executive
Report author: Company Secretary

Executive summary (Purpose and main points)

In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal.

The details of its recent use are contained within the attached copy of a section of the register**.**

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

Recommendations

The Board is requested to ratify the use of the corporate seal.

Register of affixing of corporate seal and signatories to legal documents

OCCASION	PARTIES INVOLVED	DOCUMENT APPROVED & SEAL ATTESTED BY	DATE
UPLA: for part of Beeston Hill Community Health Centre	Leeds Community Healthcare Community Health Partnerships Limited	Chief Executive Executive Director of Operations	14.06.2022
UPLA: for part of Middleton Community Health Centre	Leeds Community Healthcare Community Health Partnerships Limited	Chief Executive Executive Director of Operations	14.06.2022
UPLA: for part of Yeadon Health Centre	Leeds Community Healthcare Community Health Partnerships Limited	Chief Executive Executive Director of Operations	14.06.2022
UPLA: for part of Middleton Community Health Centre (Dental Service)	Leeds Community Healthcare Community Health Partnerships Limited	Chief Executive Executive Director of Operations	14.06.2022
UPLA: for part of Yeadon Health Centre (Dental Service)	Leeds Community Healthcare Community Health Partnerships Limited	Chief Executive Executive Director of Operations	14.06.2022

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (54)

Title: Mortality Report Quarter 1 2022-2023

Category of paper:	**For assurance**
History:	**Quality Committee 25 July 2022**

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

Executive summary

Purpose of this report:

To provide the Committee with assurance regarding the Mortality figures and processes within LCH NHS Trust in Quarter 1 22.23.

Main points to note:

- Quality Assurance & Improvement (QAIG) Group have met regularly and are quorate. The last meeting was the 14th July 2022.
- The Adult Business Unit mortality review meetings combined with the Specialist Business Unit, and the Children's Business Unit Learning from Deaths meetings have taken place regularly and have been quorate throughout the quarter.

Adults & Specialist

- The overall number of deaths is anticipated to increase for Q1 and will be clarified in the Q2 report; the timing of the reports required this quarter result in the data being analysed prior to the point in the data cycle it has stabilised.
- The percentage of deaths in under 70s in NTs of increased deprivation index is again noted as significant. It has been noted that the national premature mortality age is 75 and therefore the age profiling will be amended on future reports to reflect alignment with this.
- A significant number of deaths in the Seacroft area was noted during Q1, and although a review of the cases suggests this is not linked to any particular incidents or themes of concern, this will be carefully monitored. The upper control total (UTC) has not been breached.
- Three deaths were reported within a single weekend period in May 2022 whilst receiving care on the Virtual Ward for Frailty. Mortality reviews were undertaken by the geriatricians and VW clinical lead, with no clinical care concerns or themes identified.
- The need to review the mortality reporting and review system across Adults and Specialist has been identified, linked to the podiatry deaths previously reported to Quality Committee and the sustained numbers of deaths in the community.
- The Medical Examiner role is now established in LTHT after ongoing system pressures resulted in a delay to establishing this fully. The Trust continues to actively engage with LTHT in regard to establishing how best this role can support proactive learning from deaths in the community.
- Healthwatch conducted a survey of carers and their experience of EoLC at home, hospice and LCH from Oct-Dec 2020 as part of the Leeds Primary Care Network Community Flows Group. Whilst the sample size was small (31 families, to be considered in the context of 6800 deaths in Leeds during 21.22) learning from the report will be reviewed and considered in the context of the NT transformation program and our EoLC provision.

Children

- The review of the child death process has been completed, and work is ongoing towards developing a new SOP with clearer streamlined process, including using Datix to monitor the child deaths. This will provide assurance regarding the governance process and demonstrate evidence of learning.
- Positive feedback has been received in terms of the new format of the internal Child Death review meetings
- Work is planned to benchmark LCH processes with child death processes in other community Trusts.
- The lack of Health Equity data available for patients in Childrens Services has been noted and flagged
- It has been identified that at this early point of Quarter 2 there have been 4 SUDICs in the city, none that at initial review appear to have been engaged with LCH services other than PHINS. The team are being supported appropriately.

Learning Disability

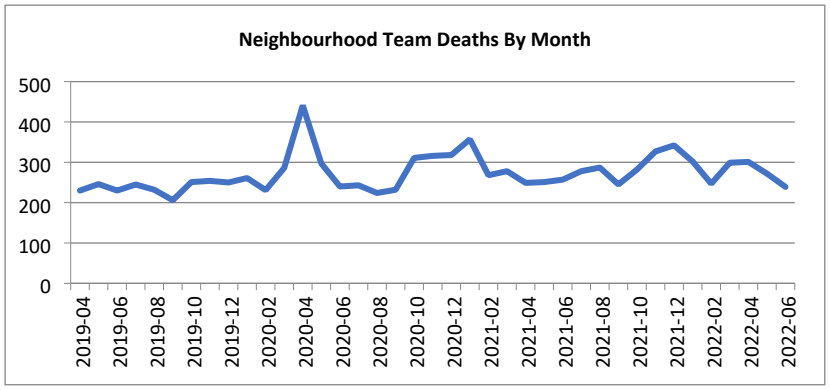
- Flags are now present on SystmOne to highlight patients with a learning disability or autism, pulled through from the primary care record
- A field is being added to datix to capture learning disability and autism which will result in the LD lead being notified of all deaths in this patient group and enable us to better identify deaths, incidents and themes for learning
- All deaths in patients with learning disabilities or autism will be additionally reviewed separately to the existing processes

Recommendations:

- Quality Committee is recommended to receive this assurance regarding Trust mortality processes during Q1 of 22.23
- Note the ongoing contribution to improving data quality within the Trust and city, and the continuous work to ensure surveillance and learning is optimal

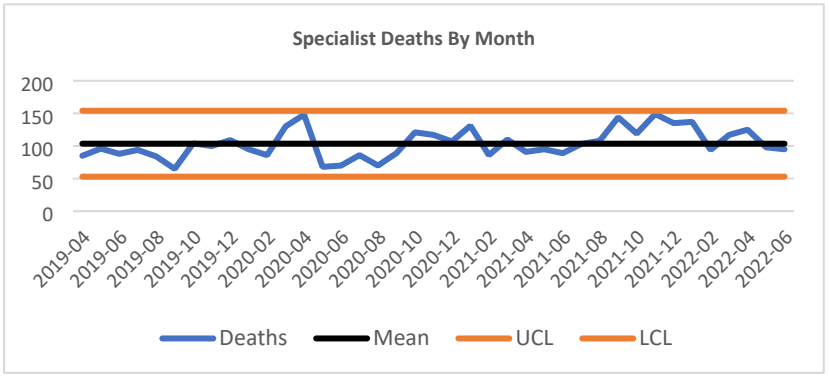
[Adult Mortality Report – QAIG], Q[1]2022/23 (April – June 2022)

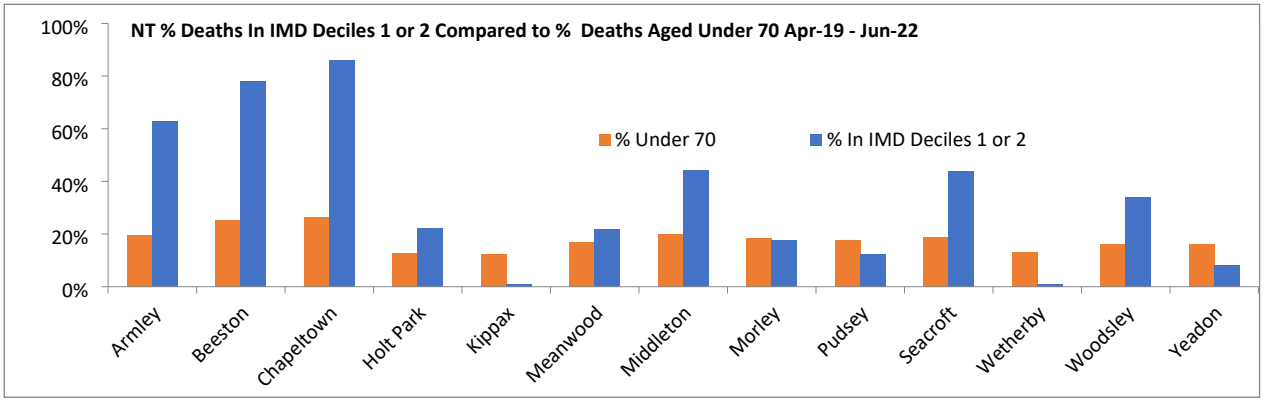
Quantitative data

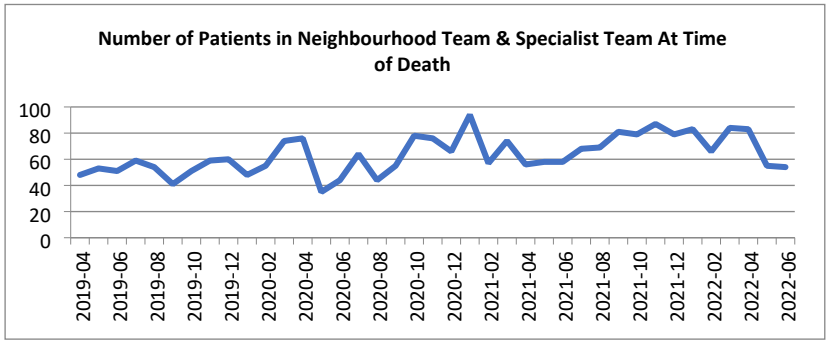


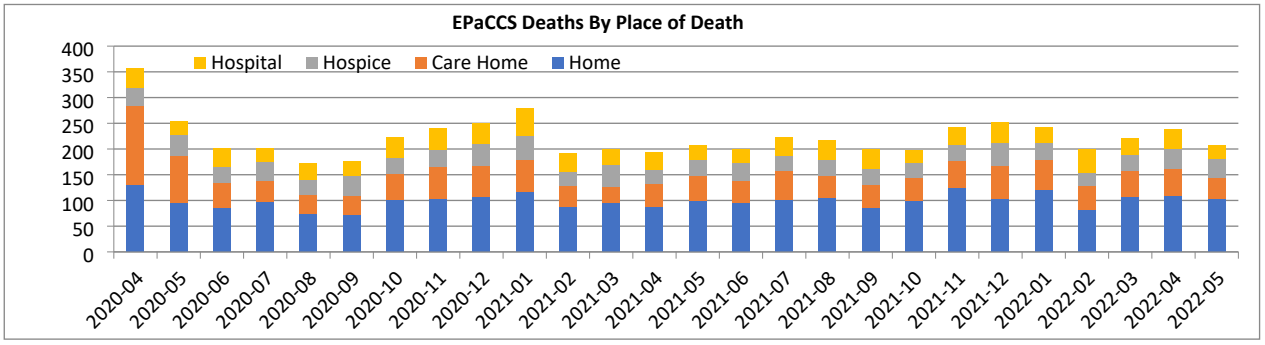
Apr - Jun 22 Mortality Figures for NTs & Selected Specialist Services				
Deaths	**April 22**	**May 22**	**June 22**	**Q1**
Total	343	315	280	**938**
NT	301	272	239	**812**
Specialist	125	98	95	**318**
Specialist not in NT	42	43	41	**126**
In NT & Specialist	83	55	54	**192**
Specialist Deaths in Multiple Units	15	13	5	**33**

Adult Data	Q3 21/22	Q4 21/22	Q1 22/23
Level 1	624	592	819*
Level 2	163	143	230*
Unexpected deaths	100	67	92
Expected deaths	522	462	477
Alliance CCB deaths	3	5	5
Virtual Ward deaths	5	5	5
LeDeR		5	0
Serious Mental Health	0	0	0*









Narrative

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

[Adult Mortality Report – QAIG], Q[1]2022/23 (April – June 2022)

Analysis:

- Total Adult deaths in Q1 22/23 = 938 (Q4 = 906). There has been an overall 3.5% increase and this is likely to increase further since the data was extracted beginning of July. Adult Business Unit deaths Q1 22/23 = 812 (Q4 21/22 = 790) Specialist Business Unit deaths = 318 (Q4 21/22 =326. 126 deaths were in Specialist services only and 192 in both Neighbourhood and Specialist teams.
- Significant increase in deaths were noted in Seacroft Neighbourhood Team and this will be monitored. No initial concerns/complaints/patient safety incidents has been identified in relation to these deaths. However, the increase in number of deaths has impacted on the capacity pressures at Seacroft NT.
- 92 deaths were reported as unexpected (Q4 67; Q3 100; Q2 77, Q1 78). There was a rise of unexpected deaths when compared to previous quarters.
- 4 patients died who had a learning disability, similar trend to previous quarter (Q4 = 5)
- In SBU, Gynaecology, MSK and Podiatry are exclude from the usual Mortality Process of completing Level 1 and 2 reviews. An audit is completed every quarter to provide assurance. In Q1 no concerns were noted in the audit.
- 3 deaths were reported within a single weekend period in May whilst receiving care on the Virtual Ward for Frailty. These deaths were immediately flagged and mortality reviews undertaken by the geriatricians and VW clinical lead. No clinical care concerns or themes were found.
- Equity — Chapeltown (86%) & Beeston (78%) deaths from within deciles 1&2 . TB and Homeless Services also high but to be expected. Beeston and Chapeltown have 25% and 26% respectively deaths <70yrs. No new trends re age band seen for SBU.
- * Level 1 & level 2 and Mental health disorder data may not be accurate, we have requested BI for clarification.

Themes

- Theme identified through mortality group of a small % of patients where staff had not effectively recognised the last hours of life /deterioration in patients condition. Lack of effective advanced planning for patients approaching end of life.
- A review of the deteriorating patient guidance and NEWS2 underway and refresher training on management of deteriorating patients being delivered across ABU.
- Improve communication and handover between SBU and ABU was highlighted in the mortality review meeting.
- There was consistent theme about communication from GP's to NT regarding deterioration of patients who require palliative and end of life care.
- There is delay from GP's to signpost rapid deterioration to clinical teams, this has led to inappropriate call outs and poor patient experience. This was fed back to GP's.

Contributions to making stuff better

- Symptom Management: new syringe driver guidance produced and new training for use and rollout plan commenced. Leaflets for "What to do after death" and "Support at end of life for patients and carers" was refreshed and embedded within ABU. This will now be shared across SBU.
- Progress is being made with the recovery plan to deliver end of life training for all clinical staff within ABU.
- Feedback from a bereaved family: the ABU Clinical Lead & Clinical Service Manager for the Palliative Care Leads met with the patient's GP and senior team members from St Gemma's Hospice with a recently bereaved husband to understand a patient's family's experience of care in the last days of life. There was significant learning from this meeting that is being taken back to the Leeds Palliative Care Network, the Citywide EoL Care Population Board and Steering Group and all partner organisations. The feedback included family concerns regarding aspects of EoL Care that included, the coordination of care and communication between the hospital team and primary care, the availability of anticipatory medication (pharmacy issue) and new EoL status information being recorded on the patient's electronic records (accessible now by patients)
- Short summary of the learning identified form LeDeR reviews was requested and this will be added to next quarter report.
- The Adult Mortality Review meeting has gained the regular attendance of Deputy Medical Director Dave Kirby, Dr Mike Stockton, Chief Medical Officer, Consultant in Palliative Care and Medical Lead, this will build the links with both Primary Care and the Leeds Hospices and ensure an objective medical perspective is brought to the mortality case discussions.

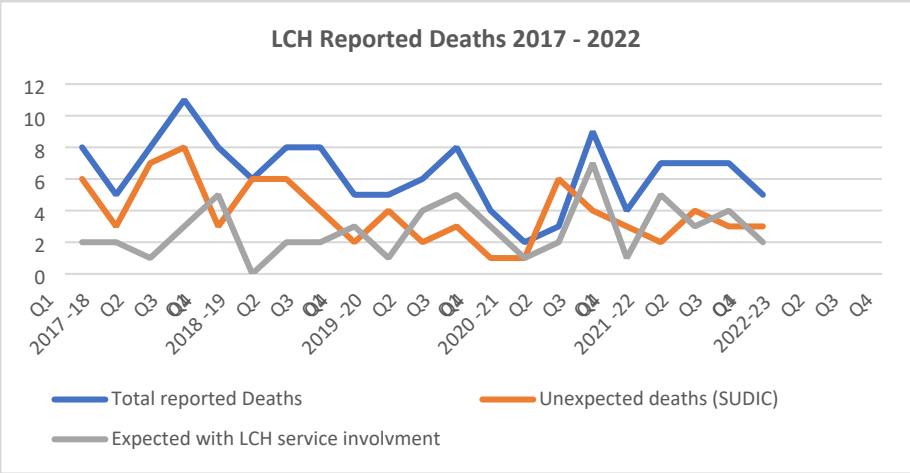
Risks

- Lack of a commissioned community suction care provision, that impacts upon complex patients residing in the community and own home. this has been reviewed with commissioners, who are now exploring how this is managed in other areas of the country. This was prompted by an increase in patients particularly with MND requiring regular suction and more intensive healthcare needs. No action required until further discussions with commissioners.
- Due to the increase in community EoL patients, there is a risk of insufficient capacity to meet patient needs/symptom management at EOL due to increase in the numbers of patients choosing to die at home and a finite resource of Neighbourhood Team & Nights Service staff.
- Insufficient Business Unit ABU and SBU senior leadership team capacity to maintain the timely review of the level to mortality reviews. Plan to review with QPD and explore potential support with this work from the NT Palliative Care Leads to support this process

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

Mortality - children's Q1 2022/3 (Apr – Jun 2022)

Quantitative data



Quarter 1 22/23	Expected with LCH service involvement	Unexpected/ SUDIC	Total
April	1	1	2
May	1	1	2
June	0	1	1
Total			**5**

Risks/issues

Risks

- Chair of the meeting continues to be concerned regarding the time that is required to commit to making the LCH Child Death Reviews process better.

Narrative

There were 5 deaths in quarter 1.

SUDICs

- Death by hanging of a 12-year-old, escalated to a 'safeguarding children practice review' (SCPR) no LCH learning identified immediate
- A 17-year-old child fleeing the Ukraine who was unknown to all Services sadly took his own life weeks after he arrived in the country. No LCH learning, there is wider multi- agency learning
- A 6-week-old baby died at home, awaiting outcome of PM. Mum had received CONI following the death of a previous infant.

Expected deaths

- A chid well know to the children's community nursing service sadly died of Metastatic Ewing's Sarcoma. The team were offered support following the child's death this will be discussed at September Child Death Meeting
- A child who has resided in Hannah House for several years died in hospital with 1a LRTI (RSV Infections), 1b Congenital Myotonic Dystrophy. This was a difficult case for staff involved, support offered by the CCN Management Team. This death will be presented at July LTHT Child Death Meeting, and then at September LCH meeting.

Making Stuff Better

Full review of the child death process completed, working towards developing a new SOP with clearer streamlined process, including using Datix to monitor the child deaths. This will provide assurance regarding the governance process and demonstrate evidence of LCH learning.

New format and Chair for the Child Death Meeting, including more scrutiny of each death, with an inclusive approach, inviting practitioners to listen to cases they have been involved in, sharing the learning and good practice. This has already had positive feedback regarding staff support and reflection.

To review Birmingham's child death process for immediate learning / actions, which is similar to the MR1 and 2 for ABU / SBU and see how this can be implemented without duplication of work.

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

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (55)

Title: Patient Experience Six Monthly Report

Category of paper: For assurance

History: Quality Committee 25 July 2022

Responsible director: Executive Director of Nursing and Allied Health Professionals

Report author: Specialist Quality Lead

Executive summary

Purpose:

1. This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH).
2. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).
3. The report provides a review of complaints and concerns, feedback via surveys, engagement activity, and wider feedback for the 6 month period 1st January 2022 to 30th June 2022; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years and presents key information in relation to Covid-19.
4. The report includes Friends and Family Test (FFT) information.

Main points:

1. There was a 6% increase in incoming complaints compared to the beginning half of the financial year. This is in line with the increase seem in other comparable organisations over the pandemic period.
2. The top 3 themes of complaints received remain consistent with the previous year.
3. The Trust received 2 Covid-19 related complaints between 1st January 2022 to 30th June 2022 and 17 concerns. The majority of these cited issues with access and appointments
4. Work continues to focus on review the process of manging concerns and complaints in line with national best practice.

Recommendations

The Board is recommended to:

Receive this report

Note the updated information

PATIENT EXPERIENCE (Complaints and Concerns) SIX MONTHLY REPORT

1.0 INTRODUCTION

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

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

2.0 BACKGROUND

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

2.2 This report will include the impact of Covid-19 on complaints, concerns, compliments, and patient experience.

3.0 LCH PATIENT EXPERIENCE

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

4.0 COMPLAINTS, CONCERNS & COMPLIMENTS

4.1 From 1 January 2022 to 30 June 2022, LCH received 51 complaints which were managed under the 2009 regulations. There was a 6% increase in incoming complaints compared to the beginning half of the financial year, when 48 complaints were received.

4.2 In comparison to the same period in the previous year 1 January to 30 June 2021, there has been a 21% increase in complaints received, from 42 to 51 complaints. Anecdotally from discussions with regional Complaints Managers the number of complaints is consistent with other NHS Trusts locally. It is anticipated that the number of complaints will continue to rise in 2022 in response to services resetting post changes made in response to Covid 19.

4.3 98% of all complaints received by the Trust were acknowledged within 3 working days (46 out of 47). One complaint was acknowledged on day 6 following late notification of request by service.

4.4 The highest number of complaints were from services in the Adult Business Unit 37% (19), followed by 33% (17) from the Children's Business Unit. Adult Neighbourhood Teams (14) and Community CAMHS (10) received the highest number of complaints during the reporting period.

4.4 29 of the 51 complaints received between 1 January and 30 June 2022 have been closed. 100% of all closed complaints were responded to within 180 days of receipt. 7 complaints were passed on to other organisations and 7 complainants withdrew their complaint following discussion with the service.

4.5 The average length of time to provide a response to a complainant was 38 days. 76% (22 out of 29) of closed complaints were closed within 40 working days of receipt, the Trust standard, a slight decrease from the first six months of the year. Of the 7 complaints closed after 40 days; all were negotiated and agreed with the complainant, 6 were either due to our request due to staff leave, or time for the service to meet the complainant in line with best practice, or on the request of the complaint. One was due to issues with other organisations delaying providing their response again the complainant was kept always informed.

4.6 Of the 29 complaints closed during this period, 19 were fully or partially upheld and 10 were not upheld.

4.7 From 1 July to 31 December 2021, the Trust received 330 concerns an increase of 42 from the last reporting period. The number of concerns reported for this period is higher than the same period last year (220) which may be an impact from service resetting. 132 concerns related to access and availability, including appointments, the majority related to Leeds Sexual Health Services 43 (33%), Community CAMHS 27 (20%) and Podiatry 20 (15%).

4.8 The Trust has received a total of 508 compliments between 1 January 2022 and 30 June 2022. This is higher than the previous report (431).

4.9 The team have been working to gain a better understanding of equity data in relation to complaints raised. Progress on this has been impacted due to 3 of the 4 substantive posts being vacant for a while and the final team member being on maternity leave. All posts have been recruited to and will be in place by September 2022. Decisions around the best source of data to use will be completed by end September 2022 with exception reporting into the performance brief by October 2022.

5.0 COVID- 19

5.1 The Trust received seventeen concerns and two complaints where the complainant cited Covid-19 as related to their concerns during this reporting period.

5.2 The two complaints were regarding access to MSK and Leeds CAMHS services and have both have been responded to.

5.3 The seventeen concerns related to seven services across the Trust with the majority citing issues with access and appointments (7/41%). These services were Long Covid Team, Leeds Sexual Health Service, MSK and Podiatry.

6.0 PATIENT EXPERIENCE (COMPLAINTS) TRAINING

6.1 Due to capacity within the Patient Experience Team, and within teams to attend training, there have been no complaint training sessions delivered between

January and June 2022. Support has been provided to teams where needed and guidance given. A revised Managing Concerns and Complaints Training will be rolled out in the autumn of 2022, following bespoke sessions for services started in Spring 2022.

7.0 OVERARCHING THEMES FROM CLOSED COMPLAINTS

7.1 The top three subjects for LCH's complaints closed during period 1 January – 30 June 2022 were:

Clinical judgement and treatment
Attitude, conduct, cultural and dignity issues
Communication issues with the patient, including written patient information

The top two issues for complaints closed in the previous 6 months remain the same, being:

Clinical judgement and treatment
Attitude, conduct, cultural and dignity issues (includes Staff attitude and communication)

7.2 Complaints citing Clinical judgement and treatment

7.2.1 In line with national reports "Clinical judgement and treatment" continues to be one of the top three subject areas for complaints at LCH for the past 5 years. Between 1 January – 30 June 2022, 36% (17 out of 47) of complaints received were due to issues around clinical judgement and treatment. Adult Business Unit reported eight complaints where this was cited as a subject, Specialist Business Unit had five and Children's had four.

7.2.2 An example of learning and improvement in this area is the need for continual review and changes in practice as part of end-of-life care. Following a complaint question raised regarding the timeliness of information provided for carers whose family member is receiving end of life care, Clinical Service Manager (Palliative Care and Community Cancer Support Services) reflected on their guidance for information on carers and updated the training and development programme to reflect the need for giving families more opportunity to ask questions and discuss their queries.

7.3 Complaints citing attitude, conduct, cultural and dignity issues

7.3.1 21% (10 out of 47) of received complaints between 1 January and 30 June 2022 cited issues concerning attitude, conduct, cultural and dignity, and was the second most common area for complaints received. The number of complaints related to attitude, conduct, cultural and dignity issues was highest in the Specialist Business Unit with five complaints received, followed by the Children's Business Unit with three and Adult's Business Unit with two.

7.3.2 An example of learning following a complaint around this subject is how the Podiatry Service have reviewed how they introduce themselves to patients both in clinics and during home visits in line with “Hello My Name is …”. The service now use first and last names. This followed a concern that the patient did not know who they were talking to and felt that giving a first name only did not show respect.

7.4 Complaints citing communication issues with the patient

7.4.1 For the period 1 January to 30 June 2022 17% (8 out of 47) of all complaints received highlighted communication issues, including written case notes with the patient. The Specialist Business Unit received four complaints, the Adult Business Unit three and Children’s Business Unit one complaint.

7.4.2 An example of learning following a complaint around this subject is the need to ensure when considering new providers of essential clinical products, in this case for enteral feeds there should be a way to involve users and hear their views. This is particularly important if there will be changes in the product they receive. The Home Enteral Feeding Service spent a lot of time with individual patients and their families which was appreciated but it was recognised that it could have been better. The learning from the complaint has been shared with the contacting team involved with enteral feeds changed and patients and their families asked for their ideas how this could be managed differently in the future.

8.0 CLAIMS

8.1 LCH has received eight possible claims between 1 January and 30 June 2022 of which two have proceeded to actual claims, supported by NHS Resolution.

8.2 Of the two new claims both are under Clinical Negligence Scheme for Trusts and are related to clinical care provided by Tissue Viability and by MSK.

8.3 Two potential claims have been closed after agreement that the Trust is not involved and a further six claims have been closed by NHS Resolution. Two non-clinical claims were closed under the Liabilities to Third Parties Scheme. One claim was withdrawn by the claimant. The other three clinical claims were closed under Clinical Negligence Scheme for Trusts.

9.0 **FRIENDS AND FAMILY TEST**

9.1. During the reporting period of 1 January and 30 June 2022 there have been 2629 Friends and Family Test (FFT) responses, this is an increase on the previous six months. The overall percentage of patients or their carers reporting a very good or good experience was 92.24%, with 3.65% stating the experience was poor.

9.2 The increase in the number of responses to the FFT has been due to work by Engagement Champions in services along with the Business Unit Quality Leads.

9.3 To increase accessibility the FFT is available in print and online. Services have been creative in sharing the online URL and QR codes for example via text message, email, creating posters and laminating copies of the QR code to carry with them on visits and in clinic appointments.

9.4 There are also an easy-read version and the online version has been translated into the top 5 used languages in Leeds (Urdu, Punjabi, Polish, Romanian and Slovak). Services can use Trust interpretation and translation procedures if the need other languages. The languages being translated will be reviewed in December 2022, with colleagues from HealthWatch.

9.5 Use of the FFT continues to have impact, although it should not be seen as on the sole patient engagement activity undertaken by Trust. Other Patient Engagement activities are reported in the Patient Involvement Strategy update.

9.6 An example of change is following comments to the MSK service regarding the lack of face-to-face appointments, difficulties with virtual or telephone appointments, lack of communication, and arrangement of appointments. The service has;

- reviewed how they manage patients' expectations around appointments and how options are discussed and shared with patients.
- started planning an Always Event project on how virtual and telephone appointments are offered.

9.7 Another example is when Leeds CAMHS received feedback relating to a poster in the waiting area at Kirkstall Health Centre being inappropriate. The service Engagement Champion reviewed the comment with Youth Board colleagues, and CAMHS service managers, resulting 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.

9.8 In addition to the FFT, services continue to develop specific surveys with support of the Patient Experience Team, which complement the FFT for example:

- Community Diabetes Freestyle Libre Glucose Monitor Survey to see if patients with a learning disability, who have been fitted with a glucose monitor with the aim of better understanding their experience of using the monitor.

- Children's Speech and Language Therapy (CSLT) Complex Communication Autism Assessment Parent Training Survey aiming to help evaluate how helpful current training is and where improvements can be made.

- Podiatry Neighbourhood Team Patient Survey aiming to hear from patients who have recently been seen by a Podiatrist as part of a new service pathway, to find out what worked well seeing a Podiatrist prior to Neighbour Team intervention and what could be improved moving forward.

10.0 NEXT STEPS

10.1 The post of Complaints and Claims Officer, currently vacant will be filled in September 2022 as will the Patient Engagement Officer post.

10.2 The Patient Experience Team will be reviewing their current complaint management processes in line with the Draft Parliamentary and Health Service Ombudsman (PHSO) Complaint Handling Guidance (2022), this will include roll out of training for staff

10.3 Work to support the implementation of the Health Equity and Third Sector Strategies will continue to help improve access and experience of vulnerable communities and those at highest risk of health inequalities.

10.4 To participate in the Patient Involvement Strategy review 2022

11.0 RECOMMENDATIONS

The Board is recommended to:

Receive this report

Note the updated information

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (56)

Title: Bi Annual Patient Safety Report

Category of paper: For assurance

History: Quality Committee 25 July 2022

Responsible Director: Executive Director of Nursing

Report author: Incident and Risk Assurance Manager

Executive summary

A report on Patient Safety is produced bi-annually to provide the Board of Directors with the assurance that Patient Safety is being well managed, the incidents are appropriately investigated, and that learning is acted upon to improve patient care.

Patient Safety is inclusive of patient safety culture, patient safety incident management, and the management of Central Alert System notifications that affect the safety of patients.

Recommendations

The Board of Directors are recommended to:

Receive and note the contents of this paper
Provide any feedback as required

1.0 BACKGROUND

This report will provide an overview of our work within Patient Safety in the last six months. The report will focus on the learning emerging from incidents, how the learning is being shared and how we are providing assurance that learning is being embedded to ensure continuous quality improvement.

The report will provide an overview of our concordance of the Central Alert System patient safety notifications.

2.0 PATIENT SAFETY AND INCIDENT MANAGEMENT

LCH continues to complete readiness work for the implementation of the Patient Safety Strategy. A city-wide Patient Safety Strategy Partnership Group has been established and is led by LCH and the Integrated Care Board.

The group meets monthly with representatives from partners across Leeds. Leeds Teaching Hospital Trust (LTHT) are an early adopter of the Strategy and have developed their Patient Safety Incident Response Plan and are now working within the Strategy. LTHT have shared their progress with the group including areas of success and challenge.

There is an LCH Patient Safety Strategy Implementation Plan that has been refocused this period to areas where we can make progress whilst awaiting the formal national launch. Our focus has been on involving patients and we have secured an informal patient safety partner who has engaged with LCH on an initial six-month voluntary agreement to complete bespoke pieces of work.

The required policy and job description have been developed for the formal Patient Safety Partners. We are considering how best to progress these roles with the support of the ICB to reflect a Leeds wide approach.

As we await the national launch of the Patient Safety Strategy we have adopted the ethos of the Strategy to investigate less and learn more. We do continue to hold three Rapid Review meetings per week to assess whether any moderate harm or above incidents require external notification as Serious Incidents and further review.

We have also tested different methodologies in our Serious Incident reports this period in agreement with the ICB. This will support the adoption of the different approaches to review once the Strategy is launched and our Patient Safety Incident Response Plan is completed.

Within this we have developed significantly more robust Rapid Review reports that has meant we can gain the learning at an earlier stage and have much greater understanding of the incidents. This has meant less incidents have transferred to Serious Incident.

Sickness and absence in Adult Business Unit clinical teams has contributed to delays within the Rapid Review process that is currently working within a 3 month backlog. A new team of Clinical Incident Management Practitioners (CIMPS) has been developed by the Adult Business Unit with the support of the Clinical Governance Team. The team are dedicated to incident management to address the backlog and become expert incident management practitioners. This has also resulted in the more detailed reviews being completed. There is a risk assessment in place for the delays within the management process.

Our compliance with Duty of Candour and external reporting has reduced in the previous two months. This is being reviewed to understand where further support can be provided, both at a clinical team level and within the Clinical Governance Team. Initial assessment has identified staff sickness, both in clinical teams and the Clinical Governance Team that has impacted business continuity.

The areas of highest incident reporting are detailed within the bi monthly Performance Brief and the monthly Business Unit reports in addition to the Serious Incident report that provides a detailed overview of serious incidents over the period.

3.0 THEMATIC REVIEWS AND LEARNING

The Clinical Governance and Business Intelligence Teams supported by the Health Equity Lead are working towards ensuring there is a health equity focus within incident management to understand how themes and learning link to equity. A dataset of deprivation deciles, ethnicity and age have been created for Falls, Pressure Ulcers and Access incidents. The teams are now checking data quality and assessing how the data can be consistently produced in a way that can be used to inform learning and actions from incident management.

Monthly Patient Safety Workstream meetings have continued wherever possible. The meetings are a forum for sharing information to promote oversight of Patient Safety within the context of the Business Units and teams. The meetings have identified clear areas for thematic review and deep dives within teams or incident categories. The deep dives provide assurance or highlight recommendations to improve service provision. The reports, findings and outcomes from the deep dives are reported in the Quality Lead monthly report and the bi monthly Performance Brief.

The completed deep dives and thematic areas of learning are shared in the monthly Quality Lead Business Unit report. Details of these reviews are captured below, presented by Business Unit:

Adult Business Unit

Seacroft Neighbourhood Team

An assurance deep dive for Seacroft NT is ongoing, this has been paused due to absence and will restart as soon as possible.

Delayed referrals to podiatry and lack of embedding lower limb pathways of care

A recurring theme was noted from Rapid Review and Serious Incident investigations regarding the lack of adherence to the lower limb pathways for care and delays with referring patients with foot wounds to podiatry. In response, the clinical care framework for lower limb wounds was re launched and a new specific wound assessment template for lower limb wounds was launched to support embedding the learning into practice.

Transcribing Medication Errors
Following an increase in incidents relating to transcribing anticipatory medication for patients approaching the end of life, an additional 0.5 WTE of a Pharmacy Technician was prioritised for Seacroft where some of the incidents are concentrated. Recruitment is ongoing. Seacroft is a locality with a high and complex caseload who receive a higher number of patient referrals requiring end of life care when compared to other teams.

The Palliative Care Lead worked with the Medicines Safety Officer to produce a learning from incidents poster that was circulated (Appendix One). Incidents reduced in Q1, with only one incident relating to transcribing in Seacroft.

End of life care/symptom management
Feedback was received from 2 families stated they felt alone with loved ones and did not feel that patient symptoms had always been managed as well as they could have been in their last hours of life. One family are interested in making a video and another would like to write their experience down to possibly be shared in staff training sessions. The Patient Engagement Team and End of Life Specialist Nurse are progressing this opportunity to improve service delivery through the eyes of the patient and family.

Falls
A deep dive into a highlighted concern about the increasing number of moderate and major harm falls incidents within ABU in Quarter 2/3 2021 was completed. The review found there was recurrent learning in relation to: reduced concordance with completion of falls risk assessments or delays in completion; a specific lack of awareness of the risk of osteoporosis or follow up action to support those patients with bone protection; a lack of insight into the risk of postural blood pressure or follow up to either provide safety netting advice to patients or to consider any medication impacted low blood pressure; recognition, prioritisation and planning of physiotherapy intervention to rehabilitate patients and reduce their risk of falling.

Recommendations from the review were made to improve falls assessment. These will be monitored by the Falls Steering Group.

Pressure Ulcer Management
Following discussion at the Pressure Ulcer Steering Group, the Self-Management Team are planning to support patients to self-manage their own pressure ulcer prevention to promote greater insight and understanding by patients into the need to relief pressure, how to relief pressure effectively and the risk of not reliving pressure. An Equity and Quality Impact Assessment is being completed.

Leaking Bio-Connectors

A theme of leaking bio connectors for picc lines was escalated to the manufacturer in February 2022 and shared across the Business Units for awareness raising.

Non-invasive ventilator
A colleague thought the blank screen meant the machine had self-turned off and accidently turned the machine off for a period of five minutes prior to realisation. This was assessed to be a potential serious incident and resulting in Service wide learning. Training has been delivered to the team involved and a learning from incidents poster completed for circulation to all teams' and services in the Business Unit.

Children's Business Unit

CAMHS

A review of the complaints and concerns within CAMHS was undertaken in May due to an increase in concerns and complaints since February 2022. There is further work ongoing to review whether these relate to LCH care or Clinical Partners. To support this Clinical Partners have been added as a team to Datix. The review found that the overall referrals have significantly increased in the last 4 years, but the overall percentage of complaints has not, concerns are starting to show a rise in numbers, however due to total referrals the incidence remains low.

Information Governance incidents continued to be one of the highest reporting categories. Work took place to reduce these incidents in Q1. This included the circulation of Learning from Patient Safety Memos, one for Patient Identity Checks (CAMHS) and Patient Identity Checks – Insulin, both were circulated within the three Business Units.

Incident category access, appointments, admission, transfer, and discharge
Following a deep dive in February 2022 to review patient safety incidents in 2019 - 2021 within CBU, it was agreed a further dive should be undertaken to review the access, appointments, admission, transfer, and discharge incidents.

The review focussed on the period from April 2021 to March 2022 due to a spike in incidents. There was a total of 87 incidents. There were three main subcategories of the incidents, appointments (27), problems with referrals (26) and appointment other (24). The review found that the highest reporting team were ICAN followed by CAMHS, 0-19 PHINS, Children's SLT and Children's Community.

Key findings related to failures within referral process, that did not however impact on appointment timescales, and delayed referrals that did not result in harm. A new emerging theme for March 22, related to Paediatrician cover for the child protection medical clinics, this is a staff issue rather than an access issue and is detailed below. The review also found incidental learning of data quality as several incidents were incorrectly categorised or were not LCH incidents.

The review concluded there was evidence of work undertaken to improve processes, with new systems in place. It was evident that Covid had an impact on

these systems and some of the delays. There was no resulting harm and human factors were a theme within some of the incidents.

Child Protection Medicals
The issue regarding the cover for the Child Protection Medical Clinic has continued. This has impacted on the Paediatric Neuro disability Clinic where one clinic had to be cancelled affecting 5 children as the Child Protection Clinic took priority.

A risk assessment and options appraisal is underway and is being escalated via the Performance Report to the Quality and Performance Panel. The risk score will initially be high due to the risk to the child.

Specialist Business Unit

Health and Homeless Integrated Team
A deep dive of complex incidents reported by the Health and Homeless Integrated Team (HHIT) was completed. It was evident from the deep dive that there was an emerging theme around lack of housing options in Leeds, safeguarding and modern-day slavery. This was highlighted to all services across LCH for awareness and escalation to appropriate services if required. HHIT is continuing to learn and understand the signs, escalation routes and points of referral to enable support. The team have enrolled on training with the charity 'Hope for Justice'. An action plan was developed from this deep dive.

Adult Speech and Swallowing Team
A deep dive in the Adult Speech and Swallowing Team was completed to assess the expected/unexpected death incidents over the period 1 January 2019 to 31 December 2020 for any contributing factors from being on a waiting list. The deep dive provided assurance that all patients were triaged appropriately and offered an appointment at appropriate times. The deaths were not directly related to the waiting times within the service. The review found that more patients were waiting over 18 weeks, resulting in more deaths being reported via Datix. Findings and learning did relate to patients who were palliative and may not have received quality care and offered comfort at this stage. The service created an action plan to mitigate the risks. This is regularly monitored by Service, Senior Managers and the Clinical Governance Team.

MSK
An MSK deep dive (triangulated through incidents and feedback) was completed to understand if there has been any impact of the service stopping and resuming at times in the last 2 years. The review concluded that there were no reported patient safety incidents in relation to the waiting times in MSK. A theme for learning from the review related to managing patient expectations in relation to clinical judgement, and the use of virtual treatment. Additional learning was to document all discussions in the patient record.

It was recommended that the service explore how to improve patient experience in relation to the theme highlighted in this report, create an action plan and share in the Performance Panel meeting.

Podiatry
Concern was raised by the Infection Prevention Team regarding an increase in incidents related to scalpel blades not being removed when sending instruments packs for sterilising. The service has completed an audit and action plan which has been shared in the Business Unit report. The audit will continue.

Secure Estates
There was an increase in number of self-harm incidents within the Secure Estates over the preceding six months. A previous deep dive had been completed in June 2021. This deep dive encompassed incidents in the last 12 months, with increased focus on the last six month period.

The review concluded that the service had a good reporting culture embedded within the team. And demonstrated an increasing incident trend over the previous 4 months. The increases related to the self-harm category and the incident harm level has also increased since February 2022. All moderate harm incidents were reviewed at the Rapid Review meeting and no lapses in care were noted.

The top two categories reported were ‘abusive, violent, disruptive or self-harming behaviour’ and ‘medication’ However, the number the medication incidents had stabilised and remained within the confidence intervals

Assurance
During the period we have embedded a post Serious Incident audit process whereby every Serious Incident action plan has an action for the actions to be audited where possible. The audits should be initiated three to six months after the action plan is fully completed and a due to start being completed. In addition, all Falls or Pressure Ulcer Serious Incident reports are shared with the respective steering group to assess for themes and to consider against the steering group improvement plan.

5.0 CENTRAL ALERTING SYSTEM SAFETY ALERTS (CAS)

There were 52 alerts assessed by the Patient Safety Team during the six-month period. Of those, 40 were assessed to be inapplicable eight were shared for information only with the relevant services. Four were assessed as requiring action:

5 May 2022 Risk assessing **Potassium permanganate. This is routinely used in the NHS as a dilute solution to treat skin conditions**. It is not licensed as a medicine. Risk assessments must be completed when prescribing. Action underway. Due 4 October 2022. **Open.**

25 April 2022 A recall of **Outdated version of the Patient Information Leaflet (PIL) included in batches of Depo-Medrone with Lidocaine (Methylprednisolone acetate and Lidocaine hydrochloride).** Affected batches recalled in MSK and Podiatry. **Closed.**

17 May 2022 Instruction to take **Immediate actions following confirmed cases of MPX virus.** The actions are:
1. Providers to ensure that they have appropriate PPE for the assessment and treatment of patients presenting with possible MPX virus.
2. Services should consider a differential diagnosis of MPXx virus in any patient who meets the possible case definition in the attachment.
3. Inform local IPC teams and infectious disease/microbiology/virology consultants if a diagnosis of MPX virus is being considered so that appropriate testing and infection control measures can be implemented. Actions completed. **Closed.**

22 May 2022 **Urgent message following detection of Vaccine Derived Polio Virus type 2 in London sewage samples**. Action required: Services to undertake a Polio vaccination check and offer. Primary care colleagues and school aged immunisation providers should:
1. Opportunistically check that patients are up to date with their polio-containing vaccines and catch-up anyone who is un/under vaccinated. This is particularly important in practices where vaccine coverage for the primary DTaP/IPV/Hib/HepB course is below 85%.
2. Check immunisation status of newly registered children and adults with a particular emphasis on new migrants, asylum seekers and refugees. Bring them up to date with the UK schedule at the earliest opportunity.

Catch up clinics are already established, 0-19 complete movement in immunisation checks in visits and there is a Leeds wide discussion regarding any further action required. **Open.**

During the period NHS England issued a list of Enduring Standards that detail previous CAS Alerts that must be embedded in practice. Escalation has been completed via the Clinical Governance Report regarding an area of non-concordance with the Local Safer Surgery for Invasive Procedure (LocSIPPS) in Dental. The remaining standards are currently being reviewed.

A monthly meeting is now held with the Patient Safety Team, Quality Leads, Medicines Safety Officer, Medical Device Safety Officer and Head of Clinical Governance to review and close the alerts to ensure there is robust assessment and panel agreement to close.

A detailed overview of the CAS Alerts received and managed will continue to be contained in the bi monthly Performance Brief.

6.0 Recommendations

The Board of Directors are recommended to:

Receive and note the contents of this paper.

Provide any feedback as required.

Appendix One – Transcribing Medication Errors Learning Poster

Learning from Incidents

Leeds Community Healthcare NHS Trust

Team/service Adult Business Unit

What happened

Incident title

Differences in Leeds Community Healthcare NHS Trust (LCH) and Leeds Teaching Hospitals Trust (LTHT) Guidance for end of life anticipatory medication

This happened

- There have been transcribing errors and prescribing delays due to a lack of understanding about the differences betwteen LCH and LTHT guidance
- GPs have queried the need to re-prescribe
- This has led to near misses and potential delays in symptom management for palliative patients
- Summary of key differences between guidance:
  - First line opioids; LTHT recommends Morphine Sulphate and LCH Diamorphine
  - LTHT guidance does not include use of ranges for opioids
  - LTHT guidance includes lower dose Levomepromazine (2.5mgs) for nausea
  - Medicines are dispensed from LTHT labelled in mls rather than mgs
  - Dose intervals are1 hour in LTHT and 30 mins in LCH guidance

Changes made to avoid recurrence

- LCH and Specialist Palliative Care partners have worked together to minimise the differences between LCH and LTHT guidance
- A range of end of life symptom management and prescribing guidance is available on EPaCCS (Electronic Palliative Care Coordination System)
- Clinicians can access advice/support e.g. Palliative Care Leads, Medicines Management, Specialist Palliative Care Teams and GPs
- Increase in Non Medical Prescribers available in Neighbourhood Teams that are confident to prescribe anticipatory medication at end of life

Lessons learnt

- Assess the urgency to re-prescribe and transcribe
- If symptom management is needed urgently LTHT prescribed medication can be transcribed and administered according to the EDAN; a review from a prescriber should be requested at the earliest opportunity
- Refer to medication information on the EDAN to support transcribing e.g. to convert mls into mgs
- Refer to LCH Independent Prescribers in the first instance wherever possible
- Consider whether prescribing deviates from guidance because it is patient specific e.g. renal impairment
- Anticipatory medication prescribed in accordance with LTHT guidance is a valid prescription
- Guidance' allows clinicians to use clinical judgement, clinicians must assess if prescribed doses are 'reasonable and appropriate' even if not in line with LCH guidance

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

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (57)

Title: Serious Incident Summary Report

Category of paper: For assurance

History: Quality Committee

Responsible director: Executive Director of Nursing and Allied Health Professionals

---

Report author: Incident and Risk Assurance Manager

Executive summary

A report of the Trust's management of serious incidents is produced bi-annually to assure the Board that Serious Incidents are being investigated and managed effectively. The report provides assurance that learning is acted upon appropriately to improve patient care and experience.

All Serious Incident are subject to an investigation to understand the cause/s and contributing factors to the incident. The investigation seeks to understand the chronology of events and the possible reasons the care has not been delivered in line with the expected standard.

The investigation process explores LCH systems, processes and contributory factors to patient safety incidents to identify learning for improvements and reduce the risk of reoccurrence

The learning identified, and reflected within this report, has been shared with individuals, Services, and across the Business Units as appropriate to facilitate reflection, discussion, and improvement.

Recommendations

The Board are recommended to:

- Receive and note the contents of this paper.

Serious Incident Report

1 Introduction

This paper specifically considers LCH patient safety incidents, which have been reviewed and reported as serious incidents following the guidance from NHS England's Serious Incident Framework, published in March 2015. LCH is also incorporating guidance from the National Patient Safety Strategy 2019.

Upon completion of a Serious Incident investigation, the resulting report is reviewed by a panel held within forty-five days. The panel is chaired by either the Assistant Director of Nursing and Clinical Governance, the Assistant Director of Allied Health Professionals and Professional Practice or the Head of Clinical Governance. The report is then approved for submission to the Service's commissioner by the Executive Director of Nursing and Allied Health Professionals or Executive Medical Director.

2 Background

A report on serious incidents is produced bi-annually to assure the Board of Directors that the incidents are being managed, investigated, and acted upon appropriately. The report also assures that action plans are developed from the investigations to ensure patient safety, care, and experience improvements.

Action plans are developed to ensure that learning identified from the investigations is considered from the process and system perspective. Where individual learning is identified, appropriate supportive actions are implemented to ensure colleagues and teams are supported to learn and develop.

A selection of serious incidents is identified every quarter to be shared via the LCH Safety Summit.

3 Strategic Executive Information System (StEIS) reportable Serious Incidents for the Reporting Period.

The Trust reported twelve Serious Incidents on the StEIS system during the reporting period (January 2022 to June 2022). Following further review, four were de-logged from StEIS as not meeting the serious incident criteria these are:

- 2x Patient Falls
- 1x Unstageable Pressure Ulcer
- 1x Information Governance

Therefore, eight progressed to a full Serious Incident investigation with Skin Damage remaining the highest reported SI category.

Serious Incidents by Category and Quarter Reported
Table 1

Incident Category	Jan - Mar	Apr - June	Total
Diagnosis, failed or delayed	0	1	1
Information Governance / Records	1	0	1
Medical device/equipment	1	0	1
Medication	0	1	1
Patient accident that may result in an injury	1	1	2
Skin Damage	4	1	5
Treatment, procedure	0	1	1
Total	7	5	12

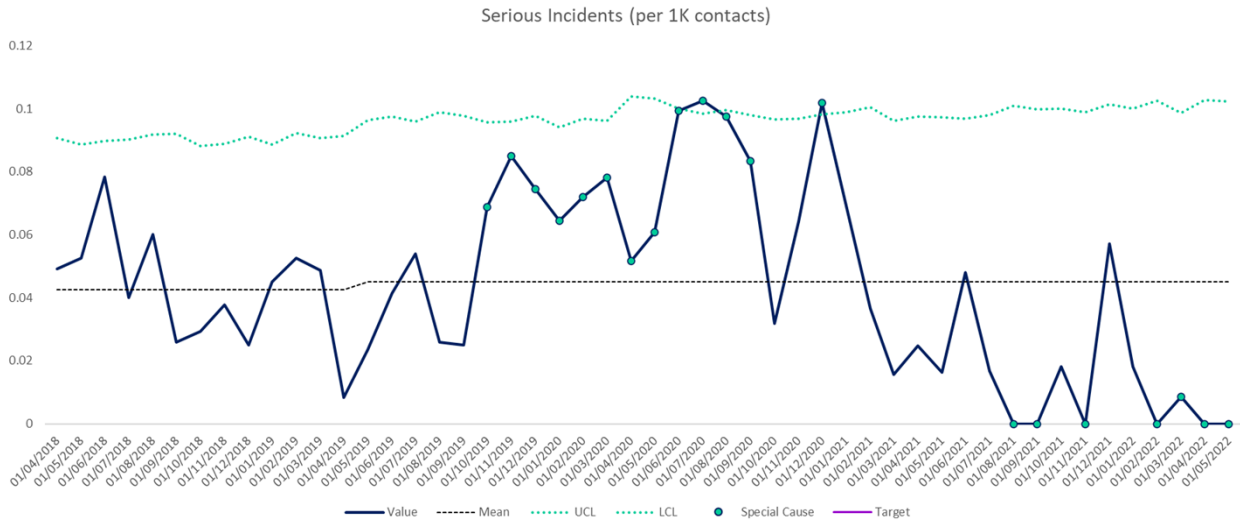
As of 12th July 2022, four of the incidents above remain under investigation. Four have been completed and finally approved by the Executive Director of Nursing and Allied Health Professionals. The action plans generated from serious incident investigations are agreed at the final review meeting and added to Datix® for monitoring purposes.

After the Serious Incident investigation has been concluded a dedicated action planning meeting is held, to ensure learning is captured in action plans and can be measured / monitored for completion.

The Trust has not recorded any Never Events in this reporting period[1].

Serious Incidents Rate

Table 2



[1] Never Events Policy - NHS England » Never events

The Statistical Process Control (SPC) graph shows the rate of SIs per 1000 contacts is within expected limits. Since January the rate of incidents per 1000 contact has consistently been below the mean, this is due to multiple reasons including the robustness of the Rapid Review Meetings with quality reports presented and the Trust continued journey to implement the national Patient Safety Strategy that aims to investigate incidents in a more meaningful way to gain the most learning.

This year, there is a stronger emphasis on learning. Following each review, learning and actions are identified and shared with specific Teams and the relevant Business Unit via the Datix action function and assigned to a responsible person with specific timescale of completion. The Trust has worked hard to integrate lessons from prior incidents to prevent recurrence, including how we care for our elderly and vulnerable patients.

StEIS Reporting Timeframe in Quarters Four and One 2022/23

During this reporting period, six of the eight incidents (83%) reported on StEIS were reported within 48 hours of the Rapid Review Meeting decision, in line with national requirements.

The remaining two (17%) incidents were reported on day four. The delay with the first was related to an IT issue and was escalated to Leeds Integrated Care Board (ICB), who supported completion. The second delay related to a similar issue, which was resolved locally by the Patient Safety Team.

Serious Incident Outcomes

Of the 12 serious incident investigations declared, eight concluded that there were lapses in care. The remaining four were confirmed at the 25-day and 45-day meetings to have no causative / contributory lapses in care; however, significant learning was identified for the teams involved and the incidents delogged on StEIS.

Rapid Review Templates

Following a request from the community nursing service, a specific meatal tear template has been produced in collaboration with the Continence Urology and Colorectal Service (CUCS). The aim was to prompt high quality rapid review investigations and to reap early learning in relation to meatal tear incidents, that have resulted in moderate harm. The change has resulted in improved quality of rapid reviews and a reduction of further information requests to Services to conclude rapid review conversations.

Learning from closed SIs January – June 2022

The learning from the concluded serious incidents is shared with the reporting teams using the leaflet for learning. The most frequent learning identified from Investigations from the reporting period were:

- To ensure regular review of patient management and care by registered staff.
- To ensure daily discussion of concerns in cluster handover and safety huddle to ensure senior staff overview of patient management and care
- The importance of establishing patients' mental capacity status to confirm consent to treatment and care.
- To improve documentation concerning regarding handover and escalations of concerns pressure risk assessment and management.
- Ensure clear communication of end-of-life planning from team to GP
- The importance of ensuring all components of the initial assessment is completed to ensure correct plan of care is in place to meet patient's needs.
- The importance of monitoring patients' nutritional status and weight in relation to managing risk for development of pressure ulcers.

4 Risks

Recurring Themes

Incorrect categorisation of incident and harm levels remains a theme in incidents that have been reported. There is an ongoing discussion within the Patient Safety Team to increase access to Datix user training by developing a podcast training video to share with Services via Mid-day Brief and the My LCH - Patient Safety page.

The Datix System Manager has provided some one-minute guide to support staff with common housekeeping procedures in Datix; these are available via the My LCH Patient Safety page.

Datix

As part of the review and validation of incidents within datix, it was recognised that changes had been made to the Datix Software, resulting in an unintended reconfiguration of the system, The amendments have caused changes to notifications, loss of dashboards and potential data loss. Some key purpose-built report queries in datix that aided real-time incident review and management, robust report writing, and data extraction are no longer available. This resulted in the need to develop and implement manual processes to produce the information to adequately support decision-making and assurance which creates a delay.

The Patient Safety Team have completed a risk assessment on 25th May 2022 and shared with the Risk Management Team and the Head of Clinical Governance.

There is a planned remodelling of Datix to ensure the system is streamlined and clinically driven to support more accurate and robust incident data.

5 Assurance

During this reporting period, the patient safety team completed a review of the incident reporting and serious incidents process, in line with the Patient Safety Strategy 2019. The review evaluated the robustness of processes in place for identifying, investigating, reporting, and managing incidents. This included how lessons learned are identified, communicated, and disseminated across the Trust. Following the audit, a suggested action is that the Quality Lead would complete a final review of Serious Incidents in datix with a final data cleanse and quality assurance checks before closure.

Patient Safety Summits

Following the national Patient Safety Strategy, the Trust has demonstrated its commitment to ensure maximum learning is identified and shared to enhance wider learning across the Trust including instigating Patient Safety Summits. We have held one Patient Safety Summits in Quarter 4. Due reduced capacity within the Clinical Governance Team, the Quarter 1 summit was cancelled; this will be rescheduled in August 2022 when the Team capacity has returned to normal.

Preceptorship and Pressure Ulcer Training

Pressure Ulcer Prevention training has been incorporated into the LCH Preceptorship programme core week for all Business Unit staff and all disciplines. Once established, this will also be captured in the central recording system. Ad-hoc training and supervision about Pressure Ulcer prevention and management took place within the Neighbourhood Teams through the re-deployment of the Tissue Viability Nurses during the pandemic.

Serious Incident Investigation Templates

During this reporting period, an Internal Concise Serious incident template was developed to ensure consistency in reporting, support improvement in recording, and enhance the quality of investigations.

6 Duty of Candour

All incidents in this report are subject to the statutory Duty of Candour process as notifiable safety incidents. Incidents are considered in line with the serious incident criteria at a Rapid Review Meeting. The team providing care informs the person/people affected, gives an apology, explores any requirements for the investigation from the patient or family perspective and explains the LCH investigation process.

The Service populate the letter confirming the initial discussion and it is posted by the Patient Safety Team. The CQC Regulation 20 states this should occur as soon

as practicable. Within LCH, we have continued to monitor our performance against a ten-day timeframe.

One serious incident during this period did not achieved this standard, as a letter was not sent to the family within the required timescale by the team; this was not followed up due to reduced capacity within the Patient Safety Team. However, a duty of candour conversation was held between the Service and family within ten working days.

Of the remaining eleven cases: two stated they do not wish to have any communications sent to them; two, the team have been unable to contact (several unsuccessful attempts have been made and the letters have been completed and saved in Datix should a next of kin contact LCH); seven met the Duty of Candour regulation.

Recommendations

The Board are recommended to:

- Receive and note the contents of this paper.

Trust Board meeting held in public: 5 August 2022

Agenda item number: 2022-23 (58)

Title: Health and Safety Compliance Report

Category of paper: for assurance

History: Business Committee 27 July 2022

Responsible director: Executive Director of Finance and Resources

Report author: Risk and Safety Manager

Executive Summary

This report provides information on the current level of compliance with health and safety legislation and policies. It also provides an update on the developments and effectiveness of the Trust's health and safety management system. It informs the Committee that developments are being made towards addressing the missing elements of the health and safety management system that are required to ensure continuous improvement of health and safety performance.

The Committee is particularly asked to note:

- There have been four work-related injuries reported to the Health and Safety Executive under Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 2003 (RIDDOR) since January 2022.

- Whilst some progress has been made, there are delays in meeting the timescales set out in the Risk and Safety Team action plan due to:
    - Unplanned absences of the Risk and Safety Team
    - The lack of availability of staff from other services/departments
    - The increasing reactive workload resulting from information requests, accidents and incidents, and in-depth investigations

- Roles within buildings for security, fire and first aid require review to ensure that there are adequate numbers of trained staff available to respond in an emergency. This remains difficult as there are very few, if any, staff within each building who consistently occupy the building throughout the week. Staff whose roles would lend themselves to these kinds of duties are now more likely to be working from home at least some of the time.

- The legal compliance audit of Leeds Community Equipment Service identified breaches against ten different legal requirements, but also good practice and improvements have been acknowledged.

Recommendations

The Board should note the progress made with implementing the health and safety management system and arrangements and that a risk-based approach is being taken to progress any work that has been delayed.

1. Introduction

'Looking after the health and wellbeing of staff is far more than supporting staff to develop healthy lifestyles;: there is a legal duty to protect as detailed in the NHS Constitution'. NHS Workplace Health and Safety Standards.

This report provides the Committee with a summary of the principal activities and outcomes relating to the promotion and management of health and safety within Leeds Community Healthcare NHS Trust, since the last report was received in January 2022.

It provides a review of the management arrangements, legal compliance, accident performance data and health and safety activities and describes further planned activities which are required to strengthen the health and safety management system in order to fulfil the Trust's health and safety obligations.

2. Background

It is Leeds Community Healthcare NHS Trust's (LCH) staff who deliver the organisational objectives and therefore it is important to ensure the continued health, safety, welfare and development of the workforce and to minimise the distress and disruption caused by any injuries or work-related illnesses which may occur.

LCH's aim is to provide and maintain a safe and healthy environment. This can only be achieved through effective leadership by senior management, participation of all staff and open and responsive communication channels.

The Trust is required to monitor and review its arrangements for managing occupational health and safety, to ensure legal compliance and demonstrate that continuous improvements are being made to protect the workforce, visitors and third parties who may be affected by its work activities (Health and Safety at Work etc Act 1974).

The Health and Safety Executive (HSE) advises that a formal Board review of health and safety performance is essential. It allows the Board to establish whether the essential health and safety principles – strong and active leadership, worker involvement, and assessment and review – have been embedded in the organisation. It tells a Board whether its system is effective in managing risk and protecting people. In LCH this is met through an annual report on compliance to the Board, and 6-monthly reports to the Business Committee in order that it can assure the Board on progress towards compliance.

3. The Risk and Safety Team

The Management of Health and Safety at Work Regulations 1999 requires the Trust to appoint one or more competent persons with sufficient training, experience and knowledge to advise and support the Trust to meet its legal requirements.

The Risk and Safety Team structure which includes the regulatory competent persons is detailed in the diagram overleaf.

Risk and Safety Team structure

It should be noted that there is a high dependence from a very small number staff members to carry out these specialised job roles. Due to the complexity of skills, knowledge and specific training requirements, there is a risk that if a staff member were to leave the Trust or become unable to attend work, the existing team members would not have the capacity nor competence to fulfil the duties of their colleagues. A business continuity plan is in place to mitigate this risk, including the use of specialist agencies to supply temporary cover.

3.1 Risk and Safety Team Training and Development

Three members of the Risk and Safety Team attended the Safety, Health and Wellbeing live event in Manchester. This event consisted of seminars about the importance of the 'tone from the top' (safety culture) from a solicitor's point of view, the need to consider the ergonomics of work activities and how monitoring the health of employees is often neglected but can significantly contribute to the prevention of future ill health.

4. Risk and Safety Action Plan 2022/23

The Risk and Safety Team action plan for improvement is behind schedule due to team members' unforeseen absences, the unavailability of other services whose input and cooperation is required to fulfil some of the actions and the high and increasing amount of reactive workload that is generated by incident/accident reports, subsequent investigations and requests for guidance and/or assistance by employees. The action plan has been reviewed and actions have been prioritised.

In progress:

Assure software

- There has been a soft launch within the Risk and Safety, Facilities and Estates departments of the risk assessment and inspection/audit software to ensure these elements are managed effectively, including the outstanding non-conformances. Further training and configuration of the software is required.

Communications

- The Risk and Safety communications strategy has been documented, detailing how the Trust is to be kept informed of legal updates, lessons learned from events, alerts, bulletins, and an overview of health and safety performance has been documented.

Auditing:

- Leeds Community Equipment Service has been subject to a legal compliance audit (see section 5.2.2) by the Risk and Safety Team. The service was selected as its staff conduct a number of potentially high-risk manual handling activities, incidents of staff harm have been reported and assurance was required that there were suitable and sufficient procedures in place to keep staff safe. Audits of three other services are due within 2022/23.
- Health Technical Memorandum (HTM) 05 sets out recommendations and guidance for the management of fire safety in healthcare buildings. The review of compliance against fire legislation and HTM 05 is partially completed.

Risk Assessment:

- A review of the first aid needs assessments across all sites has not yet commenced. Fire aid requirements need to reflect the occupancy levels and activities within each building. First aid roles should ideally be given to members of staff who consistently occupy a building to ensure adequate coverage and response. This review will need to be conducted following the review of facilities management and once the Trust has agreed its strategy on how people will work across the estate.

Training and Competence:

- The identification of staff competency gaps in 'high-risk' services to understand the training requirements has been delayed due to limited Risk and Safety Team resources, including staff availability.

Policies and Procedures

- The development of the security management system, policies, and procedures including the development and implementation of the violence, prevention, and reduction standards has not progressed as originally planned due to the increasing reactive workload of the Security and Safety Lead.
- The development of fire procedures to standardise processes and document additional functions is still to be actioned and will be given priority when the fire risk assessment programme is back on track.

4.1 Health and Safety Policy

LCH are legally required to have a written health and safety policy that is relevant, current, and meets all legal regulations to help keep staff safe and prevent accidents from happening. Most organisations set out their policy in three sections and the revised LCH policy will follow this format:

- **The statement of general policy on health and safety at work** sets out our commitment to managing health and safety effectively and what we want to achieve.
- **The responsibility section** sets out who is responsible for specific actions
- **The arrangements section** contains the detail of what you are to do in practice to achieve the aims set out in the statement of health and safety policy. This

arrangements section could include risk assessment, training, consultation, evacuation.

The health and safety policy and policy statement are currently under review. The revisions will include:

- The responsibilities section will be clearer to aid directors, managers and staff to understand their role in health and safety compliance. There are many more specific specialist roles being added (such as the Safety Champions, Radiation Protection Advisor).
- The arrangements section will include the health and safety management system that has been developed - including the new requirements for audits (not just inspections), KPIs, annual improvement plan etc.
- Health and safety compliance reporting has also been incorporated into the revised document, including the reports to Business Committee and the Trust Board.

Any policy amendments will require approval by the Board. Once revised it will be brought to the attention of all employees, highlighting the changes that have been made.

4.2 Health and Safety Legislation Register

A register of legal compliance has been developed and references 49 relevant Health and Safety Acts, Regulations and Codes of Practice including those relating to Health and Safety, Fire Safety and the Environment.

The results of the Risk and Safety Team's legal compliance audits feed into register and further actions required to meet legal compliance are documented, alongside a Red/Amber/Green rating.

A review of the Trust's Fire Safety compliance and the current fire safety management system is underway.

Compliance against the legal requirements is now monitored twice a year by the Health and Safety Group.

Since the last report, the Personal Protective Equipment regulations were amended to extend the Trust's duty towards those persons who are classified as limb (b) [1]workers. This has limited impact on the Trust as PPE was already provided to this group of people.

The Trust remains non-compliant against some legislative requirements including (but not limited to):

---

[1] limb (b) are those who generally have a more casual employment relationship and work under a contract for service; this group are known as limb (b) workers and do not currently come under the scope of the Personal Protective Equipment at Work Regulations 1992 (the PPER 1992)

- The Health and Safety at Work etc Act 1974. This is due to a lack of information, instruction, training and supervision related to work activities. The health and safety policy when revised and approved will require the implementation of the new health and safety training and competence procedure and reinforce the requirement for supervision of staff.

- Control of Substances Hazardous to Health 2002. This is due to the lack of COSHH assessments held within the Trust; many services only hold safety data sheets.

- The Management of Health and Safety at Work Regulations 1999. Specifically non-compliance is against the requirement for all services to have undertaken risk assessments to identify potential hazards to employee health and safety and anyone who may be affected by their work activity. The significant findings must be written down.

Actions to ensure compliance are described within this report and are included in the Risk and Safety action plan.

4.3 Policy and Procedure developments

Policies

The following policies have been developed or reviewed:

- Risk Management Policy and Procedure

The following policies are currently under review and/or development:

- Health and Safety Policy
- Security Policy

Procedures

The following supporting procedures have recently been developed or reviewed:

- Fire Risk Assessment Procedure
- Health and Safety Training and Competency Procedure
- Health and Safety Communications Strategy

The following procedures still require development before being approved by the Health and Safety Group:

- Risk and Safety - Management of change procedure
- Health and Safety incident reporting, investigation and RIDDOR (staff) Procedure
- Security Procedures, including a procedure for actions to take by staff encountering weapons, and procedures for reviewing CCTV images
- Risk and Safety Legal Compliance Procedure
- Risk and Safety, Control of Records Procedure

4.4 Risk Assessment

The completion and review of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999 and was a weak area identified by the HSE's inspection of the Trust. A software system called Assure has been purchased for audit, inspection and risk assessments.

Discussions are being held with the Clinical Governance Team to discuss and agree when Assure should be utilised instead of the Datix software.

The Risk and Safety Team continues to upload safety data sheets to develop the control of substances hazardous to health (COSHH) risk assessments that are currently being completed outside of the Assure software system to ensure that they are available to services. The Senior Health and Safety Advisor, who is the only competent person for COSHH within the Trust able to complete this activity and the programme of work is now substantially delayed due to competing priorities and team absences.

The trial of the Display Screen Equipment (DSE) assessment on the Assure portal by the 0-19 Team is scheduled for July 2022, prior to it being rolled out wider. An e-learning package for managers reviewing the DSE assessments has been developed.

5. Health and Safety Performance

Performance information is based on reactive and proactive performance monitoring (also known as leading and lagging indicators). Reactive monitoring reviews incidents and events that have occurred whilst proactive monitoring identifies what is in place to prevent injury and ill health.

5.1 Reactive safety performance

5.1.1 Staff Accidents and Incidents

LCH's incident reporting system is Datix and it is used to report and record accidents. Incident reports are forwarded to the Risk and Safety Team to review the contents of the report and determine the severity of the incident.

The Risk and Safety Team is the Trust's statutory reporter of accidents that are required to be reported to the Health and Safety Executive (HSE) under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR

The number of reportable incidents made to the HSE for employees are as follows:

- There were five RIDDOR incident reports made in 2020 - 2021
- There were ten RIDDOR incident reports made in 2021 – 2022
- Two RIDDOR incident reports have been made to date in 2022 – 2023

Since the last report was received in January 2022, the following significant accidents and incidents have been reported:

- A Healthcare assistant was struck on the cheek by a patient within impaired capacity during a home visit to provide care. The staff member suffered bruising and swelling to their left cheek (investigation is ongoing)
- A patient who had refused to have a profiling bed was repositioned in bed by a staff member who consequently hurt their back (investigation is ongoing)
- A member of staff was exposed to a blood borne virus due to a needlestick injury
- A member of staff lifted a bed onto raisers to perform a repair, whilst returning the bed to the floor, they damaged tendons in their right arm (investigation is ongoing)

In addition to the above incidents, a member of staff member has reported that they were not provided with the correct equipment to work at home during 2021, and it is alleged that this has resulted in them suffering from a slipped disk.

Independent investigations into significant or potentially significant events are undertaken by members of the Risk and Safety Team to ensure that root causes are identified, and lessons for improvements can be shared. Obtaining information from the services that allows the investigations to be made in a timely manner often proves difficult. Consequently there are delays in the identification of improvements or communications that required to prevent recurrence.

The Health and Safety Group has identified that there is gap in how the Trust learns and makes improvements. Once there is increased staff capacity within the Clinical Governance Team, a meeting will take place to discuss how this can be improved.

The Risk and Safety Team has identified that the RIDDOR requirement for Dangerous Occurrences were not always recognised within the Trust, and therefore not reported to the HSE. This requirement has been highlighted with the Infection Prevention and Control Team who oversee any sharps incidents and Datix has been amended to assist in the identification of RIDDOR incidents.

5.1.2 Occupational Health

Occupational health data can potentially be used to identify themes and problems which are occurring within the Trust. The Health and Safety Group received the first report in June 2022 since the Occupational health provider went into OPEL 4 in 2021.

The Occupational Health provider has identified the number of injuries relating to work activities, but this information does not extend to identifying the work activity that caused the injury to occur. Consequently the data does not assist with the identification of high-risk activities. Occupational Health have declined the request for this additional information to be provided due to the additional time it would take for them to interrogate each staff member’s file. However they did report that they had identified an issue with the practice of leg bandaging.

5.2 Proactive Safety Performance

5.2.1 Health, Safety, Security and Fire Inspections

The Trust's health, safety, fire and security inspections focus on hazards in the work environment; they are a check on workplaces and work activities to ensure that they are healthy and safe. Inspections can help prevent incident, injuries, and illnesses by addressing identified hazards. In the case of security, inspections consider threats and identify vulnerabilities, these are then addressed to reduce potential consequences.

5.2.1.1 Health and Safety Inspections

Health and Safety building inspections are carried out on an annual basis. These inspections have recommenced in June 2022 and findings are added to the Assure software so that actions can be tracked to closure.

5.2.1.2 Fire Safety Risk Assessments

As previously advised, the Fire Advisor has prioritised the Fire Risk Assessments to ensure that all of the retained estate will have been assessed in the last three years, the expected date for this work to be completed is June 2023.

Many Fire Risk Assessment actions are allocated to either Estates and Facilities for resolution. There are a significant number of actions that are outstanding and some that cannot be assigned due to a lack of clarity of job roles/responsibilities. This is being addressed in the current Facilities review, and meetings are scheduled to discuss and agree the processes that need to be in place.

5.2.1.3 Threats and Vulnerability Assessments (Buildings)

The Security and Safety Lead is reviewing LCH security arrangements. A new methodology of identifying threats, risks and vulnerabilities for occupied buildings is being documented, and all buildings are undergoing a review. This work programme is delayed due to the high number of reactive requests requiring support and involvement of the Security and Safety Lead; however a number of improvements have been made to building security as a result of incidents including:

- Additional guarding has been put in place at Holt Park after staff were subject to anti-social behaviour by a group of youths.

- Measures have been taken at Stockdale House to increase security after a patient presented on various occasions after threatening staff over the telephone. Measures included a supporting front of house staff and implementing escalation processes, the removal of signage identifying which floors LCH occupy, additional CCTV cameras in the reception area and entrances to LCH occupied floors, and reminders for staff not to let people tailgate.

- All staff have been reminded to wear their ID badges or face a challenge when working at LCH offices and health centres. Entrance signage and screen saver messages reinforce this message.

5.2.2 Risk and Safety Team Audits

The Risk and Safety Team planned to audit four high-risk services during 2022/23, to identify areas for improvement and ensure the services are legally compliant. The schedule for these has been pushed-back due to the lack of service availability.

Leeds Community Equipment Service's (LCES) compliance audit was undertaken in March 2022. The audit identified that the senior manager of the service were committed to ensuring the health and safety of their staff was managed effectively. Leeds County Council ensure that the senior managers receive NEBOSH certificate training (a recognised health and safety course).

Many new risk assessments, procedures and processes had been put into place, alongside a training programme for staff about the risks and controls required to keep the staff safe.

There were twenty-five findings identified, ten were concerned with legal compliance, twelve were minor non-conformances and three were observations for improvement.

The legal areas for improvement were identified as:

- Risk Assessment
- Waste Management
- Control of Substances Hazardous to Health
- Provision of tools and equipment
- Lifting operations and Lifting equipment
- Staff exposure to smoke
- First aid arrangements

A meeting is planned with LCES to agree and document the action plan required to address the findings.

The Podiatry legal compliance audit is underway, however due to staff absences in the Podiatry Service and in the Risk and Safety team, the time taken to undertake the audit has been extended. This may affect the Risk and Safety Team's ability to complete the subsequent audits on the Dental Service and Leeds Sexual Health Service within the defined timeframe.

The Risk and Safety Team continue to support services to complete the actions from the findings identified by the Control of Substances Hazardous to Health (COSHH) that was carried out in March 2021.

5.3 Health, Safety, Fire and Security Training

The Management of Health and Safety at Work Regulations require employers to provide adequate health and safety training at different points in their employment (e.g. at recruitment, on being given new or different responsibilities, when new work equipment, technologies or systems of work are introduced). This training must be repeated periodically, where appropriate.

5.3.1 Closed Circuit Television (CCTV)

A review of the CCTV processes within the Trust identified that there were no formal arrangements or documented procedures in place, alongside insufficient training and no formally nominated persons to review footage. These are legal requirements.

A CCTV course has been designed and delivered by the Security and Safety Lead in conjunction with the Information Governance Team; the first course was held in June 2022. A further course is to be organised to ensure that there are sufficient trained individuals who can undertake this task.

5.3.2 Telephone Conflict Resolution Course

It was identified that the conflict resolution training provided to staff members only focused on face-to-face encounters and did not address the increasingly aggressive phone calls that staff can be exposed to.

An initial course was run by the Security and Safety Lead and Good Sense (a conflict resolution training company) in May 2022 which received positive feedback. A further course is to be held in July 2022. A number of services and individuals have expressed interest in attending a similar course as telephone aggression is reported to be increasing as the Trust's services remain under pressure.

5.4.3 Fire Safety Training

Fire Safety training is being hosted virtually via MS Teams to remove the need for staff to travel to receive the training and to maximise the Fire Safety Advisor's time.

There continue to be insufficient trained fire wardens within the buildings; this is a particular issue as there are very few staff who consistently occupy each building who can be relied upon to assist in the event of a fire. A review of this situation, and the need for other safety roles, such as single points of contact for security and those with first aider duties is planned as part of a wider review of facilities management and building occupancy.

6. The Health and Safety Group

The Health and Safety Group, chaired by the Executive Director of Finance and Resources, provides a structured approach to communication and consultation. It continues to meet every two months and provides a forum where Business Unit representatives, Staff-side, the Risk and Safety Team, Human Resources, Facilities and Estates can work together to resolve health and safety issues. Issues which require escalation are raised with the Business Committee.

7. Fire Safety Group

The Fire Safety Group meets quarterly and ensures that the Trust is meeting its fire safety legal obligations and that a suitable fire safety management system is in place.

A review of the Trust's compliance against relevant fire legislation and the HTM 05-01 Managing Healthcare Fire Safety – NHS England, has been partially completed to

date. Once the review is complete, an action plan will put in place to address identified non-conformances and/or other improvements that are required. The action plan, and progress towards its completion, will be agreed by the Fire Safety Group and progress monitored by the Health and Safety Group, which will escalate any issues to the Business Committee by exception.

8. Manual Handling

Members of the Risk and Safety Team will attend the newly established Manual Handling Group. No meetings have been held to date.

9. Next steps

A number of developments are planned to ensure that the Trust continues to develop a robust health and safety management system:

- The continued development of health and safety policies and procedures,
- Schedule for the communication strategy to be devised and documented.
- Legal compliance audits of Podiatry, Dental and Leeds Sexual Health Services.
- Documenting of the health and safety training requirements per job role for selected high-risk services
- Review of Fire Safety arrangements against the HTM 05-01 Managing Healthcare Fire Safety – NHS England.
- Auditing first aid arrangements and carrying out first aid needs assessments.
- Security Optimisation Project to recommence
- Further role out and configuration of the Assure software
- Involvement in the planning of the 'No bystanders' (managing abusive patients and relatives) summit that is being organised by the Adult Business Unit
- Continued focus on completion of the Fire Risk Assessments

10. Recommendations

The Board should note the progress made with implementing the health and safety management system and arrangements and that a risk-based approach is being taken to progress any work that has been delayed.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public : 5 August 2022

Agenda item number: 2022-23 (59)

Title: 3rd Sector Strategy Progress Update

Category of paper: Assurance

History:

Progress Update to March 2022 Business Committee
Verbal update to January 2022 Business Committee
3rd Sector Strategy year 1 implementation plan approved by July 2021 Business Committee
Business Committee 27 July 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.

As reported in the update to March Business Committee, implementation of the year 1 plan was impacted by most workstreams being paused from November '21 – March '22 because of service pressures.

Since the March '22 update, notable developments include:

- Launch of the 1 year Enhance programme with most of the 14 third sector delivery partners going live with referrals 20 June - all delivery partners will be accepting referrals by the end of July. Programme monitoring and a programme of learning events will enable identification and sharing of learning about what works well, including in developing effective relationships and partnership working with Neighbourhood Teams. A quote from an Enhance partner is as follows:

  "We respect each partner's position within the community and use our combined skills, resources and knowledge to provide a more person-centred and bespoke service to our older people. Collectively we are more responsive to people's needs. We're confident that working with partners on Enhance will strengthen everyone's voice. We want to continue to build equal respect and understanding of each individual role, share skills and resources to make all our roles a little easier and work to together to provide the best care and intervention to our older citizens. We all have a piece of the jigsaw - together we build a better picture".
- success in Childrens Business Unit developing a network of 3rd sector organisations who publicise to their members the involvement opportunities across LCH childrens services and who also promote LCH's Youth Board. Via Voluntary Action Leeds 'Being Collective' and 'Doing Good' websites and the Young Lives Leeds bulletin. CBU will engage with third sector partners to develop an inclusive Parent forum.
- work with BASIS (NHS Charities Together funded project which LCH partnered) to develop services' awareness and understanding about the needs of women sexworkers and / or women who are sexually exploited and the barriers they experience, develop services to be accessible and inclusive, and BASIS supporting women to access services:
  - Integrated Wound Clinics – working towards establishing a drop-in clinic in a city centre location
  - CUCS – BASIS raising awareness of the service, helping dispel perceptions and providing support to access the service
  - Sexual Health – attending a weekly drop-in session has resulted in a significant increase in women accessing testing. Sexual Health service to provide training for BASIS. BASIS is participating in commissioner workshops to inform re-commissioning of the service
  - Homeless & Health Inclusion Team (HHIT): further developing support e.g. nurse attending a drop-in has been very helpful in establishing trust and understanding about outreach.

A focus at the July Steering Group was the heightened workforce challenges experienced widely across the third sector – recruitment, turnover and burnout, exacerbated by increased demand and greater acuity, impact of the cost of living crisis and not being able to compete with salaries offered in other sectors. Several actions are being explored including discussing with the Health Care Academy developing its Health and Well-Being offer to the sector.

Recommendations

Business Committee is asked to consider whether it is assured about progress in implementing the year 1 implementation plan.

LCH 3rd Sector Strategy Year 1 Implementation Plan on a Page

Date: **20/07/2022**

Workstream and Actions	Narrative (changes)	Lead	RAG
1. DEVELOP INCLUSIVE, ACCESSIBLE SERVICES			
Support People with Sensory Impairment (PSI) to 'bridge the last 3 metres'	Over 60 staff participated in sensory awareness training, mainly front of house: positive feedback. Propose train SMT next and then agree roll out plan to clinicians. 2 health centre access audits done: to identify another site.	Chris Jessop	
Develop easy read information	MyLCH page developed with examples of easy read resources and guidance. LCH Learning Disabilities Lead to link with Forum Central about the 3rd sector 'Being Me' strategy group leading within the system on agreeing a common easy read approach across NHS, LCC & 3rd sector partners and advising LCH on easy read docs and guidance	Lisa Smith	
Develop equality of representation in services	EQIA re-audit in July postponed due to business continuity measures, once recommenced will include engagement with Touchstone to inform further development and embedding of EQIA. Nice guidance: Guidance reviewed = NG214 homeless integrated care; and the Quality Standard relating to foetal alcohol syndrome diagnosis. Services will be asked to consider how Third Sector can support a further specific review of the applicable standards.	Em Campbell	
Deliver more services in or co-deliver with community / 3rd sector partners	As part of the expansion and widening of integrated wound clinics exploring providing clinics in Enhance partner premises alongside their social activities and 3rd sector providing transport. See 2 below: Enhance programme. See 3 below: NT self-management facilitator team	Caroline Schonrock	
2. CONNECT BETTER			
Optimise NT ability to connect service users & carers to local services & support	Plans in place to interview NT Co-ordinators to ensure the future Neighbourhood model is informed by learning from NT Co-ordinators experience and knowledge of connecting service users to community support and services. To meet with Burmantofts and Richmond Hill PCN hub to explore how NTs and Specialist Business Unit services best connect and to optimise resource across new primary care roles and & LCH resource.	TBA post interviews	
Develop NT-Neighbourhood Network collaboration to meet local need	Enhance: Implementation group and task/ finish groups established. Go live 21st June with 10/14 providers accepting referrals. Comprehensive reference document produced for NTs, outlines referral process and service offer etc. Referral form and process map co-produced with third sector and describes the patient journey.	Katie Smith	
Ensure effective 2-way information flows with vulnerable communities	Communities of interest update: Forum Central is working with Healthwatch who have secured some of the short term Health Inequalities funding to develop the model; Mary Halsey now in post and is reviewing the network and links across our membership and the wider system	Pip Goff, Helen Rowland	

LCH 3rd Sector Strategy Year 1 Implementation Plan on a Page

Date: **20/07/22**

Workstream and Actions	Narrative (changes)	Lead	RAG
3. ENABLE MORE EFFECTIVE SELF MANAGEMENT			
Develop self-management approaches and resources	Enhance programme – see 2 Connect Better above. To work with Forum Central to develop LCH website and intranet in terms of 3rd sector partnership content and links: enables sharing of resources and making connections	Gail Fort, Caroline S	
NT: develop collaboration with 3rd sector	NT Self-Management: the team continues to embed within third sector buildings and in utilising the sector at point of discharge. Also undertaking work with the sector to address health inequalities particularly in the West where there has been support with getting to and from appointments.	Steph Lowen	
4. CO-PRODUCE SERVICES			
Childrens services to engage more inclusively	Considerable success developing involvement links with 3rd sector organisations. Voluntary Action Leeds advertise LCH Youth Board on the Being Collective and Doing Good websites - generated 12 applicants to join the Youth Board (now 42 members); on the Young Lives Leeds bulletin distribution list. Planning to develop an inclusive Parent forum. Scoping how young people can 'volunteer' in LCH services.	Debra Gill	
Co-produce elements of the new Neighbourhood Model	Leeds Older People's Forum co-production lead supported initial discussion about potential for co-producing elements of the Enhanced Community Response. To consider as we develop the model	TBA	
Co-produce Specialist Business Unit service delivery models with 3rd sector	Leeds Sexual Health: LCC has extended the contract until June 2024. Once we know tender requirements 3rd sector partners will lead co-production of pathway elements to enable access, reach and ensure we meet the needs of specific populations	TBA	Not started

Leeds Community Healthcare NHS Trust

Agenda item 2022-23 (60)

Public Board workplan 2022-23
Version 3: 20 06 2022

Topic	Frequency	Lead officer	3 December 2021	4 February 2022	31 March 2022	27 May 2022	17/06/2022 End of year	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		Not for this meeting	X	X
Quality and delivery										
Chief Executive's report	every meeting	CE	X Inc system pressures update	X Inc system pressures update	X Inc system pressures update	X Inc system pressures update		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 Blue box		X -blue box		X -blue box
Staff survey	annual	DW			X					
Safe staffing report	2 x year	EDN&AHPS		X -blue box				X		
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 presented 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 Annual report 2021-22		X		X
Strategy and planning										
Organisational (Trust) priorities position paper	Annual	EDFR			X 2022-23 new					
Trust priorities update	3x year February/May/October	EDFR/EDN&AHPS	X blue box	X blue box (not presented)		X blue box end of year report			X -blue box	
Third Sector Strategy	2x year (February and August)	EDO		X -blue box (Deferred March)	X -blue box			X -blue box		
Estate Strategy	2xyear (August and September)	EDFR			X deferred August			X Blue box item -deferred October	X Blue box	X Blue box item
Digital Strategy	2x year	EDFR			X -blue box				X -blue box	
Business Development Strategy	2x year(March and October)	EDO			X -blue box not presented in March 2022				X -blue box	
Business Intelligence Strategy	2x year First presented Feb 2022 and August	EDFR		X				X -blue box -deferred until February 2023		
Learning and Developement Strategy	2x year (October and March)	DW			X -blue box not presented in March 2022				X -blue box	
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	2xMarch/Ocotber	EDN&AHPS			X				X	
Health Equity Strategy	3 x year(March, August and December in 2022)	EMD	X		X Board workshop			X		X
Children, Young People and Families Strategy		EDN&AHPS				X				
Quality Strategy	2xyear May and December	EDN&AHPS				X - Blue box item				X - Blue box item
Workforce Strategy	2x year May and December	DW				X - Blue box item				X
Research and Development Strategy	As required	EMD								
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	annual	CS						Defer to December X		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 Defer to June	X			
Committee terms of reference review	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 - Blue box item				X - Blue box item
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
Sustainability report	2xyear (March and October)	EDO			X				X -blue box	
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

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public : 5 August 2022

Agenda item number: 2022-23 (61ai)

Title: Quality Committee minutes 23 May 2022 (time 0930 to 1230)

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
	Ruth Burnett	Executive Medical Director
	Rachel Booth (RBo)	Non-Executive Director
	Alison Lowe (AL)	Non-Executive Director
	Ian Lewis (IL)	Non-Executive Director
In Attendance:	Diane Allison	Company Secretary
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Thea Stein	Chief Executive
	Stuart Murdoch	Deputy Medical Director
	Dave Kirby	Deputy Medical Director
	Brodie Clark	Trust Chair
	Nicky Clay	Clinical Head of Service, MSK and Pain (Item 13a)
	Berani Ganesan	Pain Consultant, Leeds Teaching Hospitals Trust (Item 13a)
Apologies:		
Minutes:	Lisa Rollitt	PA to Executive Medical Director

Item: 2022-23 (11)

Discussion points:

(a) Welcome and introductions

The Chair welcomed members and attendees. No apologies were received.

(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.

i. Revised list of Quality Committee directors' declarations 2021/22

The Committee received the paper and noted the revisions.

(c) Minutes of the previous meeting 25 April 2022

The minutes of the meeting held on 25 April 2022 were reviewed and agreed as an accurate record.

(d) Matters arising and review of action log

It was agreed that the items on the action log due for completion at this meeting were on the agenda or had been completed outside of the meeting.

i. **Future update on virtual wards, enhanced response, community vs hospital costs and benefits**

The Executive Director of Nursing and AHPs confirmed it had been agreed that this information would be included in the Safe Staffing report, presented to Quality Committee in July 2022 to avoid duplication of work.

ii. **Protected characteristics and turnover**

The Executive Director of Operations presented the paper.

A Non-Executive Director (AL) spoke about the reported data. It was agreed that this provided a useful benchmark position, however further understanding of the reasons people leave the Trust through high quality exit interviews was required.

It was agreed that a further iteration of the report would be presented to the Committee in July 2022 to provide more clarity on the data and what this means for the Trust.

Action: Further iteration of the report to be presented to the Committee in July 2022

Actionee: Executive Director of Operations

2022-23 (12)

Key issues

a) Covid-19 update: current pressures

The Executive Director of Nursing and AHPs gave an update on the current position, commenting on the improving picture and reduced impact on both workforce and

patients including Care Home residents. It was reported that Health and Care staff would be included in the Autumn booster campaign.

b) QAIG key issues for escalation

The Executive Medical Director provided feedback from the QAIG deep dive which took place on 17 May 2022 and focussed on the data sources available to services, including health equity and public health data, which could be used to stratify waiting lists.

The Committee heard that the QAIG conversation concluded further conversations with services were required for individual requirements based on an agreed set of principles.

The Chief Executive stated that a paper would be presented to the Senior Management Team (SMT) in relation to how waiting lists were stratified moving forward and this would then be presented to a future Committee. The Committee Chair asked if the Business Intelligence (BI) support would be able to assist with this work. The Chief Executive stated that the resources within BI were limited but where available to do this work. It was also noted that there were some data quality issues around how clinicians code the data that were being worked through.

The Trust Chair asked about the possibility of outsourcing this work to external companies and it was agreed that the Chief Executive would explore this as an action.

Action: Exploration to take place around the possibility to outsource data analysis

Actionee: Chief Executive

c) CIVAS: DVT incident trend and improvement actions: update on progress

The Executive Director of Nursing and AHPs presented an update from the Community Intravenous Administration Service (CIVAS) following the spotlight presentation to the Committee in February 2022. It was noted that the paper showed no correlation in trends or themes around the incidents, and it was agreed that a further paper to provide assurance when the ongoing actions were concluded would be presented at a future Quality Committee meeting.

Action: Assurance paper to be provided to a future Quality Committee meeting once ongoing actions concluded

Actionee: Executive Director of Nursing and AHPs

d) Cancelled and rescheduled visits: update

The Executive Director of Nursing and AHPs presented the paper, highlighting that data quality issues were being addressed in relation to the recording and retrieval of SystmOne data where care plans had been re-scheduled, as this was currently providing some data inaccuracies.

The Committee was concerned to hear of the significant number of patients who did not receive a call when their visit was to be cancelled or rescheduled and requested this was addressed as a priority.

There were a number of questions asked about clinical risk. The Executive Director of Nursing and AHPs stated that no significant increases had been seen in patient safety incidents at the present time to suggest an escalated position of clinical risk, however it was recognised that there was a risk, and it was noted that the essential visits criteria had been revisited to aid decision making in order to provide the safest care possible.

It was clarified that no data existed to suggest disparity in relation to ethnicity and deprivation however this was being considered in ongoing conversations, data capture and analysis.

A Non-Executive Director (AL) asked about the possibility of reducing the number of visits being arranged in order to address the capacity issues. The Executive Director of Nursing and AHPs stated that a stabilisation plan was being developed which focussed on actions to increase capacity or reduce demand. More self-care facilitators were being recruited. An increased used of virtual technology was also being considered.

The Non-Executive Director (AL) also spoke about the three teams which were outliers and asked if there had been any deep dives completed. The Executive Director of Nursing and AHPs confirmed that the issues were being investigated and monitored, and an ongoing deep dive was taking place in the Seacroft NT currently.

There was a conversation around sickness and absence management to effectively address capacity shortfalls related to unplanned absence. The Executive Director of Operations agreed to undertake a spot check audit in the coming weeks on absence management with the leadership team to gain assurance this was being managed robustly and effectively.

Action: Spot check audit on absence management to take place with the leadership team

Actionee: Executive Director of Operations

A Non-Executive Director (RBo) spoke about the pressures on staff and asked about the support available in terms of health and wellbeing (HWB). The Executive Director of Nursing and AHPs stated that a comprehensive HWB offer existed including an ongoing review of supervision and the recent introduction of LCH Schwartz Rounds. It was also noted that additional HWB support across NTs was in place with the introduction of wellbeing facilitators.

The Chief Executive spoke about the development of a culture where staff didn't feel they had time to access support. It was noted that work was underway to address how the culture could be changed and look at ways to make staff feel in control of their health and wellbeing.

The Trust Chair stated that the paper was lengthy and presented the problem but did not lay out the issues that had been discussed in this meeting. The Executive Director of Nursing and AHPs noted the comments.

The Committee requested a further formal update in July 2022, with a verbal update at the next Committee meeting given the agreed limited assurance with the current position.

Action: Formal update to be provided in July 2022, with a verbal update at the Committee meeting in June 2022

Actionee: Executive Director of Nursing and AHPs

2022-23 (13) Service Spotlight

a) Spinal Pathway – collaboration and improvement since a Never Event

A Deputy Medical Director (SM) introduced Nicky Clay, Head of Service, MSK and Pain, who presented the spotlight on the spinal pathway collaboration and improvement since the Trust's Never Event where a patient received a wrong site spinal injection.

The Committee heard about the introduction of Local Safety Standards for Invasive Procedures (LocSSIPS) in all interventional services, where these were not in place previously and a significant transformation of the spinal injection clinic, resulting in a more efficient and effective team approach and increased capacity. In addition, an improved pathway for the acute spinal radicular pathway was resulting in cost and pathway efficiencies and a more patient centred evidence-based approach to care.

The Head of Service, MSK and Pain also emphasised the collaboration with key partners to improve patient outcomes and staff development.

A Non-Executive Director (AL) asked if there was any link with the Leeds Community Support pain peer service, delivered by Touchstone. The Head of Service, MSK and Pain confirmed that this was a part of the LCH Community Pain Service.

The Committee Chair asked how many other spinal surgery services there were in West Yorkshire. The Head of Service, MSK and Pain clarified that it was a tertiary service and LTHT provided this in the West Yorkshire region.

A Non-Executive Director (IL) stated that he was pleased to the see the breadth of response to the Never Event and the developments that had taken place to improve the pathways for patients. He suggested that it would be helpful to see an audit of the outcomes in terms of response to the changes that had been made to understand the impact.

In response to a query from the Executive Medical Director about the complexity of the pathways, the Head of Service, MSK and Pain clarified the processes following referral into the MSK service.

2022-23 (14)

For discussion: Quality governance and safety

a) Performance Brief

The Committee received the Performance Brief and noted its contents.

b) Performance Brief: annual report

The Committee received the Performance Brief annual report and accepted this as the Trust position.

c) Clinical Governance Report

The report was presented by the Executive Director of Nursing & AHPs highlighting the staff engagement events which had been celebrated including an integrated community clinical conference with Primary care, and activities to celebrate International Nurses Day.

In response to a query from the Committee Chair around the open Patient Safety Alert relating to inadvertent oral administration of potassium permanganate, the Executive Director of Nursing and AHPs assured the Committee that there were systems in place to prevent the reoccurrence of such an incident.

There was a conversation about learning from incidents and putting this into Quality Walks. It was acknowledged that now restrictions had eased, the involvement of Non-Executive Directors in the Quality Walks was encouraged.

The Chief Executive also spoke about the Children's Business Unit (CBU) report and asked about a timeframe for when the Committee would receive further details around CBU waiting lists (CAMHS, Mind mate SPA, ICAN). It was agreed that this would be considered and could be the focus of a future spotlight.

Action: CBU waiting list to be a focus of a future spotlight at Quality Committee

Actionee: Executive Director of Nursing and AHPs

In response to a query from the Committee Chair, the Executive Director of Nursing and AHPs spoke about the changes to the Clinical Governance team, stating that she was confident that senior cover was in place and was being well managed.

The Committee offered suggestions to improve future reports.

d) Quality, staffing and finance: triangulation (NTs)

The paper was presented by the Executive Director of Operations who highlighted that the Quarter 4 report covered the ongoing impact for Neighbourhood Teams as a result of further COVID-19 and other pressures. It was noted that in Mid-December, the Adult Business Unit (ABU) escalated to OPEL 3e reflecting the impact of staffing shortages on care delivery and need for additional actions and oversight.

The Executive Director of Operations drew the Committee's attention to the reported reduction in staffing at the end of the year, stating that the admin staff had been removed from the NT project to create an admin service.

It was noted that there had been a pressure on the teams to take more virtual ward referrals, with a limit of 35 to 40 referrals being put in place to support the system.

A slight improvement in appraisals was noted since the introduction of the abridged appraisals which had received positive feedback and would continue.

The Committee Chair referred to End of Life care and asked if the end of life care demand was equal across the City. The Executive Director of Operations stated that this varied on a week to week basis.

The Trust Chair asked about the Seacroft NT as a recurring service of concern. The Executive Director of Nursing and AHPs stated that the team had a high acuity of the caseload and people with complex needs, high numbers of people requiring virtual frailty ward input and ongoing vacancies. In addition to strengthening leadership, work was ongoing to look at close working with Third Sector partners to strengthen integration and increase efficiency.

A Non-Executive Director (AL) suggested giving consideration to a change of geographical boundaries given these factors and whilst it was recognised that this was not possible in relation to the PCN footprint, it would be considered for caseload clusters.

It was acknowledged that the report on cancelled and rescheduled visits superseded the data that had been presented in this report and the reporting anomaly was identified. It was therefore accepted that the quantitative data on cancelled and rescheduled visits in this report was not accurate.

e) Quality Strategy: update on Q4

The 6 monthly update was presented by the Executive Director of Nursing & AHPs demonstrating progress in line with the plan.

The Chief Executive commented that although the report included input measures, further information regarding outputs in future updates were required to reflect the impact of the ongoing work.

A Non-Executive Director (RBo) spoke about the pressures and asked for reflection on how achievable the remainder of the plan was. The Executive Director of Nursing and AHPs stated that this would be considered within the next update.

It was also noted that timeframes for work in relation to patient engagement would also be considered in line with the current review of the Patient Experience and Engagement Strategy.

f) Risk Register

The report was presented by the Chief Executive. The Company Secretary highlighted the increased Risk 877: *Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand* as previously discussed.

A Non-Executive Director (AL) referred to Risk 1099: *No documented CCTV procedures* and asked about the robustness of Information Governance (IG) processes in the Trust. The Company Secretary stated that IG were involved, however this was a security/estates issue and clarified that procedures for CCTV had been confirmed and this was being worked through by the Trust's new security lead.

g) Mortality report: Q4

The report was presented by the Executive Medical Director in conjunction with the Mortality annual report. Please refer to the minutes below (Item 14h).

h) Mortality: annual report

The Executive Medical Director presented the report stating that the data analysis was being factored into the NT transformation work.

The ongoing work with regards the Level 2 mortality review processes was noted.

The Executive Medical Director spoke about the Health Equity data, and it was acknowledged that the report included pieces of data to provide an idea of the work that was underlying and what was happening as a result of this. A Non-Executive Director (AL) referred to Sudden Unexpected Death in Childhood (SUDIC) figures and asked about work that was ongoing with partners across the City. The Executive Medical Director stated that the Health Equity breakdown for Children would be included as a focus of work for the next year.

It was noted that the Trust had seen small improvements in relation to identifying Learning Disability deaths and work on this this would be a priority for the forthcoming year with a specific focus on learning from deaths.

i) Pressure Ulcer steering group annual summary

The summary was presented by the Executive Director of Nursing & AHPs.

A Non-Executive Director (AL) asked about the role of the self-management facilitators in this area of work. The Executive Director of Nursing and AHPs stated that this was under discussion, and it was confirmed that a meeting was in place to discuss this role in pressure ulcer prevention.

The Chief Executive spoke about the Category 4 Pressure Ulcer (PU) incidence in the Seacroft NT and asked if there was any further learning from this. The Executive Director of Nursing and AHPs stated that the incidence was multi-factorial and there was an ongoing focus to continue to embed the learning. The Assistant Director of Nursing and Clinical Governance stated that the detail of the learning had been captured in Serious Incident report. It was agreed that it would be helpful to include the data for incidences such as this in future PU reports.

It was agreed that the Committee felt the report provided reasonable assurance.

j) IPC annual report

The report was presented by the Executive Director of Nursing & AHPs who described the continued focus on Covid-19 over the last 12 months and the movement towards recovering the pro-active work.

It was acknowledged that 64% of staff had been vaccinated against Influenza, the highest total of any other organisation in West Yorkshire.

The Trust Chair asked about Care Homes. The Executive Director of Nursing and AHPs stated that the Trust provided IPC across the whole of the City under the cooperation agreement, and this would continue, including audit activity.

The Committee Chair asked about the recurrent data around needlestick injuries. The Executive Director of Nursing and AHPs confirmed this would be the subject of a citywide focus.

2022-23 (15)

For discussion: Clinical Effectiveness

a) Patient Group Directions
The Committee received and ratified the Patient Group Directions.

b) NICE guidance compliance update
The Executive Medical Director presented the update, stating that the activity was now held within Datix which was a more robust Trust process. The Committee accepted the update as the Trust position and welcomed the proposal for a future update on historical compliance where this was outside of the Trust's responsibility.

c) Research and Development strategy update
The update was presented by the Executive Medical Director, acknowledging the lack of detail within the paper.

The Committee heard how progress continued in relation to cross boundary research with Primary Care.

It was noted that further analysis of the role of the R&D team within the Trust had taken place and that recruitment to the Head of R&D would be a joint post with LTHT. The intention of this was to provide a 0.5WTE role within LCH, with the remaining 0.5WTE considering the left shift of research in to out of hospital care.

A Non-Executive Director (IL) commented on the importance of a comprehensive discussion at this Committee on the role of R&D and its integral part in the Trust. Further conversations were planned between the Executive Medical Director and a Non-Executive Director (IL).

The Trust Chair suggested that a Board workshop on R&D would be helpful.

2022-23 (16)

For noting: Sub Group minutes

a) Safeguarding Children's and Adult's Group: 21 April 2022
The Committee received the minutes.

The Committee Chair expressed concern at the number of apologies given and late arrivals to the meeting. The Executive Director of Nursing and AHPs stated that she would discuss this with the meeting Chair.

Action: Number of apologies and late arrivals to be discussed with meeting Chair
Actionee: Executive Director of Nursing and AHPs

2022-23 (17) Policies and reports for approval or noting

a) Work plan
b) Items on workplan not on agenda
The items were noted as:

a. Outcome measures approach (deferred to July 2022)
b. CQC improvement plan (concluded)
c. Internal audit (no audits to report on)
d. Board member service visits (no visits to report on)

2022-23 (18) Matters for the Board

Committee's assurance levels and additional comments

The Committee agreed that the overall assurance levels:

Risk 1.1: Reasonable assurance

Risk 1.2: Reasonable assurance

Risk 1.3: Reasonable assurance with limited assurance specifically in relation to cancelled and re-scheduled visits in NTs

The Committee remain concerned in relation to the NT and cancelled and rescheduled visits. Whilst actions and measures were clearly articulated, the current position offers limited assurance of the Trusts position in maintaining and continuing to improve service quality

Risk 1.4: The Committee was unable to provide a position of assurance in relation to this risk from the papers presented.

Risk 1.5: Reasonable assurance

2022-23 (19)

Reflections on Committee meeting

There were no further reflections on the Committee papers.

2021-22 (20)

Any other business

The Executive Director of Nursing and AHPs gave a brief update on Monkeypox in Leeds. The Committee heard that there were currently 2 suspected cases in Leeds, although this had not been confirmed. The IPC team were focussing on this with partners in the City and further updates would be given when available and required.

Date and time of next meeting

Monday 27 June 2022 9.30am – 12.30pm (Via MS Teams)

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public : 5 August 2022

Agenda item number: 2022-23 (61aii)

Title: Quality Committee minutes 27 June 2022 (time 0930 to 10:15)

Category of paper: For noting

Attendance

Present:	Helen Thomson (HT)	Non-Executive Director (Chair)
	Steph Lawrence	Executive Director of Nursing and AHPs
	Ruth Burnett	Executive Medical Director
	Alison Lowe (AL)	Non-Executive Director
In Attendance:	Diane Allison	Company Secretary
	Thea Stein	Chief Executive
Apologies:	Ian Lewis (IL)	Non-Executive Director
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Rachel Booth (RBo)	Non-Executive Director
	Sam Prince	Executive Director of Operations
	Stuart Murdoch	Deputy Medical Director
Minutes:	Lisa Rollitt	PA to Executive Medical Director

Item: 2022-23 (21)

Discussion points:

(a) Welcome and introductions

The Chair welcomed members and attendees. Apologies were received from two Non-Executive Directors (IL & RBo), the Executive Director of Operations, the Deputy Medical Director, the Trust Chair and the Assistant Director of Nursing and Clinical Governance.

(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 23 May 2022

The minutes of the meeting held on 23 May 2022 were reviewed and agreed as an accurate record.

(d) Matters arising and review of action log

2022/23 (12b) QAIG Key issues for escalation: Deep dive 17/05/2022

It was noted that the item was on the agenda and agreed the action was complete.

2022/23 (12d) (i) Cancelled and rescheduled visits: update

The Executive Director of Operation was not present at the meeting to provide this update.

2022/23 (12d) (ii) Cancelled and rescheduled visits: update

It was noted that the item was on the agenda and agreed the action was complete for June 2022. It was acknowledged that the update report would be presented at the meeting in July 2022.

2022/23 (16a) Sub Group minutes: Safeguarding Children's and Adult's Group: 21 April 2022

The Executive Director of Nursing and AHPs confirmed that she had discussed the issue of the number of apologies with the meeting members. It was agreed that the action was complete.

2022-23 (22)

Key issues

a) Covid-19 update: current LCH / system pressures

The Chief Executive provided an update to the Committee, stating that system pressures continued. A slow rise in Covid-19 rates had been reported in the Community, including Care Homes. There had been a number of hospitalisations, although it had not been confirmed whether the people who were in ICU had been admitted with Covid-19 as the primary cause.

The Committee also heard it was predicted there would be a surge in Covid-19 cases in the coming weeks.

A Non-Executive Director (AL) asked if the charges for Lateral Flow testing kits were impacting on Care Homes. The Executive Director of Nursing and AHPs stated that these tests were provided free of charge.

The Committee Chair asked if there had been an increase in staff being absent from work due to Covid-19. The Chief Executive stated that this was the case.

The Committee Chair asked if it had been possible to capture the number of staff who had been diagnosed with Long Covid. The Chief Executive stated that this data was being captured and would ask Workforce to provide this data.

The Chief Executive informed the Committee that she had met with the National Discharge Team, who were satisfied that the Trust and the system are doing everything possible across the system in terms of discharge. As a result, Leeds and the Trust has been signed off as not being an area of concern.

Action: Data on the number of staff with Long Covid to be provided to Quality Committee

Actionee: Chief Executive

The Chief Executive spoke about the impact on staff of rising fuel prices and increased cost of living, requesting that this be a regular agenda item at Quality Committee. There was a conversation about the number of measures which had been put in place by the Trust to assist staff health and wellbeing with the current situation, including access to money and debt management advice. It was agreed that this topic would be added as a regular agenda item going forward.

b) QAIG key issues for escalation from workshop on 16 June 2022

The Executive Director of Nursing and AHPs gave a verbal update following the QAIG workshop on Open/Closed Cultures. The workshop had provided good engagement and ideas across all the workstreams, and these would be fed into the next update report to Quality Committee.

c) Cancelled and rescheduled visits: verbal update

The Executive Director of Nursing and AHPs stated that the work that was being undertaken to address this issue was resulting in a significant reduction in cancelled and rescheduled visits. It was reported that there had only been two cases of visits being cancelled without a phone call to the patient since the last report, and this was due to human error. It was acknowledged that the written report due to Quality Committee in July 2022 would provide more detailed information.

2022-23 (23) Service Spotlight

a) Health Equity Strategy

It was agreed that due to the number of apologies given, this item would be postponed until the October Quality Committee meeting.

2022-23 (24)

For discussion: Quality governance and safety

a) Risk Register

The report was presented by the Chief Executive. The Executive Director of Nursing and AHPs stated that Risk 1070: *Capacity pressures in Neighbourhood Teams impacting ability to deliver full range of clinical supervision and annual appraisals* had been de-escalated in error and did indeed remain at risk level 12.

2022-23 (25)

Policies and reports for noting/approval/discussion

a) Safeguarding annual report

The Executive Director of Nursing and AHPs presented the report, highlighting the challenges faced by the Safeguarding Team due to Covid-19 sickness absence.

The Executive Director of Nursing and AHPs spoke about the work that had been undertaken around self-neglect, stating that a multi-agency team had been put in place to look at these cases.

A Non-Executive Director (AL) commented that although the report identified the key achievements of the team, they were not linked to the impact/outcomes.

The work on delivering the Prevent Duty was also noted by the Committee.

It was agreed that it was important for the Quality Committee to recognise the achievements of the Safeguarding Team over such a challenging year, and the Executive Director of Nursing and AHPs agreed to do this on the Committee's behalf.

Action: Recognition by the Quality Committee of achievements of the Safeguarding Team to be fed back to the team.

Actionee: Executive Director of Nursing and AHPs

b) Safeguarding strategy update

The Executive Director of Nursing and AHPs presented the report, stating that the work on the implementation of the Safeguarding Strategy 2020-2023 was on track and it was agreed that the impact of the work would be included in future reports.

The Committee Chair queried whether there had been an increase in referrals since children had returned to school following the Covid-19 pandemic. The Executive Director of Nursing and AHPs stated that this was the case and there had been a backlog, however it was hoped that the number of referrals would soon stabilise.

A Non-Executive Director (AL) referred to self-neglect and asked if this included work around hoarding. The Executive Director of Nursing and AHPs stated that this was also the case, and it would be made more explicit in future reports.

2022-23 (26) Matters for the Board
Committee's assurance levels and additional comments The Committee agreed that as the main workshop item (Item 23a) had been postponed, it would be inappropriate to assign a level of assurance to the Board for this. However, the Company Secretary stated that she would produce a report that outlined the Committee's discussions about the items that remained on the agenda.
2022-23 (27)
Reflections on Committee meeting There were no further reflections on the Committee papers.
2021-22 (28)
Any other business The Executive Director of Nursing and AHPs spoke about a meeting she had attended with the Clinical Lead, Children's Business Unit and the parents of a child whose story had been explored at a previous Board meeting. It was noted that the meeting was very positive, and the parents had offered to do some sessions with Trust staff. The Executive Director of Nursing and AHPs stated that she would keep Quality Committee updated on the progress.
Date and time of next meeting Monday 25 July 2022 9.30am – 12.30pm (Via MS Teams)

Leeds Community Healthcare NHS Trust

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 25 May (9.00 to 12.00 noon)

Present:	Richard Gladman (Chair)	Non-Executive Director
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Helen Thomson	Non-Executive Director (HT)
Attendance:	Jenny Allen	Director of Workforce (JA)
	Diane Allison	Company Secretary
	Dr Jill Halstead- Rastrick	Clinical Head of Service - Podaitry & Dental (Item 15)
	Hannah Turp	Project Manager (Item 17a)
Apologies:	Khalil Rehman	Non-Executive Director (KR)
	Thea Stein	Chief Executive
Note Taker:	Bridget Lockwood	Business Support Manager

Item 2022/23 (13): Welcome and introductions

Discussion points:
The Committee Chair welcomed everyone to the meeting.

a) Apologies: Apologies were noted from the Chief Executive, and a Non-executive Director (KR)

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 27 April 2022
The minutes of Public and Private meeting dated 27 April 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.

It was agreed that that following actions could be closed:

2021/22 **(39b)** A premises management action plan and risk analysis to be presented to the January 2022 meeting for further discussions. A new action regarding the production of a facilities report & action plan has been added to the action log to replace this action.

2021/22 **(40b)** The narrative accompanying the dashboard with the right level of detail to be incorporated into the performance brief from November 2021. It was agreed that there was improved narrative and supporting SPC charts in the performance briefs.

Item 2022/23 (14): Organisational and system context

Discussion point:

Covid and system pressures update
The Committee noted that the only information available on infection rates was data provided by the Office for National Statistics (ONS) due to the decline in mass testing, current data indicated that 1 in 45 people had the virus.

The position in the hospitals in Leeds remained pressured due to the significant number of people presenting at A&E and the lack of available beds for those admitted. System wide work was underway to relieve the position and a number of discharge workstreams would be scrutinised and challenged by a team from NHS England that were visiting Leeds on 14 June 2022. Neighbourhood Teams continued to accept patients referred by 2.00 pm for visits the following day. Following a question from the Committee Chair, the Executive Director of Operations confirmed that ambulance handovers were happening within the required timescales but there were challenges in securing reablement and home care for patients medically fit for discharge. A significant piece of work on integrating reablement with our intermediate care services was taking place, with a target to make progress on this by October 2022. Key elements of this work included the creation of a single queue for reablement and Neighbourhood Teams, an integrated allocation process, and a more transparent reporting system so that the system could monitor pressures 'at the door' of community services.

Organisational update
The Commiteee noted that Neighbourhood Teams were currently reporting either Opel level 3 or Opel level 3e, with Silver Command arrangements in place at a Trust level. Planning for the four day Bank Holiday weekend was underway to ensure resilience in teams. A potential area of particular concern was the Police Custody Service due to the increased number of arrests that usually take place over a bank holiday period. Staffing levels were being increased, however, it was noted that the Trust was attracting more people to work in this service.

Vaccination programme
The Joint Committee on Vaccination and Immunisation (JCVI) had published their expectations for the autumn vaccination campaign - this included those over 65 years, care home residents, health and social care workers and the clinically extremely vulnerable aged 16-64 years. This equated to 325k people in Leeds. The expectation was that the majority of vaccinations would be delivered by GPs and community pharmacies, with a small team ready to vaccinate those who find it difficult to access services.

The Committee Chair asked if the Trust was able to monitor the number of staff absences due to Covid-19 and the impact this was having on teams. The Director of Workforce confirmed that the Covid absence rate was monitored through a daily absence report and this week the absence rate due to Covid had dipped below one percent for the first time in some months and had halved since April 2022.

Item 2022/23 (15): Service focus - Podiatry

Discussion point:
Dr Jill Halstead-Rastrick, Clinical Head of Service (Podiatry and Dental) attended the Committee to deliver a presentation on the challenges of the pandemic and its impact on the service, staff and patient care, current pressures and challenges, and future plans for the Podiatry Service. The Committee noted that the service had been paused while some staff were re-deployed and there had been an impact on patients, in terms of incidents and complaints, and on staff.

The Committee Chair thanked the Clinical Head of Service for an excellent presentation. The Executive Director of Operations expressed their pride in the service, particularly in their approach to what had been, and continued to be, enormous challenges in terms of improving backlog and

waiting times, and vacancy rates. Discussions within the city needed to be resumed in order to establish exactly what service the NHS could provide, and to ensure that those most in need had the appropriate access to podiatry services.

A Non-Executive Director (HT) complimented the service on its 'can do' approach and asked how the waiting list was split between adults and children. The Clinical Head of Service confirmed that most patients were adults, children were mainly seen by the service for foot pain and nail surgery.

The Director of Workforce reflected on the excellent and very effective work that had been carried out on staff health and wellbeing within the service, which had been reflected in the Staff Survery results in 2021, and all the work being undertaken to address recruitment and retention challenges. The Director of Workforce asked if there was any other thinking about how some work might be undertaken by non-registered professionals due to the national shortage of registered podiatrists. The Clinical Health of Service accepted that this was the service's biggest concern and outlined a number of models to best utilise and diversify skills, including the use of some Band 3 roles to further support Band 4 roles in providing oversight rather direct patient care. The Trust was leading the way on this and was supported by Health Education England in this work.

The Executive Director of Finance and Resources queried the reference to two patient deaths in the presentation. Further information was shared with the Committee and it was agreed that this would be followed up after the meeting. It was noted that the service had invested in technology to enable the diagnosis of early vascular disease and a GP letter template used by the service had now been adopted nationally.

The Executive Director of Finance and Resources queried the use of a Band 2 role in the service. The service had been unable to recruit to some Band 3 Podiatrist roles so Band 2 posts had been recruited to carry out foot care in patient homes and assessments in clinics. This had allowed one more appointment per morning to be offered and had supported health and wellbeing within the teams as the Band 2 postholders had also been able to offer educational support to patients and carry out some of the paperwork required.

The Committee Chair commended the innovative approach taken by the service and felt that other services could learn from the team. They also asked how the Trust could encourage more staff to stay. The Clinical Head of Service responded that a number of offers would help with this including, developing staff, offering career opportunities, enabling staff to work more flexibly, and allowing staff to take up secondments so that they could bring back other skills to the service, and potentially stay in the profession longer. The Director of Workforce confirmed that including talent management, exploring with staff where they wished to be in two, three and five years' time was being considered for inclusion in the Trust's appraisal process. The Director of Workforce invited the Podiatry team to pilot this.

Outcome: the Committee noted the service focus presentation by the Podiatry Service.

Item 2022/23 (16): Strategy and planning

Discussion points:

a) Procurement Strategy progress report

The Executive Director of Finance and Resources introduced the report and highlighted the increase in the number of single tender waivers in 2021/22 due to the continued effects of the pandemic and the need to procure goods quickly to support service delivery. The cyclical trend around contract awards was noted, along with ambitions to improve the procurement function in the coming year. The Procurement Manager had been re-deployed during the pandemic.

The Committee noted that there were operational difficulties within Shared Business Services (SBS) and Leeds and York Partnership NHS Foundation Trust (LYPFT). The Trust would support LYPFT to resolve these issues, alongside a Transformation Director that had been engaged by

them to review the supplies and logistics functions and produce a strategy for change. This work had been delayed due to difficulties LYPFT were experiencing in recruiting skilled procurement staff.

The Committee Chair asked whether the Trust would consider taking control of the procurement functions in-house. The Executive Director of Finance and Resources felt that the Trust should support LYPFT to resolve the issues and added that it would not be possible for the Trust to provide the operational service provided by LYPFT.

The Commitee Chair asked whether agreed targets had been achieved in 2021/22. The Executive Director of Finance and Resources agreed to follow this up.

Action: (Executive Director of Finance and Resources)
Data on whether targets for supplies and logistics had been met in 2021/22 to be provided.

Outcome: The Committee noted the impact of the pandemic on the procurement functions ability to achieve its ambitions and objectives in 2021/22, and that these objectives would be taken forward into 2022/23 to further implement the Procurement Strategy and disseminate good practice, strengthening governance and improving efficiency.

b) Workforce Strategy progress update
The Director of Workforce introduced the bi annual update and highlighted that the context of the pandemic had permiated in the focus of the Strategy between October 2021 and March 2022.

The Committee noted that recruitment and retention continued to be a challenge with significant work underway to address this, in addition to a review of processes and time to hire. The fourth cohort of the Allyship programme was underway and this, and reverse mentoring continued to thrive. The Equality, Diversity and Inclusion Forum had been established with a focus on inclusion-related issues and driving organisation-wide action. The organisation had received improved Staff Survey results for 2021 and health and wellbeing continued to be an area of focus both locally and at an organisational level. Teams within the Workforce Directorate continued to see high levels of demand and the Well-led indicators reflected the challenges that remained.

A Non-executive Director (HT) asked how successful the healthcare support worker recruitment event had been in April 2022. The Director of Workforce responded that 12 of the 14 offers made on the day were still being progressed and these will continue to be monitored.

A Non-executive Director (HT) reflected on a number of positive ideas that emerged from the conversations at the recent Board workshop on resourcing and asked if these workshops should take place more frequently. The Director of Workforce welcomed these conversations, along with those at Business Committee, operational forums and the Resourcing Steering Group, given that resourcing was a significant risk for the organisation. The Executive Director of Operations highlighted that after struggling to recruit to the Domestic Assistant roles for some tme, the Trust had received 36 applications in a recent recruitment initiative due to a move away from using NHS Jobs as the means to apply for jobs.

The Committee Chair shared a request by a Non-executive Director (KR) to see data on workforce portability over the next months.

The Commiteee Chair asked how progress could be tracked when targets had not been developed or were not due to be reported until future years of the three year Strategy. The Director of Workforce clarified that some targets were set for future years and agreed to clearly set out in future updates when targets were due and how these were being monitored.

The Committee Chair queried the Trust's position on hybrid working and what a future model might look like. The Director of Workforce confirmed that a set of principles on hybrid working had been agreed by the Senior Management Team with an acknowledgement that how these are applied

would be contingent on the type of service, whether this was clinical or non-clinical, and where the service is delivered. There would no longer be an expectation that all work needed to be carried out in real life, and could be virtual, especially for non-clinical services. The Executive Director of Finance and Resources confirmed that the position for each team was being reviewed in order to determine the size required for the headquarters building. The Trust was also moving to a position where all non-clinical delivery rooms were available for all staff to use. The Committee Chair accepted that decisions on hybrid working were operational but requested further clarity on the implications of hybrid working on Estate requirements in the revised Estate Strategy and in the Digital Strategy. The Committee Chair requested that the principles that govern the future approach to hybrid working, agreed by SMT, be shared with Committee members.

Action: (Director of Workforce)
The principles for hybrid working in the Trust to be shared with Committee members for information

Outcome: The Committee noted the update against the Workforce Strategy

c) Estates Strategy progress update
The Commiteee noted the Community Estates Plan 2022-37, a citywide paper which outlined the context for the development of a revised Trust Estates Strategy. Service plans and how they will meet population health needs in the future would need to be developed in order to draft a revision. A piece of work on service strategy had been commissioned and priorities included keeping buildings safe, to take opportunities as they arise, enable the headquarters move, and the clinical administration space project.

The Committee Chair acknowledged that work to refresh the Strategy had been paused due to the pandemic and requested more information on a longer term vision, how this fitted with the rest of the city, and what the Trust sought to achieve by the end of the financial year. The Executive Director of Finance and Resources agreed to work with the Associate Director of Estates to map this out over the rest of the year.

The Director of Workforce asked if the implications for staff of any change management had been included in the thinking around the Strategy. The Executive Director of Finance and Resources confirmed that this would form part of the vision for how staff worked in the future and the implications for staff were significant in terms of how buildings were used in the future, where people were based, and how they would travel there, given the Trust's sustainability ambitions.

Action: (Executive Director of Finance and Resources)
A target date for the new Estate Strategy including milestones to be achieved to be determined

Outcome: The Committee noted the developing Community Estates Plan for the city

d) Facilities management update
The Trust had received a report commissioned to outline the future organisational form for facilities management within the Trust. An interim Facilities Manager had been appointed for six months to provide the internal management structure, ensure that policies and procedures were in place, and to provide leadership on the compliance of any standards required of the Trust. The premises assurance model would be more robust if these areas were addressed, and the capacity and expertise brought by the individual would allow time to consider how a future model might work.

The Committee Chair felt that the action relating to waste management had been covered and could now be closed, however, he questioned whether the risk areas from the original risk analysis on premises management had been addressed. The Executive Director of Finance and Resources agreed to invite the Interim Facilities Manager to present a written update on progress to the Committee in three months.

Action: (The Executive Director of Finance and Resources)

Facilities Manager to present a written update on progress relating to the premises assurance model in three months time,

Outcome: The Committee noted the verbal update

Item 2022/23 (17): Change Management and Projects

Discussion points:

a) E-Rostering update

The Project Manager delivered a presentation on the e-rostering project closure. The rollout of e-rostering had concluded and the Trust had achieved the NHS England Level 1 target. The project had been a helpful solution for the Trust to utilise during the pandemic. 90 per cent of services now utilised the system to manage capacity, and neighbourhood teams were now able to do this in line with clinical skills. The team were now looking to transition the project to a business as usual service.

The Committee Chair commended the team for a terrific project and for all their hard work during the pandemic. The Director of Workforce also acknowledged the great job the Project Manager and the team had done in delivering a complex project on time, in very difficult circumstances. The challenge now was to leverage the technology to manage resources better. The Committee Chair asked how this might be achieved. The Project Manager responded that the team would now maintain core processes and system, and expand the approach to using the system as a resourcing tool, including training for managers. The neighbourhood teams were currently utilising the system to establish safe staffing levels. Local partners also used Allocate software so joint work was underway, including the provision of staff passporting arrangements, and the Covid vaccination team was a good example of how this worked well.

The Committee Chair queried any further developments. The Project Manager outlined the e-Community project which would provide further information and data in order to further leverage the system. This would enable the allocation of work according to the skills of clinicians and the time required to see each patient, and would automatically calculate routes to reduce travel time, and to limit the time clinicans need to spend inputing expense claims. An update would be provided to the Business Committee in the autumn.

A Non-executive Director (HT) thanked the organisation for its support for the project.

Action (Executive Director of Operations)

An update to be provided on the Digital Allocation project (October 2022)

Outcome: The Committee noted the update

b) Patient Administration project update

The Executive Director of Operations provided a verbal update and it was noted that eight engagement events had taken place and half the individual meetings with staff had been concluded. Following the conclusion of the individual consultations, a summary of the feedback would be shared with the Senior Management Team to determine the next stage of the review. Work was underway to further engage with some teams and managers.

The Committee Chair asked if the new model would be launched. Staff were already being moved over to the new admin teams and this would continue to happen gradually over the rest of the year. The Executive Director of Operations expressed a preference for an admin celebration event focussing on career progression and the creation of a professional admin function, rather than a launch.

Outcome: The Committee noted the verbal update

c) New staff hub update (Stockdale replacement)
The Executive Director of Finance and Resources briefed the Committee that following the Strategic Outline Case, the Senior Management Team had considered two available options based on the size of building required. The project team had visited both sites and both were confirmed as being suitable for the Trust's needs. A final business case was being drafted to determine the cost implications and to what extent each building met the Trust's needs. The business case would be presented to the Business Committee and the Trust Board for a final decision. External programme managers to support the change programme would be engaged, including a digital manager to facilitate the move to a new building.

The Commitee Chair asked if the assumptions had changed regarding the size of building required. The Executive Director of Finance and Resources confirmed that this had been revised and the options under consideration were between 50 and 75 per cent of the size of space leased at Stockdale House. It was difficult to determine how much space would be required given the need to iterate this with remote working, however, it was likely that there would be a reasonably short break on a 10 year lease. The Trust would have a portfolio of buildings that could be utilised by staff rather than there being a requirement for staff to work at a headquarters building. The Executive Director of Finance and Resources confirmed that the Stockdale House lease expired in October 2023 and that sustainability, including public transport options, would be taken into account in the final business case.

The Committee Chair asked for assurances that the Trust Sustainability aims were being fully considered in selecting the new building.

Outcome: The Committee noted the verbal update.

Item 2022/23 (18): Performance Management

Discussion points:

a) Performance Brief and Domain Reports

i) April 2022
The Committee noted that the report included data only to allow the Business Intelligence Team to concentrate on the year end report for 2021/22 The Committee Chair asked if any early trends should be noted from April's data on staffing. The Director of Workforce responded that levels of short term sickness were within agreed tolerance levels, half of this sickness absence was due to Covid-19 and this rate was now in decline. Turnover remained at around 15 percent, with more work to do on this, including scrutiny of hot spot areas. Appraisal rates continued to improved and statutory and mandatory training rates had been consistent over the last five to six months.

Long term sickness absence, predominantly due to stress and anxiety, was of greater concern, and included 30 cases of Long Covid. Corporate and operational teams continued to work hard to create an environment where staff are well and in work, and the Committee noted that HR Business Partners and line managers work together to offer support, and to determine how further support might be offered to facilitate a return to work. The Executive Director of Operations informed the Committee that an action had been agreed at the Quality Committee on 23 May 2022, for completion within a month, to ensure that all those on sick leave had been contacted. The Director of Workforce added that a number of offers were in place for all staff to access, including the Employee Assistance programme and mental health first aiders.

ii) Annual performance brief summary (2021/22)
The Committee Chair asked the Executive Director of Operations if they had any reflections on the challenge to reduce waiting lists. The Executive Director of Operations reflected that the wave of escalation in March 2022 had limited progress and hindered improvements that had been made to that point. A number of temporary staff and locums had been recruited to assist with this work

and some of these had subsequently been offered permanent employment. The Committee would receive an update on the work being undertaken by the Head of Strategy, Change and Development at its meeting in June or July 2022. It was noted that budget restraints may constrain this work at some point.

The Director of Workforce observed that the year end report reflected a year of Covid-19 waves and sickness absence, however, the capacity enhancing work had had an impact.

The Committee Chair commented on the improved analysis in the report and the Executive Director of Finance and Resources agreed that improved narrative along with SPC charts had been incorporated in this report. Future reports would replicate this style, with further statistical analysis on areas of underperformance, hot spots and areas of good performance.

The Committee Chair asked the Executive Director of Operations if the neighbourhood triangulation report might be included in the performance brief. It was agreed that this would continue to be presented to the Business Committee as a separate report.

Please see Private discussion minutes for annual finance update.

Action: **(Executive Director of Operations)**
Waitlists position paper to be provided at the next meeting.

Outcome:
The Committee noted the Performance Brief reports for 2021/22 and April 2022

iii) Operational and non-clinical risk report
The Company Secretary introduced the report which summarised changes to non-clinical risks on the risk register. The following changes were noted:

- One new risk: (Risk 1099) relating to the need to improve procedures to ensure the use of CCTV complied with the law. An action plan was in place to aim to ensure compliance within the next month
- Two escalated risks: (Risk 877) risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand, and (Risk 1072) management of children's community feeding team's increased caseload and workload

A Non-executive Director (HT) confirmed that risks 1099 and 877 had been reviewed at the Quality Committee meeting on 23 May 2022.

Outcome:
The Committee noted the recent revisions made to the risk register.

c) Quality, staffing and finance: triangulation Neighbourhood report
The Executive Director of Operations confirmed that the Quality Committee had also reviewed this report.

The Committee Chair shared concerns raised by a Non-executive Director (KR) regarding neighbourhood team capacity and asked if any new initiatives were in place to address workforce capacity issues. The Executive Director of Operations outlined the Enhanced project with third sector organisations which aimed to move some patients to the care of one of 14 third sector organisations taking part. Work was also taking place to better integrate reablement services with the Trust's intermediate care services and it was hoped that improvements would be seen by October 2022. Work was also underway with homecare providers to seek to utulise their staff when not with clients. These projects were in their infancy but results would be seen in the longer term.

The Committee Chair asked if the report could include SPC charts to better illustrate trends. The Executive Director of Operations agreed to check if this would be possible.

Action: (Executive Director of Operations)
Neighbourhood triangulation report to include charts to illustrate trends if possible.

Outcome:
The Committee receive the report and noted areas of achievement and those still to progress.

Item 2022/23 (19): Minutes to note

Discussion points:

Health and Safety group minutes (Chair approved) to note – 7 April 2022
The Committee Chair asked if the organisation intended to continue the use of the lone worker app. The Executive Director of Operations responded that the app was not being utilised as it should be but a helpful conversation had taken place with Trade Union representatives at a recent JNCF meeting about how the app might be better received culturally. The implications if staff chose not to use the app also needed to be worked through.

Outcome: The Committee noted the minutes from the Health and Safety Group meeting held on 7 April 2022.

Item 2022/23 (20): 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 agenda items.

The Committee agreed a reasonable level of assurance had been provided for the strategic risks on all the papers and topics discussed in today's meeting, with some areas noted as being under pressure, such as health and safety and procurement.

The Committee Chair would brief the Trust Board on the updates relating to the Change Programme, financial position, system and internal operational pressures, including the neighbourhood teams.

Item 2022/23 (21): Business Committee Governance

Discussion point:
The Committee Chair requested that the workplan be refreshed at the next Committee agenda setting meeting to ensure the correct topics were included from autumn 2022 onwards.

Action: Committee Chair, Executive Director of Finance and Resources and Company Secretary to review the workplan at the next agenda setting meeting.

Future work plan
The Committee reviewed and noted the work plan and rescheduled deferred items.

Item 2022/23 (112): Any other business

None discussed.

Leeds Community Healthcare NHS Trust

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 29 June (9.00 to 11.30 am)

Present:	Richard Gladman (Chair)	Non-Executive Director
	Helen Thomson	Non-Executive Director (HT)
	Khalil Rehman	Non-Executive Director (KR)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Jenny Allen	Director of Workforce (JA)
	Diane Allison	Company Secretary
Apologies:	None recorded	
Observer	Nigel Hodgkins	Head of Service – PHINS
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resoruces

Item 2022/23 (23): Welcome and introductions

Discussion points:
The Committee Chair welcomed members of the Committee and Nigel Hodgkins, Head of Service (PHINS) as an observer to the meeting.

a) Apologies: None recorded.

b) Declarations of interest
Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda to ensure there was no known conflict of interest prior to papers being distributed to Committee members. No additional potential conflicts of interest regarding the meeting's agenda were raised.

c) Minutes of meeting dated 25 May 2022
The minutes of Public and Private meeting dated 25 May 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 (61): To provide a response about the health equity and digital access for families
The Executive Director of Operations reported that the ICAN service had now converted to 'all face to face' consultation unless the family specifically asked for a digital consultation. Work was underway to collect equity information going forward. **Action Closed.**

Item 2022/23 (01): Health and Safety Group update / escalations
An update would be provided following discussions at Joint Negotiation Consultation Forum (JNCF) on 13 July 2022. The outcome of discussions both at Senior Management Team meeting (SMT) and JNCF regarding the Lone Worker App was rolled forward to July 2022 meeting.

Item 2022/23 (16): Procurement strategy update
The Executive Director of Finance and Resources said that the absence of KPIs in the Annual Procurement Report was because the work had been suspended in 2021/22 during Covid when the procurement manager was focusing on managing the personal protective equipment supply. **Action Closed.**

Item 2022/23 (21): Business Committee Governance
The review of the workplan for the remainder of the year was conducted but is being considered further as an iterative process. **Action Closed.**

Item 2022/23 (24): Organisational and system context

Discussion point:

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.

Numbers of patients in hospitals were increasing. The system was under pressure, not just from Covid but mainly from people who remained in hospital with no medical reason to reside there. One of the issues was the lack of community care beds for prompt discharge.

The Executive Director of Operations said that in terms of the Trust there was still significant pressures in services and a concern at the Young Offenders Institute, mainly due to the increased Covid related sickness.

Vaccination programme
The Trust was expecting to receive guidance on the Covid vaccination programme shortly.

In response to the Committee Chair's question about implications of staff for the next set of booster jabs being extended the Executive Director of Operations said that at the moment bank staff were working on the Leeds Teaching Hospitals NHS Trust bank and negotiations were underway to bring them onto the LCH bank. There was also an issue about the cost of per item of service for general practices and pharmacies being an added risk to consider, assuming the same level of service is provided as in previous waves. Again details were expected.

The Committee was advised that the monkeypox outbreak had been declared a public health emergency, and that the Sexual Health Service had been asked to set up a vaccination campaign. Appropriate sites were being set up for vaccinating for patients infected through both sexual contact and non-sexual contact including children.

Item 2022/23 (25): Strategy and planning

Discussion points:

a) Estates Strategy progress update
The Executive Director of Finance and Resources provided a verbal update.

The actions on the current Estate Strategy (2019 to 2024) were continuing. The Executive Director of Finance and Resources said that the work on the refreshed strategy had already begun in the background. He noted that it was planned to include more on demographics and an understanding of population needs rather than an estates driven approach.

The Committee Chair queried the annual estates delivery plan for this financial year. There were four key estates projects for this year: completion of Seacroft refurbishment, continue to develop Burmantofts proposal, the clinical administrationspace review and relocation of the Trust's head office.

b) Fire risk assessment programme report
The report provided the Committee with an update on the progress made in reviewing fire risk assessments and the approach to reducing the backlog.

The Committee learnt of the current situation regarding the backlog that had built up within the fire risk assessment programme, and the reasons for this. The Committee recognised the pandemic had prevented assessments taking place as they required witnessing staff behaviour in relation to fire safety in buildings.

Measures and plans were in place to perform the assessments and good progress had now been made. Several fire risk assessments had been completed since the previous report submitted to the Health and Safety Group in February 2022.

A target date of June 2023 has been set for all fire risk assessments to be brought up to date, and a commitment to maintain and monitor a sustainable programme of regular fire risk assessments in future.

The Executive Director of Finance and Resources advised the Committee that a significant amount of capital money had been spent in the last financial year on fire compliance works as well as the fire risk assessments undertaken by an external company.

A Non-Executive Director (KR) asked whether the Committee would be receiving reports on a by exception basis when any issues are identified. It was noted that the Committee would be receiving assurance on a range of estates and facilities matters. The Executive Director of Finance and Resources said that the Premises Assurance Model (PAM) had a significant role to play in this which could be developed into an assurance reporting framework to be reported by the estates and facilities teams into the Business Committee and which would certainly include fire assessments.

The Company Secretary added that in terms of monitoring the fire risk assessments and progress against the targets this would be the remit of the Health and Safety Group who report into the Business Committee, but she was happy for a detailed report to be received by the Committee in six months' time on progress and any issues that arise.

The Committee Chair asked about the responsibility for buildings not owned by the Trust and whether the landlords could provide fire risk assessments to gain assurance on the work that they do. The Executive Director of Finance and Resources said that it was extremely difficult to receive any reports or information from landlords, however the responsibility for the fire risk assessments for the demised spaces occupied by Trust staff is with the Trust.

Action: Executive Director of Finance and Resources
Fire safety compliance to be incorporated into the H&S compliance reports

Outcome:
The Committee confirmed that the approach for reducing the backlog of fire risk assessments for the Trust and the proposed target date was acceptable. Any issues or concerns in the future would be escalated through Health and Safety Group.

Item 2022/23 (26): Performance Management

Discussion points:

a) Waiting list update report (tackling backlogs)
The Committee received a comprehensive report that described the existing organisational initiatives that were focussed on improving the organisation's backlogs and waiting list position

and it considered how work could be better aligned and how to create a more impactful and sustainable approach to managing people who were waiting for care.

The Executive Director of Operations said that there was significant work going on to understand the totality of waiting lists, not just the backlog. She advised the Committee that the Trust continued to contract with an external provider to deliver aspects of CAMHS assessment work.

The paper mapped a range of work being undertaken across the organisation to address waiting lists and backlogs and also introducing approaches used in other areas. A reset dashboard had been created that helped identify where support was required the most. The improving patient prioritisation project ensured that the data collection was consistent with all the waiting times expectations nationally.

In respond to a Non-Executive Director's (HT) questions about interorganisational work and tracking of progress, the Executive Director of Operations said that at the moment the wait list only included the first waits (the first appointment after referral). The next steps were to track progress month on month for assurance that this situation was improving. The dashboard was being considered on a weekly basis and would be included in the performance brief.

The Committee Chair felt that incorporating any concerns or improvement into the performance brief and the mitigation to deal with those concerns was the right approach. He said as things developed, they could be picked up to give a good overview of a true picture of all the waits in the system.

A Non-Executive Director (KR) asked about the follow up and clarity around the quality improvement pro-action plan. He queried the data on equity and waits and he also asked about the triangulation of the impact on quality, the innovations and what service users thought about some of the changes. The Executive Director of Operations said that Healthwatch had undertaken a piece of work to understand patient views on secondary care waits. She said lessons could be learnt from that experience. She would give further consideration to the equity data and whether partners could provide support.

The Chief Executive referred to a deep dive into MSK when there was concern about the level of waits and there needed to be clear analysis around health equity and assurance. A report was received at the Quality Committee clearly setting out the framework for any clinically deteriorating patients and an active approach to people on waiting list was in place. She said the conclusion of Healthwatch and others was that proactively communicating regularly was appreciated particularly for people at higher risk, and especially when people did not have access to digital technology. The Executive Director of Operations said that further work was continuing about prioritisation based on a number of factors, including clinical needs, areas of deprivation and areas where there was a particular condition that might affect the population.

The Committee Chair said that he was looking forward to an update in the future in a more structured way against each of the strands of work in the framework. Both the Business Committee and the Quality Committee should receive updates in future on areas of risk and progress as appropriate.

The Committee Chair queried what happened after 18 weeks threshold was breached and if there was an obligation to offer patients alternatives. The Executive Director of Operations agreed to report back to the Committee on this point.

In his conclusion the Committee Chair said that a new strategic risk had been introduced on the Board Assurance Framework on waiting lists. He said it felt like a confident journey, having some of the controls and governance in place and lots more work to be done in terms of transformational change, and not necessarily having full assurance that everything was under control at the moment. The Executive Director of Operations said that it was a fair assessment that for the first waits, the position was clear but for secondary waits there was less assurance.

Outcome:
The Committee receive the paper and noted the creativity and data challenges and next steps to drive down the backlogs.

Action: The Executive Director of Operations
- Waiting lists – further report (later date TBC) to include the patient's voice and update on work on hidden (secondary) waits.
- Waiting lists – Advice the Committee of the options available to offer patients following breach of 18 week wait (choices for patients).

b) Operational and non-clinical risk report
The summary report detailed the changes to non-clinical risks on the risk register and noted no new risks had been added to the Trust risk register since the last report. One risk has been de-escalated.

Outcome:
The Committee noted the recent revisions made to the Trust risk register.

Item 2022/23 (27): Business and commercial (Private)

Renewal of contract: Community Ventures Ltd (CVL) – Please see private minutes

Item 2022/23 (28): Governance

Board Assurance Framework (BAF) review
The Committee reviewed the BAF strategic risks assigned to the Committee and agreed a number of additional sources of assurance that would be either incorporated into existing reports or added to the workplan as additional items of assurance.

The Company Secretary drew the Committee's attention to four risks that were light on sources of assurance and asked for Committee's consideration. Any gaps in assurance on the BAF had been highlighted in red. The following comments were noted:

New risk: waiting lists
The Executive Director of Operations said that each business unit completed a lengthy report for the performance panel monthly meetings and the granularity of that was not appropriate to circulate regularly. It was noted that any summary of the key items would be a duplication. There was a suggestion that perhaps the Committee Chair could attend one of the performance management meetings to seek assurance.

Existing risk 2.2: Contractual requirements
The Committee agreed the series of sources of assurance were still current and up to date.

Urgent and emergency access standards
It was noted that in terms of the emergency care standards that the two hour response time had no contractual requirement to meet it.

Non-CCG contracts
The Performance Brief noted particular contracts were picked up through the regular reporting mechanisms. On an annual basis there was a review of performance of significant contracts. The Committee Chair suggested a review of the current information where there was underperformance. The Executive Director of Finance and Resources agreed to explore appropriate means of providing updates to the Committee on non-CCG contracts.

A Non-Executive Director (KR) was interested in the way this Committee or the Trust Board would assess risks of continuity and quality around those kind of new models and understand them better. The Committee Chair said that there might be an element of that related to the strategic risk about partnership arrangements and reports on contractual partnership arrangements to strengthen that source of assurance.

Productivity group reports
This group was no longer operating. Some of the productivity work continued as part of the pandemic initiative and the productivity gains had been captured and re-invested back into services. The Executive Director of Finance and Resources said this would be reviewed towards the end of summer 2023 in anticipation of more difficult financial years to come from April 2022. Should the productivity group be re-instated, he would involve people Trust wide.

The Chief Executive said that it was important that the Business Committee heard about productivity linked to the wider conversation about making stuff better, inspiring people, clinicians and patients and bring that information back. She said the work in the Children's Business Unit on productivity was an important piece of work and should be shared across organisation.

Delivering key financial target
There were a number of regular reports and sources of assurance. The Executive Director of Finance and Resources said that the prime role of the Trust Board was to manage the Trust's finances in the context of partnership and collaboration within the context of understanding the citywide situation.

Capability and capacity to use digital to support in services
This related to the context of digital strategy in terms of help desk and having enough digital tools to help people to do their jobs. The Chief Executive said that over time the Trust would become increasingly dependent on others either for providing a service or solutions shared across the city. She felt that this had created a risk in terms of relying on that, and perhaps not receiving information in a timely fashion. There was a need for better citywide reporting to gain sources of assurance.

Risk 3.1 Staff capacity and capability
It was noted that a set of regular reporting provided sufficient assurance. The Director of Workforce (LS) confirmed that it was up to date. The stability index indicator was being changed into a net movement indicator in the performance brief. Any additional sources of assurance in the quarterly workforce report, six monthly workforce strategy update and workforce focused topics should provide that assurance on those existing items.

The Committee Chair asked about the use of non-LCH resource and how to keep a track of that, and partnering with the Third Sector to outsource some elements of service provision. The Director of Workforce (LS) said assurance was sought through the system partner element of the workforce strategy in the six monthly update.

Risk 3.3 Leadership capability and developing managerial leadership
A number of particular sources related to the strategy update and staff survey. The Director of Workforce (LS) said that workforce focused events specifically on leadership could be evaluated to provide assurance. She said there were also discussions taking place with teams responsible for leadership and management courses.

A Non-Executive Director (HT) noticed that nothing had been listed on equity in terms of leadership opportunities for people with protected characteristics. She asked whether that would be captured explicitly in the workforce strategy report. She said updates in terms of WRES and WDES is captured in the performance brief, but more was needed. The Workforce Director (LS) said she would consider that outside the meeting to establish sources of assurance.

Risk 3.4: Health and safety management system
It was agreed that leading and lagging indicators were required and it was confirmed that these were being developed by the Health and Safety Group to monitor and measure progress.

The Committee Chair said that it would be good to hear about progress with key performance indicators and to receive a health and safety action plan as part of a future update to the Committee

3.5 Business Continuity
The Executive Director of Operations said that the feedback from the external assurance assessment, and as well as internal assurance, suggested regular reporting on outcomes of any exercise.

Risk 4.2 Partnership arrangements
A six monthly financial performance report on partnerships is to be produced for the July 2022 meeting. The Company Secretary said that it was difficult to coordinate minutes from external groups and to track external meetings aligned with Trust meetings and that thought needed to be given on effective reporting of partnership activity and issues.

Action: Executive Director of Finance and Resources
Report on performance against non CCG significant contracts (date TBC).

Action: Head of Corporate Governance, Safey and Risk
Revise BAF in line with committee suggestions.

Outcome: The Committee reviewed the sources of assurance and agreed a number of revisions.

Item 2023/23 (29): Change Management and Projects

a) Change management priorities list
The Committee discussed the criteria that should be applied to determine which of the current programmes and projects should be major change programmes. SMT were to discuss this further and consolidate their views. There was a total of 29 projects and SMT were to agree the top 10 or so priority ones which were important, urgent and/or critical and ensuring the right balance was achieved across all directorates.

The Chief Executive suggested that the headoffice move was time critical, finance critical, and an urgent project that required oversight at committee level.

The Committee Chair said that after agreeing the top 10 projects the Committee should review, add or subtract accordingly. He also reaffirmed the importance of a holistic and overarching program management and tracking framework to track the wider range of change management projects being undertaken. The Chief Executive said that where there were a range of programmes and projects connected with the workforce strategy, this was already being reported to the Committee via the strategy updates and this could lead to duplicate reporting.

Outcome:
The top 10 projects to be debated at a subsequent meeting.

b) ICAN health equity/ digital access
Comments were noted earlier in the meeting when the action log was reviewed.

Item 2022/23 (30): Minutes to note

Discussion points:

Health and Safety Group update (meeting dated 23 June 2022)

The Executive Director of Finance and Resources provided a verbal update from the meeting dated 23 June 2022. He highlighted the main items for the Committee's attention.

A greater than normal number of significant incidents had occurred and were being investigated. The Executive Director of Finance and Resources said there was a good opportunity to learn from the investigations into the nonclinical incidents.

In the annual occupational health report there were high level of did-not-attends for Leeds Community staff referred to the service when compared with other trusts' staff. Further work was underway to try and understand the cause of it.

Outcome
The Committee noted the verbal update from the Health and Safety Group meeting held on 23 June 2022.

Item 2022/23 (31): 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 agenda items.

The Committee agreed a reasonable level of assurance had been provided for the strategic risks on all the papers and topics discussed in today's meeting.

The Committee Chair would brief the Trust Board on the updates relating to:

- Fire Risk Assessments
- Tackling wait lists and backlogs
- Estates management agreement
- Board Assurance Framework (BAF) review
- Major change programmes
- Estates Strategy progress update

Item 2022/23 (32): Business Committee Governance

Discussion point:

Future work plan
The Committee reviewed and noted the work plan and rescheduled deferred items.

Item 2022/23 (33): Any other business

None discussed.