Bundle Public Board Meeting 2 February 2024

Agenda

Final Agenda Public_Board_Meeting_2 February_2024

94 09:00 - Welcome, introductions and apologies: Amanda Jackson, 0-19 PHINS Clinical Team Manager (South Team) and Baby Bubble Leeds Lead, Leeds Community Healthcare NHS Trust - (Shadowing the Execuitve Director of Nursing and Allied Health Professionals) Apologies: Alison Lowe OBE – Non-Executive Director

95 Declarations of interest

96 Questions from members of the public

Minutes adoption for approval

97 09:10 - Minutes of previous meeting and matters arising:

97.a Minutes of the meetings held on: 8 December 2023

Item 97a Draft Public Board minutes 8 December_2023

97.b Actions' log

Item 97b Public Board Actions log February 2024

98 09:15 - Patient's story: Community Neurology Rehabilitation Service

99 09:35 - Chief Executive's report

Item 99 CEO report - February 2024 v2

100 09:45 - Mid-winter Update on System Flow

Item 100i Mid winter and system flow_update Cover Sheet

Item 100ii Mid-winter system flow update

101 09:55 - Committee Chairs' Assurance Reports:

101.a Audit Committee: 15 December 2023

Item 101a AC Chairs assurance report Dec 2023

101.b Charitable Funds: 15 December 2023

Item 101b Charitable funds Committee Chair Assurance Report_December 2023

101.c Nominations and Remuneration Committee: 15 December 2023

Item 101c Nom and Rem Committee December 2023 - Chair Assurance report V1.0

101.d Quality Committee: 22 January 2024

Item 101d QC Chairs assurance report Jan 2024 FINAL

101.e Business Committee: 24 January 2024

Item 101e Business Committee Chair assurance report Jan 2024 FINAL

101.f Committee membership proposed amendments - Rachel Booth to join Audit Committee

102 10:15 - Performance brief

Item 102 Performance Brief - December 2023 -Board Version Amended Feb 2024

103 10:25 - Significant Risks and Board Assurance Framework (BAF)

Item 103 Significant risks and risk assurance report Jan 2024 Final

104 10:40 - Freedom to Speak Up Guardian Report (John Walsh presenting)

104.a Update report

Item 104a FTSUG report Feb 2024

104.b Self reflection toolkit

Item 104bi FTSUG planning tool cover paper
Item 104bii FTSU planning tool (2)79 RG (2)

105 10:50 - Safe Staffing Report
Item 105 Safe staffing report January 2024

106 11:00 - Patient Experience Six Monthly Report
Item 106 Trust Board Patient Experience Six Month report July- Dec v2 (002)

107 11:10 - Trust Board Priorities 2023-24 – update report
Item 107 Trust Priority Q3 Exception Report for Board

108 11:20 - Third Sector Strategy update
Item 108 3rd Sector Strategy Update - Jan 2024 FINAL

109 11:30 - Mortality report : Quarter 3 2023-24
Item 109 Mortality report Q3 23_
Item 109i Adult Mortality Report Q3 23 24
Item 109ii QAIG flash report CBU Child Death Q3 23 24 FINAL

110 11:35 - Standing orders and standing financial instructions - for approval
Item 110 Review of SOs SFIs and Scheme of Delegation Feb 2024

111 11:40 - Patient Safety incident Response Framework process – for approval
Item 111 3 PSIRP LCH FINAL Draft

112 11:50 - Frontline Digitisation update
Item 112 Frontline Digitisation Paper for Public Board 25012024

113 11:55 - Any other business and questions on Blue Box items

114 Close of the public section of the Board

115 Blue Box: Information Governance Annual Report
Item 115 IG DPO update. Final

116 Blue Box: Research and Development Strategy update
Item 116 RD Strategy Update Jan24

117 Blue Box: Board workplan
Item 117 Public Board workplan 2023-24 v5 25 01 24

Leeds Community Healthcare NHS Trust

Agenda Trust Board Meeting Held In Public
Venue:
Leeds Mencap
The Vinery Centre
20 Vinery Terrace
Leeds LS9 9LU

Date 2 February 2024
Time 9:00 – 12:00noon
Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2023-24 94	9.00	**Welcome, introductions and apologies** *(Trust Chair)* Amanda Jackson, 0-19 PHINS Clinical Team Manager (South Team) and Baby Bubble Leeds Lead, Leeds Community Healthcare NHS Trust - *(Shadowing the Execuitve Director of Nursing and Allied Health Professionals)* **Apologies:** Alison Lowe OBE – Non-Executive Director	
2023-24 95		**Declarations of interest** *(Trust Chair)*	**N**
2023-24 96		**Questions from members of the public**	**N**
2023-24 97	9.10	**Minutes of previous meeting and matters arising** *(Trust Chair)* *For approval*	
97a		Minutes of the meetings held on 8 December 2023	**Y**
97b		Actions' log	**Y**
2023-24 98	9.15	**Patient story –** Community Neurology Rehabilitation Service *(Steph Lawrence)*	**N**
QUALITY AND DELIVERY			
2023-24 99	9.35	**Chief Executive's Report** *(Sam Prince)*	**Y**
2023-24 100	9.45	**Mid-winter Update on System Flow** *(Andrea North)*	**Y**
2023-24 101	9:55	**Committee Chairs' Assurance Reports:**	
101a		Audit Committee: 15 December 2023 *(Khalil Rehman)*	**Y**
101b		Charitable Funds: 15 December 2023 *(Steph Lawrence)*	**Y**
101c		Nominations and Remuneration Committee: 15 December 2023 *(Trust Chair)*	**Y**
101d		Quality Committee: 2021 – 22 January 2024 *(Helen Thomson)*	**Y**
101e		Business Committee: 24 January 2024 *(Rachel Booth)*	**Y**
101f		Committee membership proposed amendments - Rachel Booth to join Audit Committee *(Trust Chair)*	**N**

2023-24 102	10.15	**Performance Brief** *(Bryan Machin)*	**Y**
2023-24 103	10.25	**Significant risks and Board Assurance Framework (BAF) Report** *(Sam Prince)*	**Y**
BREAK			
2023-24 104	10.40	**Freedom to Speak Up Guardian** *(John Walsh presenting)*	**Y**
104a		Update report	Y
104b		Self-reflection and planning toolkit	Y
2023-24 105	10.50	**Safe Staffing Report** – *reviewed by Quality Committee and Business Committee January 2024* *(Steph Lawrence)*	**Y**
2023-24 106	11.00	Patient Experience Six Monthly Report- *reviewed by Quality Committee January 2024* *(Steph Lawrence)*	**Y**
2023-24 107	11.10	**Trust Board Priorities 2023-24 – update report** *(Bryan Machin /Steph Lawence)*	**Y**
2023-24 108	11.20	**Third Sector Strategy update**- *reviewed by Business Committee January 2024* *(Andrea North)*	**Y**
2023-24 109	11.30	**Mortality report quarter 3 –** *reviewed by Quality Committee January 2024* *(Ruth Burnett)*	
APPROVAL/SIGN OFF			
2023-24 110	11.35	**Standing orders and standing financial instructions - for approval -***reviewed by Audit Committee December 2023* *(Sam Prince)*	**Y**
2023-24 111	11.40	**Patient Safety Incident Response Framework process – for approval –** *reviewed by Quality Committee January 2024* *(Steph Lawrence)*	**Y**
2023-24 112	11.50	**Frontline Digitisation update** *(Bryan Machin)*	**Y**
CLOSE			
2023-24 113	11.55	**Any other business and questions on Blue Box items** *(Trust Chair)*	**N**
2023-24 114	12.00	**Close of the public section of the Board** *(Trust Chair)* The Board resolves to hold the remainder of the meeting in private due to the confidential or commercially sensitive nature of the business to be transacted.	**N**

All items listed (Blue Box) in blue text, are to be received for information/assurance, having previously been scrutinised by committees. The Trust Chair will invite questions on any of these items under Item 113.

Additional items (Blue Box)		
2023-24 115	**Information Governance/Data Protection Offcer update report** – *reviewed by Audit Committee December 2023*	**Y**
2023-24 116	**Research and Development Strategy update** *-reviewed by Quality Committee January 2024*	**Y**
2023-24 117	**Board Workplan**	**Y**

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (97a)

Title: Trust Board meeting minutes 8 December 2023

Category of paper: for approval
History: N/A

Responsible director: Chief Executive
Report author: N/A

Attendance

Present:	Brodie Clark CBE	Trust Chair
	Sam Prince	Interim Chief Executive
	Richard Gladman (RG)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Helen Thomson (HT)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Bryan Machin	Interim Executive Director of Finance and Resources
	Andrea North	Interim Executive Director of Operations
	Steph Lawrence MBE	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Alison Lowe OBE (AL)	Non-Executive Director
	Dr Nagashree Nallapeta	Guardian of Safe Working (GSWH)
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	Helen Robinson	Company Secretary
	Em Campbell	Health Equity Lead, Leeds Community Healthcare NHS Trust - for Item 82
	Cat Duff	Service Manager, Integrated Children's Additional Needs Service (ICAN) – for Item 75
	Cathy Grimes	Occupational Therapist, Integrated Children's Additional Needs Service (ICAN) -for Item 75
Minutes:	Liz Thornton	Board Administrator
Observers:	Rachael Coates	Apprentice District Nurse, Shadowing Executive Director of Nursing and Allied Health Professionals (AHPs)
Members of the public:	None present	

Item 2023-24 (71)

Discussion points:

Welcome introduction, apologies, and preliminary business

The Chair of Leeds Community Healthcare Trust opened the meeting. He welcomed members of staff from the Trust who were attending to support items on the agenda or shadowing an executive director.

Apologies

Apologies had been received and accepted from Alison Lowe OBE, Non-Executive Director and Laura Smith, Director of Workforce, Organisational Development and System Development.

Item 2023-24 (71a)

Trust Chair's introductory remarks

Before turning to the business on the Agenda, the Trust Chair provided some introductory comments.

He welcomed the appointment of the new Chief Executive Officer (CEO) Selina Douglas. With a background in adult social care Selina would bring extensive and varied experience to the role. Until Selina joined the Trust Sam Prince would continue as Interim Chief Executive. He placed on record his thanks to Sam on behalf of the Board, the Trust, and its partners for the positive impact she had made and her ongoing commitment and dedication to the organisation.

The agenda for the Board meeting today was about getting up to speed, signing off and supporting the developments that had been put in place to support the city flow, a stocktake on key strategies and about recognising the achievements of staff; teams, and an outstanding top team.

Item 2023-24 (72)

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.

Bryan Machin, Interim Executive Director of Finance and Resources made a new declaration in relation to a zero-hour contract for consultancy work for Community Ventures Management Ltd who managed the Trust's estate. There were no other new declarations made.

Item 2023-24 (73)

Discussion points:

Questions from members of the public

There were no questions to address.

Item 2023-24 (74)

Discussion points:

a) Minutes of the last meeting: 7 October 2023

The minutes were reviewed and agreed as an accurate record of the meeting.

b) Actions' log

2023-24 (35: Performance Brief June 2023 – review of staffing levels: to be considered at a QAIG workshop- further update to the Trust Board on 4 February 2024. **Ongoing**

2023-24 (41): Health Equity Strategy -Update on the timescale for production of the e-book: the Executive Medical Director informed the Board that it might not be possible to produce the e-book as originally intended. Alternative options to make the information available online were to be explored. **Ongoing.**

Item 2023-24(75)

Patient story:

The story was presented to the Trust Board as a video recording produced by Healthwatch Leeds.

Laura lives on the border between Leeds and Wakefield and has two children. Her little boy, James aged six has a rare genetic condition which means he has a range of complex medical conditions. He is non-verbal and has mobility issues.

Laura's story was about the family's experience when James received inpatient treatment at the acute hospital for a procedure on his jaw and his transfer to a Specialist Inclusive Learning Centre (SILC) in Leeds over 40 minutes away from the family home in Wakefield in September 2023.

She spoke about how helpful it would be if the hospital passport which is used in Leeds could be shared more widely across organisations in the NHS to take some of the stress out of accessing treatment and allow healthcare professionals to access information about a patient's background without parents or carers having to repeat information multiple times.

James transferred to a SILC in Leeds from a school in Wakefield. Initially there had been difficulties in transferring his equipment to his new school. Problems had arisen because the original assessments were undertaken by health professionals in Wakefield where the family lived and assessments in Leeds were only accessible to patients with a Leeds postcode.

A positive was the support provided by the Trust's ICAN service. A paediatrician from Leeds Community Healthcare Trust's ICAN service held clinics at the school which meant that Laura did not have to take James out of school to attend appointments and disrupt his education. Parents were included and welcomed at consultations. Nurses were always available in school and provided excellent advice and support.

Representatives from the Trust's ICAN Service acknowledged that there had been a breakdown in communication between services in Wakefield and Leeds when James had transferred to his new school. They provided assurance that as soon as they had been made aware of the problems the referral process had been re-opened and James now had all the equipment he needed and had settled well in his new school.

The Executive Medical Director queried whether community services had sight of the hospital passport. The Service Manager said that the passport was not routinely shared by all organisations but sometimes by families. More work was required to make it more visible across different regions and make care and treatment more seamless for patients.

Non-Executive Director (HT) asked if cross border issues caused significant problems for the ICAN Service. The Service Manager explained that overall, the system worked well and transfers went smoothly. Where problems occurred, it was mainly due to a breakdown in communication, or the provision, supply, or transfer of equipment. This was sometimes related to variations in funding criteria. A significant amount of clinical time could be wasted on administration problems.

The Executive Director of Nursing and AHPs informed the Board that the story had also been shared with the West Yorkshire Integrated Care Board (ICB) to raise awareness of the issues highlighted.

Non-Executive Director (IL) welcomed the positive comments made about the Trust and referred to a performance report he had seen presented at a recent meeting of the ICB which made no mention of the services provided by Leeds Community Healthcare Trust.
The Board agreed that more work was needed to raise the Trust's profile within the city to ensure its voice was heard.

The Trust Chair suggested that a letter should be sent to the ICB and the Local Authority to highlight the problems for patients and clinicians when health and care needs crossed geographical borders.

Action: A letter to be drafted to be sent to the ICB and Local Authority.

Responsible Officer: Executive Director of Nursing and AHPs

Item 2023-24 (76)

Discussion points:
Chief Executive's report
The Chief Executive presented her report which focussed on:

- Executive Team Recruitment & Selection Update

- Trust Strategy Workshop
- Staff Achievements and awards nominations
- BME Talent Development
- Collaborative updates
- Collaborating in Partnership

The selection process had been completed for a substantive Chief Executive replacement. Selina Douglas has been offered and accepted the post. The process would begin to appoint substantively to the vacant Executive Director of Finance and Resources post.

Non -Executive Director (RG) requested feedback on a Neurodiversity Summit which had taken place on 4 December 2023 to discuss the whole system approach on the challenges faced when diagnosing and supporting those with ADHD/Autism. Brief feedback was provided with an acknowledgment that there would be a follow up event in early 2024.

The Director of Workforce, Organisational Development and System Development (JA) provided an update on the Trust Leadership Team's (TLT) approval to provide focussed time and resources on the leadership development for BME staff. The Trust was seeking to procure and finalise the approach working with ICS colleagues in terms of fit with their Aspirant BME Leaders course.

The Executive Director of Nursing and AHPs reported that the Trust had welcomed 17 new Queens nurses this year. This meant that a total of 38 Queens Nurses were employed by the Trust. She also informed the Board that the third cohort of overseas nurses had joined the Trust.

Non-Executive Director (KR) asked if the government's recent announcements on tightening the restrictions on Health and Care Workers visas would impact on the Trust's overseas staff. The Director of Workforce, Organisational Development and System Development (JA) said that she understood that the plans related to care workers and their dependants and not nurses. Further guidance would be issued shortly which should provide more clarity.

Non-Executive Director (IL) provided feedback on his attendance at the Children's Business Unit: Cirque du Celebration on 5 December 2023. The event had proved to be a very creative way of showcasing the Trust's services.

Outcome: the Board

- received and noted the Chief Executive's report.

item 2023-24 (77)

Discussion points:

Seasonal resilience and system floor

The Interim Executive Director of Operations presented the report. She remined the Board that a comprehensive paper outlining a range of service changes undertaken by the Trust and city partners to manage system flow had been presented to the Board in August 2023. The purpose of this report was to provide an update and demonstrate the impact of the HomeFirst Programme on winter planning and system resilience.

The Board was informed that the Leeds System was entering this winter in a stronger position than for 2022/23.

- The number of acute bed days associated with no reason to reside patients had reduced by over 2000 between March and September 2023 supported by the work of the HomeFirst programme.
- The purchase of short-term care home beds has been eliminated over summer in recognition this pathway does not support people to have the best outcomes.
- There are some improvements in care home and home care market sustainability and stability from last year – these providers are vital to support people into long term care.

These improvements had supported the implementation of a reporting suite that enabled leaders in the system to understand where the pressures were and work collaboratively to address them.

Non-Executive Director (HT) asked about the pressure on Primary Care and West Yorkshire Ambulance Service. She also asked about the uptake of staff flu vaccinations. Executive Directors reported that they were not aware of any undue concerns being raised across any part of the system in the city and more widely across the region. The Executive Director of Nursing and AHPs informed the Board that uptake of the flu vaccination had been very positive. A further reminder to all staff would be issued next week with a particular focus on non-registered staff.

Outcome: the Board:

- noted the assurance that the Leeds System was entering winter in a stronger position than for 2022/23 and that the whole system was working together in preparation for winter pressures.

Item 2023-24 (78)

Discussion points:

Assurance reports from sub-committees

a) – Quality Committee – 27 November 2023

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

- **Cancelled and rescheduled visits:** the Committee had received an update from the recent audit which demonstrated an increase in both rescheduled visits and number of patients who did not receive a call as part of the clinical assessment in cancelling a visit. A daily position report was provided to the Executive Director of Nursing and AHPs and a further update would be made to the Quality Committee in January 2024.
- **Clinical Governance Report:** the Committee noted that two services were concluded as 'requires improvement' following quality walks. A review had been undertaken to standardise ratings.
- **Risk register:** Risk 840 (Increase in violence and aggression in Wetherby Young Offender Institute) the Committee discussed the risk and agreed it should be closed above appetite.

The Board noted that the items discussed on the agenda had allowed the Committee to assign a **Reasonable** level of assurance to three of the four risks allocated to it.

b) – Business Committee – 25 October 2023 and 30 November 2023

The reports were presented by Non-Executive Directors (RG and RB), and the key issues discussed were highlighted:

- **Estates Revised Strategy:** the Committee noted that a comprehensive clinical strategy was required to drive the estates strategy and this would fall out of the current Trust strategy work.
- **Long term sickness:** a Committee workshop had considered the downward trend in rates over the last two years but noted that it continued to be above target. The challenge to manage absence compassionately was balanced against the need to tighten processes and have a consistent approach.
- **Service focus: Neighbourhood Teams:** the Committee heard that patient contacts remained steady albeit decreasing slowly each year, referrals were stable but showed a 10% increase year on year, and there were positive trends regarding increasing staff numbers and appraisal rates and decreasing turnover. Engagement was noted to be good within the teams, with a record 64% completion rate for the recent staff survey. Morale within the teams was currently good, and more focus had been put on workforce planning.

Non-Executive Director (IL) referred to the recent IT 'outages' and asked about the impact on the day-to-day work in the Trust. The Interim Director of Finance and Resources acknowledged that the 'outages' had impacted on routine work in the Trust and resulted in disruption. He informed the Board that the recent problems were the result of a complex series of issues. The Trust Leadership Team recognised that a review of the existing systems was required and this would take place early in 2024.

The Trust Chair asked for a report on proposed solutions and plans for changes to be presented to the Business Committee and the Board in March 2024.

Action: A report on proposed solutions and plans for changes to the Business Committee and the Board in March 2024.

Responsible officer: Assistant Director Business Intelligence.

The Board noted that all the risks allocated to the Committee had been assigned a **reasonable** level of assurance with the exception of strategic risk 7 (Failure to maintain business continuity (including response to cyber security), for which no sources of assurance had been provided to the October meeting.

c) – Audit Committee 14 October 2022
The report was presented by Non-Executive Director (KR), Chair of the Committee, and the key issues discussed were highlighted:

- **Internal audit (Audit Yorkshire):** the Committee received the following internal audit report: Youth Offenders Institute Wetherby (significant assurance). The Committee discussed the recommendations relating to strengthening aspects of the governance documentation in place via the Collaboration Agreement with South West Yorkshire Partnership Foundation Trust (SWYPFT). It was agreed that a further discussion at Business Committee would be beneficial around the Trust's arrangements for holding third party providers to account.
- The Committee was concerned about the number of overdue internal audit recommendations and the potential impact on the end of year Head of Internal Audit Opinion if the situation did not improve. Work would be undertaken prior to the Audit Committee meeting in December to review and prioritise the overdue recommendations.
- **Data security:** the Committee received a report on digital layers of defences: internally, externally, and nationally.
- **Security management:** The existing functions had been consolidated into the 'LCH Security Service' and details of its focus and activities were discussed. The Committee acknowledged the work done on lone working and recognition of on-going risks but was assured that following the mobile phone upgrades, the risks would be significantly mitigated.

The Board noted that strategic risk 3 (failure to invest in digital solutions) had been assigned a **Limited** level of assurance although it did note the considerable progress reported in this area. Reasonable assurance had been provided that BAF risk 7 (Failure to maintain business continuity (including response to cyber security) was being managed.

Outcome: the Board

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

Item 2023-24 (79)

Discussion points:
Performance Brief: October 2023
The Trust Chair led members through the report which sought to provide assurance to the Board on quality, performance, compliance, and financial matters.

The Board was updated on the Trust's financial position and the break-even forecast for the Trust in 2023/24. Discussions were held regarding system pressures and the forecast system deficit, and the Board heard how some non-recurrent money had been released to support Leeds Place. The financial position for 2024/25 was anticipated to be more difficult, and work had started to establish all organisations' underlying positions.

There were no questions related to the performance brief.

Outcome: the Board:

- noted the levels of performance in October 2023.

Item 2023-24 (80)

Discussion points:

Significant risks and Board Assurance Framework (BAF) summary report

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

The Board noted:

- there were no risks scoring 15 (extreme) or above on the risk register as of 8 November 2023
- no new risks scoring 12 or above have been added since the last report was received in October 2023.

Non-Executive Director (RG) noted the closure of Risk 1128: Industrial Action and observed that this might need to be reconsidered given the recent announcements about further action by junior doctors.

Outcome: the Board

- noted the risks, which had been scrutinised by Audit, Quality and Business Committees
- noted the assurance levels for strategic risks assigned to the Board's committees.

Item 2023-24 (81)

Discussion points:

Guardian of Safe Working Hours (GSWH) – Quarter 2 report 2023-24

The Executive Medical Director presented the report in the absence of the GSWH. The report sought to provide the Board with assurance that 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 report identified issues affecting trainee doctors and dentists including morale, training, and working hours.

The Board noted the significant progress made with Child and Adolescent Mental Health Service (CAMHS) historic ST rota issue.

The Director of Workforce, Organisational Development and System Development (JA) informed the Board that due diligence checks of the historic rotas had not found any data to suggest non-compliance. A further report would be made to the Board on the outcome of this work.

Outcome: the Board

- Supported the GSWH with the on-going work related to CAMHS ST historical rota compliance and payment issues.
- Supported the GSWH with the work in progress to improve medical staffing and HR support for junior doctors in the Trust.
- Noted that there was a risk a fine would be 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 were identified.

Item 2023-24 (82)

Discussion points:

Health Equity Update

The Executive Medical Director presented the report which provided an update on delivery of the strategy and plans for 2023/24. The Trust was now in year 3 of a more coordinated approach to identifying and tackling inequity. The report included plans for 2023/4 that would support a Board workshop at the end of the year to plan how the Trust would continue to embed equity in care, pathways and corporate activity that supported them.

The key findings were highlighted:

- Progress continues to be made on each of the Trust's Health Equity strategic objectives. Each of these were working to identify and/or address inequity and benefitting groups/communities who experienced inequity. Of particular note were:
  - Delivery of phase 1 of the new cultural conversations programme with eight teams and cultural conversations training to support leaders of those teams
  - Follow-up review of access data, including the use of newly developed rate per 1000 population to support understanding of equity in referrals and waiting list
  - Work to support patients and carers with Cost of Living, particularly in lead up to winter.

Non-Executive Director (KR) welcomed the update report as a good summary of the work so far. He suggested that future reports should include linking the data analysis to the challenges related to financial resources.

The Board discussed how the Trust could work in collaboration with other organisations across the city to review priorities and share data to allow more sensible decisions to be made about planning services.

The Trust Chair welcomed the update report which provided the Board with assurance that the work underpinning the delivery of the strategy was progressing well. He suggested that future reports should provide more assurance that partnerships across the city were secure and work was not being duplicated. The Board would also welcome more information about the roll out of the Cultural Conversations programme and the key emerging messages.

Outcome: the Board:

- received and noted the update on strategy delivery and action plans for the next reporting period
- received and noted the equity analysis of waiting lists by deprivation
- supported the use and further development of rates per 1000 population as a measure of equity.

Item 2023-24 (83)

Discussion points:

Mortality report quarter 2

The Executive Medical Director presented the report which provided the Board with assurance regarding the Mortality figures and processes within the Trust in quarter 2 2023-24. The report had been scrutinised by the Quality Committee on 27 November 2023.

The Board noted the main points in the report and welcomed the inclusion of equity data within the Childrens flash report for the first time. It was noted that the increase in child deaths was consistent with the national picture and welcomed the ongoing work regarding reliability of data related to deaths of individuals with Learning Disability or Serious Mental Illness.

Outcome: the Board

- received and noted the assurance provided in the report regarding the Trust mortality processes during quarter 2 of 2023-24.

Item 2023-24 (84)

Discussion points:

Net Zero Update (Annual Green Plan)

The Interim Director of Operations presented the report which had been reviewed by the Trust Leadership Team and by the Business Committee on 30 November 2023.

The report provided an updated position which highlighted the continued increase of Trust emissions and the impact on the net zero trajectory. Barriers to reducing carbon emissions such as a lack of capital budgets and rising amounts of travel in operational services were noted.

The Business Committee had agreed that a deeper dive should be carried out for the benefit of the Board, to review the system position and align on what is achievable. In the meantime, the Trust should continue to focus on achievable projects as outlined in the report.

Consideration would be given as to whether the Board should have a sustainability champion.

Outcome: the Board

- noted that the trajectory to achieving net zero carbon by 2045 was not being achieved
- agreed there should be a continued focus on achievable projects
- noted that the Business Committee had agreed that a deeper dive should be carried out to review the system position and align on what is achievable.

Item 2023-24 (85)

Discussion points:

Workforce Report and Strategy Update

The Director of Workforce, Organisational Development and System Development (JA) presented the paper which provided the Board with information about key headlines linked to the Trust's Workforce portfolio. The report had been presented to the Business Committee on 30 November 2023.

The paper also provided an updated version of the Workforce Strategy Delivery Plan for 2023/24, which showed the progress made during quarter 2, as well as a dashboard showing progress achieved against the Strategy's outcome measures to date.

The Board welcomed the stability and improvement in some of the core workforce indicators such as turnover and net movement and noted that funding that had been secured for the BME Talent Development Programme.

Outcome: the Board

- noted the workforce headlines presented in the report
- noted the progress achieved and planned in the 2023/24 Delivery Plan for the Trust's Workforce Strategy.

Item 2023-24 (86)

Discussion points:

Annual General Meeting minutes – 19 September 2023

Outcome: the Board

- approved the minutes as presented without amendment.

Item 2023-24 (87)

Discussion points:

Register of seals – quarterly report

The Chief Executive presented the report which, in line with the Trust's standing orders, recorded the use of the Trust's corporate seal and this required ratification by the Board.

Outcome: the Board

- ratified the use of the Trust's corporate seal.

Item 2023-24 (88)

Discussion points:

Any other business and close

The Trust Chair referred Board members to the additional Blue Box items (91-93) on the agenda and the papers which had been circulated to support those items. He explained that the Blue Box was for items already discussed at a committee in full and where any concerns were escalated via the Chairs' assurance reports.

The Trust Chair invited any questions or comments on the Blue Box items.

None were raised.

Item 2023-24 (89)
Discussion points: **Reflections on the meeting** A reflective discussion took place on the format of the meeting and the papers presented.
Item 2023-24 (90)
The Trust Chair closed the meeting at 11.40am
Date and time of next meeting **Friday 2 February 2024 9.00am-12.00 noon**

Additional items (Blue Box)	
2023-24 91	**Quality Strategy update - reviewed by Quality Committee November 2023** *(Steph Lawrence)*
2023-24 92	**Estates Strategy – reviewed by Business Committee October 2023** *(Executive Director of Finance and Resources)*
2023-24 93	**Board workplan – to note**

AGENDA ITEM 2023-24 (97b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 2 February 2024

Agenda Item Number	Action Agreed	Lead	Timescale	Status
8 December 2023				
2023-24 (75)	**Patient Story:** • Letter to ICB and Local Authority re cross border problems for patients.	Executive Director of Nursing and AHPs	Post meeting	Completed
4 August 2023				
2023-24 (41)	**Health Equity Strategy update:** • Update on the timescale for production of the e-book.	Executive Medical Director	2 February 2024 Board meeting	Update on 2 February 2024
2023-24 (41)	• Future reports to be more outcome focussed on the redress of inequalities across the service.	Executive Medical Director and Health Equity Lead	Next report to Board due March 2024	Report to Board 28 March 2024

Actions on log completed since last Board meeting on 8 December 2023	
Actions not due for completion before 2 February 2024: progressing to timescale	
Actions not due for completion before 2 February 2024: agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding at 2 February 2024: not having met agreed timescales and/or requirements	

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (99)

Title: Chief Executive's report

Category of paper: for information

History: Not applicable

Responsible director: Interim Chief Executive

Report author: Interim 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:

- Executive Team Recruitment & Selection Update
- NHS Oversight Segmentation Reviews
- National Education Training
- Launch of Health Innovation Leeds
- Service News
- Collaborative updates
- Collaborating in Partnership

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. Talent Development Programme

I am delighted to acknowledge the launch of our Talent Development Programme, specifically targeted at staff from Black and Minority Ethnic Groups. In line with the goals and aspirations of our Workforce Strategy LCH must go further, faster, to drive improved inclusivity and representation in leadership and management roles where there is currently under-representation of our workforce from minority groups and indeed the communities we serve.

The Trust is committed to supporting and funding development initiatives to address known inequalities and is focusing (for now) on:

- Increasing diverse representation across our banding and leadership structures.
- Eliminating unequal experiences at work, where some employees experience, or perceive, their career progression to be limited by their ethnic diversity or protected characteristics.
- Continuing to improve leadership support and opportunities to develop skills and capability for those in middle-management roles.

The first phase of the programme includes two development offers:

- We are offering people in existing roles at Bands 4-7 from Black and Minority Ethnic (BME) groups, the opportunity to apply for a dedicated leadership and development training programme. This will run from March – November 2024, with a further system leadership programme offer commencing in May 2024.
- There is also an opportunity for BME staff (of any band) to apply to undertake an accredited, bespoke ILM5 Certificate in Coaching and Mentoring. This is with the intention of increasing diversity and representation within our coaching community. The first coaching intake will commence in March 2024 and will run for approximately 8 months, including taught sessions and a need to dedicate some time to practise coaching.

The programme will be evaluated and it is intended that future cohorts will be opened to other groups

3. Executive Team Recruitment & Selection Update

Selection has now taken place for an Interim Executive Director of Finance and Resources and we are pleased to report that Andrea Osborne has been offered and accepted the post. The process to recruit to the substantive post has now

commenced with interviews expected to take place in mid-March.

4. NHS Oversight Framework

The NHS Oversight Framework (NHS OF) aims to ensure the alignment of priorities across the NHS and with wider system partners; to identify where ICBs and/or NHS providers may benefit from, or require, support; and to provide an objective basis for decisions about when and how NHS England will intervene. The NHS OF is built around five national themes that reflect the ambitions of the NHS Long Term Plan and apply across Trusts and ICBs: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability. It is underpinned by a set of high-level oversight metrics, at ICB and trust level, aligned to these themes.

Organisations are placed in one of four segments by NHSE. The purpose of this is to provide an overview of the level and nature of support required; to inform oversight arrangements; and to target support capacity as effectively as possible. Segment 2 is the 'default' segment to which all Trusts will be allocated unless the criteria for moving into another segment are met. It signals that the Trust has plans that have the support of system partners to address areas of challenge and that targeted support may be required to address specific identified issues.

For Q3 of 2022/23 LCH is one of 8 of the 10 trusts in West Yorkshire that has been placed in segment 2. NHSE has not provided a detailed rationale for these decisions. The regional team has indicated that the Q3 review has been a transitional one, to identify any significant issues by exception that would warrant a change in status.

Based on previous reviews, it is expected that the factors most likely to influence decisions on any future change in LCH's status include the following:

- Delivery of the 2023/24 financial plan.
- Supporting system flow
- Further development of virtual wards and urgent community response

The NHSE regional team is introducing changes to the quarterly review process to be introduced from the beginning of the new year. These changes will make the process more transparent and inclusive. ICBs will be involved in the review meetings with colleagues from NHSE regional finance, performance, quality and workforce teams. Within West Yorkshire it has been proposed that the System Oversight and Assurance Group (SOAG) will come to a view on the appropriate segmentation for each Trust, to inform the regional review meetings.

5. Service News

We were extremely pleased and proud to be successful at retaining the Leeds Sexual Health Service, which went out to tender last year. The new service maintains a partnership with Leeds Teaching Hospitals Trust and expands it to include primary care, through the Leeds GP Confederation, and the local 3rd sector, through Forum Central. Innovations will include a new interactive website, which will be led by local communications agency, Magpie. The new service will go live 1 July 2024.

6. Launch of Health Innovation Leeds

Health Innovation Leeds is a new approach by the city's health and care research and innovation partners. Under its banner, the city will collectively showcase its world-leading developments and help people navigate its market-leading offer. In doing so, city partners aim to secure greater influence and investments by building on its international reputation as a competitive health innovation hub.

Leeds will capitalise on the recently announced £160 million boost as one of the Government's new UK Investment Zones, accelerating the city's infrastructure plans. Leading the Health Innovation Leeds launch is Leeds Academic Health Partnership (LAHP). LAHP is one of the biggest partnerships of its kind in the UK and the only one in Yorkshire and Humber. Its wide-ranging membership comprises the NHS, universities, the City Council, charities and regional partners in health, care, business and skills.

Leeds Academic Health Partnership brings together members' expertise to help solve some of the city's hardest health challenges.

7. National Education Training Survey (NETS)

Leeds Community Healthcare NHS Trust received the results of the 2023 GMC National Education Training Survey (NETS). The Trust received an 81% response rate from Junior Doctors (up from 75% in 2022), for which the feedback was generally positive. Overall, the Trust ranked 54 out of 229 UK organisations, and ranked 5th out of the 21 organisations across the Yorkshire and Humber Region.

Senior Leaders were delighted to note that the Trust ranked second in the UK for 'Clinical Supervision' (2/229) and 'Feedback' (2/229), and 18th for Study Leave (18/229).

There were some negative outliers where the Trust ranked 219/229 for induction, 226/229 for reporting systems, and 195/229 for 'facilities'. The Trust is implementing a new induction programme for the February CYMPHS and Psychiatry rotation which will address the issues raised.

For trainers, the Trust ranked 102 overall in the UK out of 220, but ranked first for appraisal, and 11th for Professional Development.

The Trust also had outliers on ‘Time to Train’ (216/220) and ‘Rota issues’ (216/220). Issues related to the CYPMHS rota have been reviewed with support from BMA colleagues, and we are confident that these issues have now been addressed.

8. West Yorkshire Community Health Services Collaborative

The Community Collaborative is planning to take some important time out to further consider possible options for a cross collaborative implementation programme – in line with left shift direction and principles.

The WYCHS collaborative will develop a 24/25 work programme and associated deliverables. Early discussions indicate the focus of programmes could be around;
1) methodology to identify ‘rising risk’ populations and models of proactive care/services support this cohort,
2) consistent metrics/measurement for impact/outcomes in community services and
3) Capaity/Consistency to support YAS ‘push’ patients/alternative pathway into community and primary care.

At the January meeting it was agreed that a community services BI/Data group be established to support the development and consistency of measurables and evidence around impact/outcomes, particularly that would support ‘Return on Investment’ and ‘cases for change’ askes.

Work continues around long term investment into community and the differential levels of investment into community services at WY places, with a view to developing a recommended ‘investment standard’ for community services.

YAS colleagues alerted the meeting to the fact that they will formally launch their Strategy in January 2024. By sharing further detail from the YAS Strategy, colleagues were able to understand what the YAS Strategy means for our collaboratives members and how the Strategy will better support us working together as effective partners around supporting people where they live.

9. Collaborating in partnership

Members of the Board have attended the following City-wide and West Yorkshire-wide meetings:

Meeting	Attendee	Date
West Yorkshire Health and Care Partnership Board meeting & development session	Brodie Clark	5 December
West Yorkshire Health and Care Partnership monthly chairs, leaders and non-executive forum	Helen Thomson	19 January 2024
West Yorkshire Mental Health Collaborative Chief Operating Officers meeting	Andrea North	22 January

WY Community Health Services Provider Collaborative	Brodie Clark Sam Prince	15 January
Leeds Partnership Executive Group	Bryan Machin Ruth Burnett Sam Prince	1 December 15 December 26 January
Leeds Committee of WY ICB public meeting	Andrea North	13 December
Leeds Health and Wellbeing Strategy 2023-30 & Healthy Leeds Plan 2023-28 launch event	Brodie Clark	7 December
Leeds Clinical Senate	Ruth Burnett	13 December 25 January
Frailty Population Board	Sam Prince	18 January
WY Finance forum	Bryan Machin	15 December 26 January
NHS Leeds Finance Executive Group	Sam Prince Bryan Machin Andrea North	4 December 18 December
Academy Steering Group meeting	Jenny Allen	18 January
Leeds City Resourcing Gorup	Laura Smith	23 January
Leeds NHS DoF Meeting	Bryan Machin	4 December 19 December 9 January
Neurodiversity Summit	Brodie Clark Sam Prince	4 December
Leeds Medical Committee (LMC)	Ruth Burnett	23 January

Sam Prince
Interim Chief Executive

January 2024

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (100)

Title: Mid-winter Update on System Flow

Category of paper: Information and assurance

Responsible Director: Interim Executive Director of Operations

Report author: Interim Executive Director of Operations

Recommendation

For Board to note the content of the paper and the understand the work undertaken across the system to maintain system flow especially at times of extreme pressure.

Mid-winter summary position

- The Leeds winter plan predicted particularly pressured periods from January to the end of February 24, where it is likely that LTHT occupancy will exceed the 96% target (equivalent gap of 12 acute beds). This has proved accurate, peaking so far week commencing 22/01/2024.
- All organisations in the system are experiencing challenges in meeting demand which is impacting on system flow, leading to the instigation of 'citywide silver'.
- Actions being taken across the system have gone some way to mitigate the pressures and there is flow across the system, but we remain significantly challenged.
- An outbreak of Norovirus resulted in a temporary closure of the wars at Wharfedale.
- Areas of focus are reducing attendance in ED, admission avoidance, timely discharge and improved process time for care act assessments through investment in agency social workers.
- A peak in respiratory conditions and related admissions is predicted for late Jan 2024.
- Leeds remains in a better position than 2023/24 despite current challenges.

Background

The Leeds Health & Care Partnership Winter Plan is based on a Leeds Teaching Hospitals NHS Trust (LTHT) modelled bed deficit at 96% occupancy over the winter period. System actions and additional capacity have been introduced to mitigate the predicted deficit in beds within LTHT and support the wider system. These plans were signed off by the Leeds Health and Wellbeing Board and the Leeds Scrutiny Committee.

The Leeds plan predicted particularly pressured periods between January 2024 and the end of February 2024, where it is likely that hospital occupancy will exceed the 96% target.

The collective aim for the Leeds System is to maintain flow in the Acute Trust by reducing unnecessary attendance at the Emergency Departments (ED), reducing unplanned admissions, and enabling people to be discharged as soon as they are medically optimised for discharge, therefore reducing the overall length of stay. Enabling people to return home, and improving patient experience and outcomes, continues to drive the approach in Leeds.

As reported to the Board in October 2023 The Leeds System entered winter in a stronger position than for 2022/23.

- The number of acute bed days associated with NR2R patients reduced by over 2000 between March and September 2023 supported by improvements across the system and the work of the HomeFirst programme.

- The purchase of short-term care home beds has been eliminated over summer in recognition this pathway does not support people to have the best outcomes.
- There are some improvements in our care home and home care market sustainability and stability from last year – these providers are vital to support people into long term care.

Current position

Although pressure started to increase in December 2023 compounded by Christmas and New Year Bank Holidays and 2 x periods of Industrial Action, the system coped well. During the strikes the ICB increased capacity in primary care and added additional GP out of hours and same day support with LCD colleagues. The impact of these interventions will be evaluated to inform future decision making.

Week commencing 22/01/2024 has proved the most challenging of the winter so far. This is in line with seasonal variation and the predicted modelling for Leeds.

LTHT is starting each day with a deficit of bed capacity peaking at 66 on 23/01/2024. Partners across the system are being asked to support with actions to prevent admission and expedite discharge. The number of people with No Reason to Reside (NR2R) also peaked over the last 7 days at 307 although this reduced to 270 as of 23/01/2024.

Leeds Community Healthcare Neighbourhood Teams are under significant pressure with a high level of referral since Christmas. Neighbourhood Teams received their highest ever number of weekly referrals (734) week commencing 15/01/2024. Of these 255 were from LTHT. Referrals for End of Life Care are sustained at levels higher than pre-pandemic putting pressure on Health Case Management and Neighbourhood Teams. Whilst other services are also experiencing high levels of referral, they are continuing to respond to support patient flow.

Primary Care is under pressure with some practices declaring OPEL 4. The proportion of PCAL calls resulting in attendance at the Emergency Department (ED) as an outcome increased very slightly over the autumn to 10% in November and December, suggesting an increase in acuity within primary care. The ‘system’ has funded additional primary care capacity for respiratory conditions in adults and paediatrics to mitigate the impact.

LYPFT is also reporting significant pressure on bed capacity with high numbers of patients being treated out of area. An internal recovery plan is in place.

Citywide system ‘silver’ has been instigated to monitor the situation and determine priority actions.

Pathway and Service Initiatives

A range of initiatives, including those in the HomeFirst Programme, have been introduced across health and social care to prevent unnecessary admission to hospital and facilitate timely discharge. This has also led to more people being safely maintained at home. Where admission to hospital is required, it should where possible,

be on a planned basis and for the shortest length of stay to treat the medical needs and enable people to return home.

Admission Avoidance

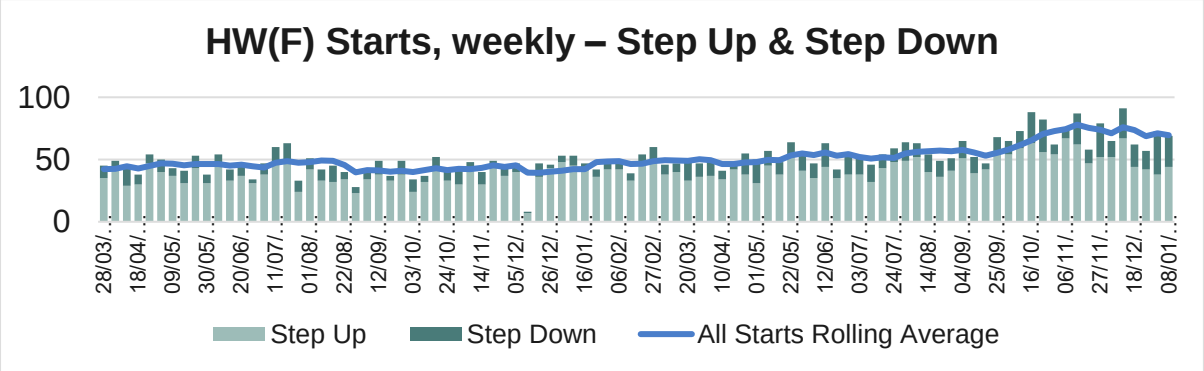
Urgent Community Response (UCR) – trial

Referrals come into the Neighbourhood Teams via the LCH Single Point of Referral from a range of sources including Primary Care, 111, 999 and the hospital. The UCR standard is to respond to >70% of referrals within 2 hours to prevent unnecessary attendance at the Emergency Department (ED), prevent admission to hospital from ED, and reduce length of stay especially in the assessment units. LCH has exceeded the target for the 5th month in a row, providing c1500 contacts per month and releasing capacity in the Acute Trust.

UCR is currently a trial pathway within Neighbourhood Teams (NT). Demand is high and NT have prioritised responding to referrals for UCR.

An evaluation of the trial is needed to establish the effectiveness of the pathway and understand the impact on the NT core service before rolling out further.

Home Ward Frailty (HWF)



Since April 2023 the HWF has shown a sustained increase in the number of people starting an episode of care per week. As shown in the table, approximately 2/3 is admission avoidance and 1/3 is hospital discharge.

The HWF supports a daily caseload of up to 47 people although this reduced temporarily to 37 during December 2023 on the advice of the Geriatricians supporting the HWF. This was to ensure patient safety during the period of industrial action.

Home Ward Respiratory (HWR)

The service is small in comparison to the HWF, supporting up to 12 patients per day. Demand for the service is high and in contrast to the HWF the majority of patients are referred on hospital discharge.

A review of the current Home Ward offer is due to commence in Quarter 4. The services in scope are;

- Home Ward (Frailty) – including staffing aligned to LCH and LTHT and LYPFT; and including an element of Quick Response
- Home Comfort
- Home Ward (Respiratory)
- Remote Health Monitoring Phase Two development

The purpose of the review;

- What outcomes is the Leeds Home Ward offer here to deliver?
- What is the true demand for the Leeds Home Ward offer – now and in the future (5 years)?
- What is the right size and focus for the Leeds Home Ward in response to this? What might we need to stop, start, continue, change?
- Analysis of Health Equity data to inform any revision to the model
- Clarify cost/benefit; input/outputs
- Ensure that plans take account of future population requirements, and interactions with other services
- Understand how the Leeds Home Ward offer responds to national guidance on virtual wards
- Review the workforce model, including skill mix
- Refresh the target operating model for the service(s) in scope
- Update the funding requirements

Enhance

The introduction of Enhance has reduced pressure on the NT core service by releasing clinical time. Funding has been agreed for 2024/25 to enable expansion to support the bed bases and services in the Specialist Business Unit. A full evaluation will be undertaken in 2024/25.

Discharge from Hospital

There are 4 main pathways for discharge from hospital;

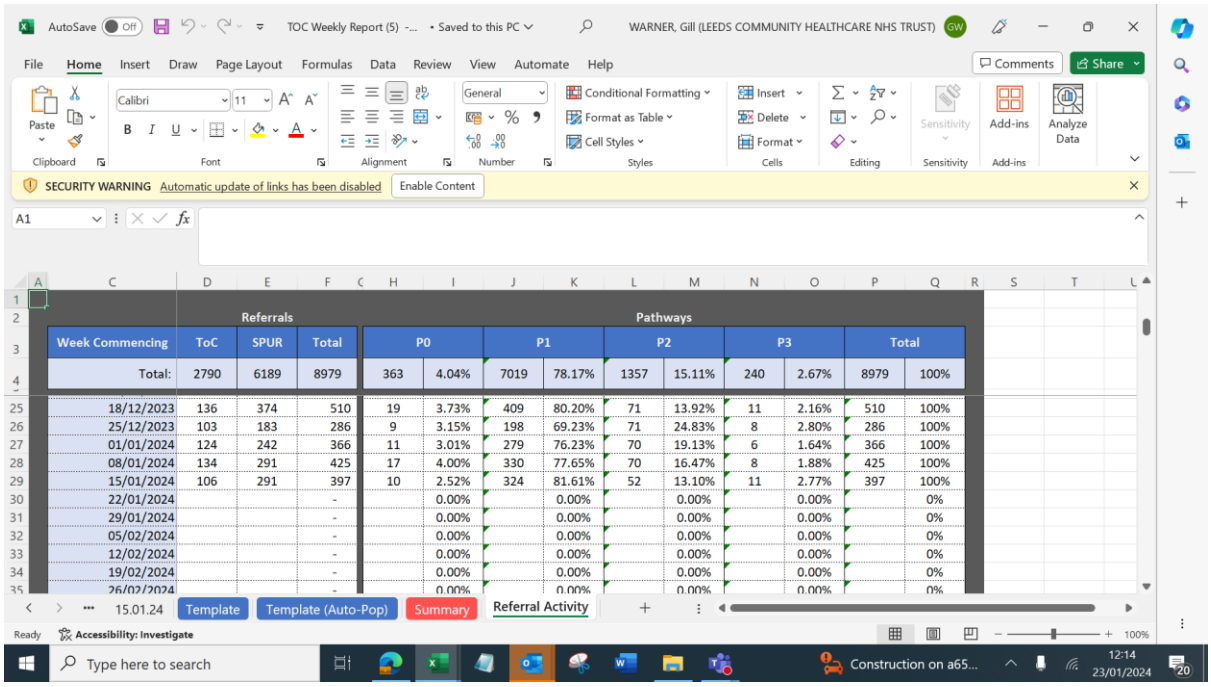
Pathway 0 – people are independently discharged with no requirement for service.

Pathway 1 - people returning home but requiring support. There has been an increase in the number of people returning home after a hospital admission. Delays on pathway 1 are primarily people awaiting Reablement support at home and those people awaiting social work assessment. There are **no delays** in discharging people to LCH services. On average it takes 7 days to be discharged on pathway 1. In order to maintain improvement, the Active System Leadership Executive Group has set a stretch target to reduce this from 7 to 3 days

Pathway 2 – people requiring admission to a community bed for Rehab and Recovery or Discharge to Assess (D2A). Optimum bed capacity is achieved by

managing flow out of the beds rather than increasing bed capacity and Health Case Management is providing dedicated input to Wharfedale to complete ‘trusted assessments and maximise flow.

Pathway 3 – people awaiting social care assessment for longterm care. With more people being discharged home on Pathway 1 and for rehab on pathway 2 there has been a reduction in the number of people going from hospital into longterm care.



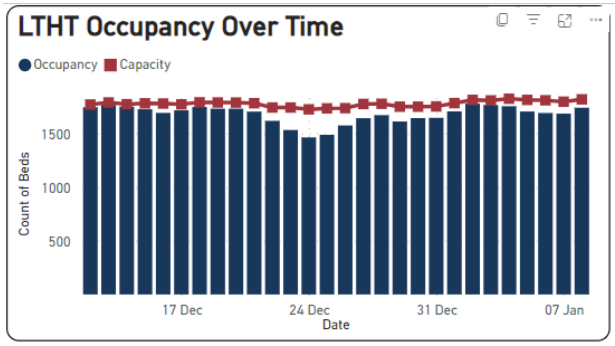
	Referrals			Pathways									
Week Commencing	ToC	SPUR	Total	P0		P1		P2		P3		Total	
Total:	2790	6189	8979	363	4.04%	7019	78.17%	1357	15.11%	240	2.67%	8979	100%
18/12/2023	136	374	510	19	3.73%	409	80.20%	71	13.92%	11	2.16%	510	100%
25/12/2023	103	183	286	9	3.15%	198	69.23%	71	24.83%	8	2.80%	286	100%
01/01/2024	124	242	366	11	3.01%	279	76.23%	70	19.13%	6	1.64%	366	100%
08/01/2024	134	291	425	17	4.00%	330	77.65%	70	16.47%	8	1.88%	425	100%
15/01/2024	106	291	397	10	2.52%	324	81.61%	52	13.10%	11	2.77%	397	100%
22/01/2024			-		0.00%		0.00%		0.00%		0.00%		0%
29/01/2024			-		0.00%		0.00%		0.00%		0.00%		0%
05/02/2024			-		0.00%		0.00%		0.00%		0.00%		0%
12/02/2024			-		0.00%		0.00%		0.00%		0.00%		0%
19/02/2024			-		0.00%		0.00%		0.00%		0.00%		0%
26/02/2024			-		0.00%		0.00%		0.00%		0.00%		0%

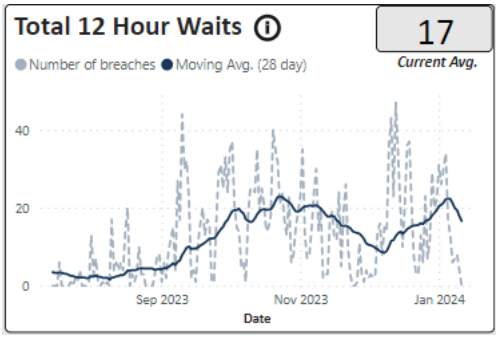
The table above shows the % of patients discharged across the pathways. Week commencing 15/01/2024 81.61% of people were discharged home on Pathway 1.

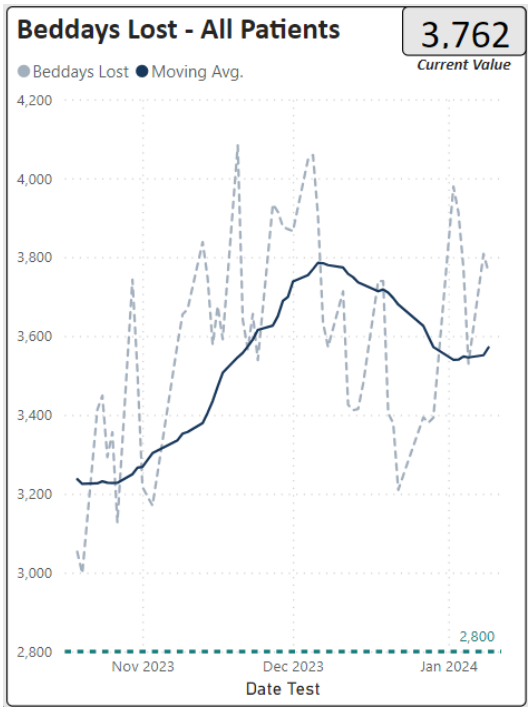
NR2R

The number of people with No Reason to Reside (NR2R) in hospital when they are medically optimised for discharge has shown consistent improvement against 2022/23. Between March and September 2023 there was a reduction of over 2000 bed days. The number of bed days lost to NR2R has increased since November 2023 which has resulted in LTHT opening an additional NR2R ward.

On average people are spending less time in hospital once they become no reason to reside (i.e. the avg bed days lost per person is decreasing) largely due to changes in ASC ways of working.







Home Comfort (Age UK)

Used primarily to re-settle people on discharge on Pathway 0. The data shows that 30% of Home Comfort capacity is also used to support people whilst on the HWF. The service helps to maintain frail vulnerable people at home and qualitative evidence from case studies indicates improved outcomes for people and a high level of user satisfaction. More work is needed to track patient outcomes and evidence longer term benefit.

Reablement

Reablement has utilised all available capacity and is currently operating with a waiting list. The introduction of short term assessment undertaken by staff in the Transfer of Care hub (ToC) with funding from the ICB for additional short term packages of Home Care has supported hospital discharge. When the pathway was introduced, it was expected they would complete 40 assessments per month however this has doubled with staff undertaking 20 assessments per week in December and January. 2 packages of care per week have also been used to support people waiting for reablement.

Active Recovery (Intermediate Care)

Outcomes from the pilot in Seacroft are promising and work is currently underway to establish the future model for the city. This work sits within the Alliance and is supported by Newton Europe.

Community Bed Capacity

There has been a sustained reduction in bed capacity since last year. In January 2023 there were 287 commissioned and spot purchased beds in the city, with an additional 98 people awaiting a bed.

In January 2024 there are 228 commissioned and spot purchased beds with 48 people awaiting a bed. This is an overall reduction of 109 beds in the system.

System Visibility Dashboard (SVD)

A system visibility dashboard has been developed to enable system wide monitoring and reporting. LCH staff are currently unable to access the dashboard due to IT issues which are being investigated by our IT & BI teams. In the meantime, it is difficult to provide consistent and comprehensive reports with data stored across multiple systems.

It is proposed that there will be a demonstration of the SVD to Business Committee in February when we can explore the capability and reporting opportunities including how we can report on Health Inequalities data across the system.

System Flow Successes since September 2023

- The number of people on Pathway 3 in hospital has reduced from circ. 90 to 63 since Sept equating to an approx. saving of 600 bed days. This has been delivered through changes in the social work process and culture around completing assessments in hospital supported by the introduction of Short-Term Assessment service.
- The Short-Term Assessment home care service has supported 108 people to have their care act assessment completed outside of hospital or CCB since it was introduced in November. Without this service the care act assessment would have been completed in hospital and over 1200 beds days would have been lost within LTHT to no reason to reside waits.
- The length of stay in the CCB beds has reduced to avg. 37 days from 42 days supporting flow through pathway 2 and maintaining timely access to beds despite the growing waiting list (waiting time is 3.7 days).
- LTHT have been able to open and shut the additional no reason to reside capacity at LTHT in response to demand pressures allowing the team to reserving the ability to flex capacity at LTHT for any future infection surges. This is a material change to previous years, when we have struggled to close additional capacity, and has been supported by the continued focus on keeping the average number of bed days lost to no reason to reside to a minimum.

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (101a)

Title: Audit Committee Chair's Assurance Report 15 December 2023

Category of paper: for assurance
History: Not applicable

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

Meeting summary

Internal audit (Audit Yorkshire)
The Committee received the following internal audit report: Cyber Essentials Plus Accreditation Follow-Up (significant assurance). The Committee discussed the mismatch between the audit findings and the recent report to Business Committee, and noted the two different scopes, with the audit following up on previous points of limited assurance rather than the Trust's readiness for accreditation. The recommendations of the previous internal audit report had been fully implemented, and just one minor recommendation had been made on the follow-up audit.

It was noted that the advisory Emergency Preparedness, Resilience and Response Core Standards Action Plan was in draft form, following all organisational self-assessments being downgraded due to the recent change in standards. The Committee voiced its disappointment over the new approach being taken and resulting drop in compliance and would share this with the ICB.

The Committee remained concerned about the number of overdue recommendations, mainly due to staffing issues at senior levels but noted the slightly improved picture. Internal Audit confirmed that they would be in a position to issue a meaningful Head of Internal Audit Opinion for 2023/24, although the KPIs were likely to fall below 100% towards the end of the financial year. Reassurance was taken from a commitment to a prioritisation of work with the Interim Director of Finance, looking ahead to which reports would be ready for which Committee prior to review at Audit Committee; and an early heads up on any reports with limited assurance.

External Audit (Mazars)
The external auditor advised the Committee that external audit work would be planned and performed so as to provide reasonable assurance that the financial statements are free from material misstatement and give a true and fair view. The aim was to complete the work earlier in 2024 than in 2023.

Contracts Register
The Committee reviewed the Contracts register. A discussion took place about how and when best value for money reviews on existing contracts took place, and consideration would be given to the efficiency testing of contracts in relation to the Trust's Quality and Value programme, particularly where there was a quality or clinical element. The Committee concluded that it would feel more assured if information was added to the report on the governance route taken for each contract, including whether they had previously been given Committee consideration.

Updated standing orders, reservation and delegation of powers and standing financial instructions
The Committee approved an amendment to the standing orders, reservation and delegation of powers and standing financial instructions, which incorporated the merger of NHS Improvement into NHS England, the publication of the Fit and Proper Person Test Framework (2023), changes in the Trust's structure and changes that the Trust's executive directors wished to introduce to better regulate good governance and management.

It was noted that there was now a requirement for all Trusts across West Yorkshire for Director level involvement and sign off of all non-pay expenditure in excess of £10k that is over and above their existing run rate. All relevant expenditure would be recorded and reviewed weekly by the Trust Leadership Team. As a second control all requisitions in excess of £10k would be reviewed by the Deputy Director of Finance before actioning to ensure the Trust remains compliant with the revised arrangements. These additional steps supplement rather than replace the authorisation limits in the SFIs during a time of increased grip and scrutiny.

Risk Management Annual Update Report
The Committee received an update on the development and effectiveness of risk management processes in the Trust. The focus on supporting risk owners to complete effective and timely risk reviews was welcomed, and the Committee supported planned work with Business Units to raise awareness of the risk management processes.

Information Governance and DPO update
The Committee reviewed the activity of the Information Governance team. It was noted that following a review of it's effectiveness, the Data Protection and Cyber Security Panel had been moved to an "operational group" (to discuss IG related workstreams) and an "approval group" (to approve the recommendation of the operational group, receive assurance, and provide assurance to the Audit Committee). The terms of reference for both groups were formally approved by the Committee.

Assurance
The Committee reflected on the relevant sources of assurance it had received at the meeting and agreed that they provided **Limited** assurance that BAF risk 3 (Failure to invest in digital solutions) was being managed, due to the ongoing inconsistencies and gaps, however the positive trajectory and amount of work being undertaken in this area was noted.

The Committee agreed that BAF 3 risk should no longer be assigned to the Committee, as reflected in the limited assurance that had been received to date. It should continue to be overseen by the Business and Quality Committees. This would be included in the next BAF update to Board.

The Committee agreed that **Reasonable** assurance had been provided that BAF risk 7 (Failure to maintain business continuity (including response to cyber security) was being managed. However, it was acknowledged that there was work to be done to maintain this level of assurance going forwards, particularly around the achievement of Cyber Essentials Plus accreditation and the completion of previous audit recommendations.

Trust Board meeting held in public: 2 February 2024

Agenda item number: 2023-34 (101b)

Title: Charitable Funds Committee December 2023: Committee's Chair assurance report

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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 15th December 2023.

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

The committee received an update from Charities fundraiser about the work during the last few weeks. This has been really positive and will be supported by the re-establishment of the Operational Steering Group from January 2024. There is work ongoing to reach out to corporate colleagues and the community to ensure we continue to raise the profile of the charity.

Finance Report

The Assistant Director of Finance – Financial Control shared the Finance Report. There were no questions on these, and all agreed it was a good update. It was also confirmed that last years annual report had now been submitted.

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.

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 2 February 2024
Agenda item number: 2023-24 (101c)

Title: Nominations and Remuneration Committee – 15 December 2023: Chair Assurance Report

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Category of paper: for assurance
History: n/a

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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting held on 15 December 2023.

Please note that the last regular quarterly meeting of the committee was held in September 2023.

Items discussed:

VSM Pay

The Committee noted that the 5% pay rise to VSM post holders had now been made following receipt of the national instruction to pay in September. Approval had been sought for this virtually and prior to payment, from the Nomination and Remuneration Committee.

The Committee also noted that the promised national VSM pay benchmarking had not yet been published but undertook to review this when it was available.

Critical Incentive Scheme Evaluation

The Committee received and discussed a comprehensive paper relating to the Critical Incentives scheme. Further actions including additional information on the relative costs of generating additional staff capacity as well as the benefits of an external review of our use of the critical incentives scheme were discussed and agreed.

Executive Appointments

The Committee noted the following:

- That the substantive Chief Executive (Selina Douglas) would commence in post on 15 April.
- Extension for interim Chief Executive role (Sam Prince).
- Extension for interim Deputy Chief Executive role (Steph Lawrence).
- Extension for interim Director of Operations role (Andrea North).
- The appointment of an interim Director of Finance (Andrea Osbourne) and that the substantive role would be advertised post the Christmas period.
- The appointment of Sam Prince as substantive Deputy Chief Executive.

Wharfedale Terms and Conditions Harmonisation

The Director of Workforce informed the Committee that 29 staff have been harmonised to onto Agenda for Change terms and conditions of service at Wharfedale Hospital and following their TUPE transfer from Villa Care. The Committee offered their congratulations to all involved in this complex piece of work.

Real Living Wage

The Director of Workforce sighted the Committee on the new Real Leaving Wage rate per hour and which was recently uplifted to £12 / hour in November. A discussion is

due to take place at Trust Leadership Team (TLT) following which there will be further interaction with the Nominations and Remuneration Committee on it.

Recommendations

The Board is recommended to note this information.

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (101d)

Title: Quality Committee Chair's Assurance Report 22 January 2024

Category of paper: For Assurance

History: N/A

Responsible director: Quality Committee Chair

Report author: Company Secretary

Executive summary:
This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 22 January 2024, and it indicates the level of assurance based on the evidence received by the Committee. This meeting was held on MS teams.

Recommendations:
The Board is recommended to note the information below as key points of assurance from Committee.

System pressures
Committee were appraised of the current position across the system, with increased pressure being felt but a more calm and joined up response when compared to last year. More people were reported to be undergoing discharge from hospital on Pathway 1, and the current average discharge time of seven days was having a stretch target applied of 3 days. A norovirus outbreak on Wharfedale had led to it being closed to admissions for seven days, but the service was still actively discharging safely where possible.

QAIG assurance report
It was agreed that a proposal for changes to the assurance received from QAIG via the flash reports would be brought back to the March Quality Committee, and Committee was informed that work had already started on this.
Committee received positive feedback following the CQC inspections at HMP YOI Wetherby and Police Custody, and were reassured that there were positive signs that the West, South and Hull and Humber services would be retendered in 2025.
Concerns around statutory mandatory training compliance were being picked up within specific teams.
Committee was assured that a plan was being developed in relation to medical devices.

Cancelled and rescheduled visits
This paper provided findings from the follow up audit completed in December, and showed an improved picture in both the North and South Neighbourhood Teams. Work was focussing in the West, and specifically around the Yeadon team which was reported to have had a positive reaction to a leadership change during January. The Executive Director of Nursing and AHPs outlined the various factors which contributed to difficulties managing this caseload, including staffing levels, increase in complex cases; and an unpredictable discharge pattern, but stated that the issue was commonplace outside of Leeds.
The Committee was reassured that an increase in the number of incidents reported hadn't been observed, and the implementation of e-Allocate was anticipated to alleviate the issue. The Neighbourhood Teams were looking at specific indicators which would flag issues within teams earlier so resources could be put into addressing them before they escalated. In addition the CQC have been in touch about some information they received from a member of staff in the Yeadon Neighbourhood Team. This has been responded to and CQC are satisfied that actions are in place.

Ofsted Report Update for December 2023 Adel Beck Secure Children's Home
The Committee received an update of the findings and recommendations from the report published by Ofsted in response to the unannounced visit in June 2023 to Adel Beck Secure Children's Home. The overall rating of Good was welcomed, and the one-minute guides were noted to have been well-received and consideration would be given to expanding their use across other Trust areas.

Patient Safety Incident Response Plan (PSIRP)
The Committee approved the PSIRP as a blueprint for responding to and investigating patient safety incidents. This will go to Feb Board. It was noted that the principle of system factors and learning were included in the overarching policy.

Service spotlight: Update on Diabetes improvements and health equity
The Committee received detail on health equity data related to the projects under the Diabetes pathway improvements, as a follow up to a previous spotlight session in

September 2023. Committee members commented that the overarching strategy was not clear and it remained difficult to see from the report what impact there had been on those with protected characteristics. Difficulties engaging with PCNs was noted. It was agreed that a further update would be brought back to Committee in 6-8 months following further work by the Project Leads, coordinated by the Executive Director of Nursing and AHPs and Executive Medical Director.

Performance brief
Performance data was discussed and the Committee was assured that work was underway with the ICB regarding the high numbers of children waiting for Neurodiversity assessments.

Safe Staffing report
The Committee noted that safe staffing had been maintained across both inpatient units over the last 6 months. A discussion was held regarding what was safe vs unsafe, given there was no threshold for what constitutes 'safe' in community services. It was acknowledged that there was a disconnect between the levels of concern derived from this report, and the staffing risks that had been escalated on the risk register. The Executive Director of Nursing and AHPs provided assurance that staffing levels were being managed on a daily basis, but that this was challenging and only achieved by cancelling and rescheduling visits, and using bank and agency staff, for example.

Schedule of KPIs
The Committee reviewed the proposed changes to the indicators. It was agreed that the Committee would need to see the next iteration for those indicators which were listed as 'under development'. The NEDs expressed anxiety around receiving a narrative in future reports but not the data, but were assured that the data would have been scrutinised on a daily and weekly basis by Quality and Clinical Governance leads, and that the narrative would be meaningful. There was a request for system pressures to be included in the Performance Brief, and so the next meeting would consider the System Visibility Dashboard and decide which indicators it would be useful for the Committee to receive.

Mortality report
Committee welcomed the inclusion of children's equity data, and requested the same information for adults to be included.

PGDs
8 PGDs had been approved by the Executive Medical Director in this timeframe, and a further 3 had been quality assured and approved by the PGD Approval Panel. The Committee was assured that safeguarding work would run alongside any treatment for patients at the younger end of the spectrum presenting with anogenital warts.

Research and Development Strategy Update
Paper received and accepted. It was noted that it was an interim report that didn't fully capture all the cultural and transformational work undertaken since the Clinical Lead for Research had joined the Trust. The new strategic approach would be launched in 2025.

Patient Experience Report
The report was received and the learning from the 3 themes of clinical judgement and treatment; attitude, conduct and cultural and dignity issues; and appointment issues was noted.

Quality Committee assurance levels – determined at the meeting

Quality Committee strategic risks	Risk score (current)	Agenda items reviewed	Overall level of assurance provided	Comments
Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm.	**9 (high)**	• System pressures update • QAIG: assurance report • Service spotlight • Patient safety incident response plan • Performance brief • Quality strategy • Risk Register report • Mortality report • Patient Group Directions • Safeguarding Children's and Adult's • Group: minutes • Integrated Care Steering Group	Reasonable	The service spotlight topic would be revisited in the Summer with a request for a unified approach and the impact on health inequality to be articulated.
Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage.	**12 (V high)**	• System pressures update • Service spotlight • Cancelled and rescheduled visits update • Performance brief • Risk Register report • Patient safety incident response plan • Mortality report • Patient experience report • Safe staffing report	Reasonable	Although reasonable assurance was agreed overall, concerns remained around the safe staffing paper. The new dashboard being developed will help with this when the paper is next due at Committee, along with the additional progress required regarding cancelled and rescheduled visits, for which work is ongoing.
Risk 3 Failure to invest in digital solutions. If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable, and the impact will be delays in	**12 (V high)**	• Performance brief • Risk Register report	Reasonable	Further conversation required re CCIO and new Deputy Director of Digital. It was hoped that the implementation of e-Allocate and work being undertaken within BI would make it easier for an assurance level to be agreed for this strategic risk.

caring for patients and less than optimum quality of care.				
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention.	**9 (high)**	• Performance brief • Patient safety incident response plan • Safeguarding Children's and Adult's • Group: minutes • Mortality report	Reasonable	

Trust board meeting held in public: 2 February 2024

Agenda item number: 2023-24 (101e)

Title: Business Committee Chair's assurance report 24 January 2024

Category of paper: For assurance
History: Not applicable

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

Executive summary (Purpose and main points)
This report identifies the key issues for the Board from the Business Committee held on 24 January 2024 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:

Strategy and Planning

Third Sector Strategy
The Committee received an update on progress on implementation of the strategy over the last six months and noted the considerable work undertaken. It was noted that the Chief Executive and Chair intended to write to the Accountable Officer for Leeds ICB regarding their concerns from recent conversations about potential cuts in Third Sector funding, to make alternative solutions, and to highlight the potential impact on Trust services and patient care if this occurred.

The Committee was pleased to be updated on recent activity including the successful networking event but requested more granularity in future reports to be assured of delivery against plan and what could be achieved during 2024/25. The Committee would also like to see more information regarding the digital agenda with Third Sector organisations.
Business Intelligence Strategy
It was noted that progress against the strategy was on track, and the Committee welcomed the breakdown of what planned activity had been achieved and what was planned for the next phase of delivery.

Procurement Strategy
The Committee heard that the Director of Finance and Resources had written to LYPFT regarding the procurement strategy due to a lack of progress and that there would be a more comprehensive update once the discussions had taken place. . It was also noted that the service costs were high when compared to other similar organisations. It was agreed that a report would be brought back to the Committee in March 2024 following further conversations about delivery with LYPFT.

LMWS Partnership Agreement
The Committee noted that the agreement, which had previously offered significant assurance, had been updated following recommendations for improvement from Internal Audit. The opportunity had been taken to make further changes, with support from the Trust's legal team. The SBU Business Manager was praised for the extensive work that had been undertaken, and the intention to use the agreement as a blueprint for other partnerships was noted.
The Committee was happy for the final draft of the Partnership Agreement to be signed off by the LMWS Service Delivery Group and Partnership Board in Quarter 4.

Change Management
The Committee received an update on the CYPMHS Electronic Patient Record Programme Closure, and noted the realised aims and objectives of the programme.
In particular, the Committee acknowledged the successful implementation of Electronic

Prescribing, noting the resulting improvements on patient experience, safety of prescribing, ease and timeliness of issuing prescriptions.

Performance Management (see Board paper)
No comments were raised by Committee regarding the safe and caring domains in the report.

On the issues highlighted under the responsiveness domain, the Committee heard that in response to the continued challenges faced by clinical and administrative services in managing their waiting times, a workshop had been scheduled during January with each business unit to review the 'responsiveness' position in every service and make recommendations relating to the oversight, management, and reporting of waiting times, supported by the Business Intelligence department. The Committee was assured that it would result in a consistent understanding, management and reporting of the Responsive Domain, and would also address how to meet the request from the Committee and Board for more detailed oversight and assurance at service level. Although this meant that there was still considerable work left to be done regarding reporting and insights from waiting times, the Committee reflected the importance of this piece of work. The Interim Director of Operations offered greater assurance that there were safety net procedures in place and the top ten areas of concern could be easily identified. It was noted that the waiting list data provided to the Committee in an appendix was already much more informative and prompted discussion about particular services.

In terms of Well-led, the Committee heard that long-term sickness absence and appraisals remained areas of focus. Following on from the workshop in October, it was reported that further work had been undertaken regarding managing staff on long-term sick, particularly in ABU, and this should be visible in future months' figures. More data on long-term sickness was requested by Committee, alongside benchmarking information where available.

In respect of Finance, the Committee was updated on the forecast £250k surplus for the Trust in 2023/24. Further discussions were held regarding system pressures and the forecast system deficit, and the Committee was made aware of the risks this brought to the organisation.

A discussion took place regarding the Podiatry service, where demand continued to exceed capacity. The Committee was reassured that conversations were taking place with the pathway team on how care could be delivered differently and concerns were expressed about how some changes might impact patients.

Revised High Level Indicator List for 2024/25
The Committee reviewed the proposed KPIs list, noting changes to the Safe domain due to the introduction of PSIRF, and the inclusion of equity measures.
As with Quality Committee, it was agreed that the Committee would need to see the next iteration for indicators listed as 'under development' before they were presented to Board. The NEDs echoed the Quality Committee's anxiety around receiving a narrative in future reports rather than the data, and supported the request for system pressures to be included in the Performance Brief.
It was concluded that the three financial KPIs were sufficient, in addition to the Committees receiving monthly reporting on the Quality and Value Programme.

Budget Setting Procedure 2024/25

The Committee noted the Budget Setting Guidance and Principles for Income and Expenditure for 2024/25. Whilst the process and principles were similar to previous years, it was acknowledged in the coming year it would be impacted by the output of the Quality and Value programme and there was some discussion about the level of information and oversight which would flow up to the Committees, it was recommended that this be discussed during the private Board session. Assurance was provided that support would be available to ensure budget holders were sufficiently equipped to carry out rigorous budget management.

Safer Staffing
The Committee noted the work undertaken and was reassured that the next 6 monthly report was expected to articulate the full triangulation of data by team and service level. It was noted that despite significant staffing pressures in some services, safe levels of care had been maintained.

Service Focus
The new Associate Director of Digital Transformation gave an introductory presentation and outlined her thoughts on the Trust's digital maturity and her plans for the role. It was noted that while it would remain separate, the review of the Digital Strategy would tie in with the review of the overall Trust Strategy and was expected to be ready for April to coincide with the arrival of the new Trust CEO.

Cyber Essentials Plus Update
The Committee noted that the Cyber Essentials plus audit had been scheduled for 7 February 2024. The Committee heard about the significant improvements made to the patching process, and the risks that remained in this area.

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 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage	12 (high)	• Change Management Report • Risk Register Report • Performance brief • Performance Management KPIs • Safer Staffing Report	Reasonable	See information included in Third Sector strategy and Performance Management sections above.
Risk 3 Failure to invest in digital solutions. If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable and the impact will be delays in caring for patients and less than optimum quality of care	9 (high)	• Change Management Report • Internal Audit Report - Cyber Essential Plus Accreditation control gaps • Risk Register Report • Business Intelligence Strategy Update • Performance brief	Reasonable	
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may	9 (high)	• Performance brief • Performance Management KPIs	Reasonable	

be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention.		• Internal Audit Report - Cyber Essential Plus Accreditation control gaps • Health and Safety Group Minutes		
Risk 5 Failure to deliver financial and performance targets: If the Trust does not deliver key financial and performance targets, agreed with NHS England and the ICB, then it will have adverse consequences for financial governance and cause reputational damage.	12 (high)	• Risk Register Report • Performance brief • Performance Management KPIs • Procurement Strategy update • Budget setting procedure 2024/25	Reasonable	See information included in Performance Management section above.
Risk 6 Failure to have sufficient resource to for transformation programmes: If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.	9 (high)	• Change Management Report	Reasonable	
Risk 7 Failure to maintain business continuity (including response to cyber security): If the Trust is unable to maintain business continuity in the event of significant disruption then essential services will not be able to operate, leading to patient harm,	12 (high)	• Internal Audit Report - Cyber Essential Plus Accreditation • Performance brief	Reasonable	

reputational damage and financial loss.				
Risk 8 Failure to have suitable and sufficient staff resource (including leadership): If the Trust does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, then the impact will be a reduction in quality of care and staff wellbeing and a net cost to the Trust through increased agency spend.	12 (high)	• Performance brief • Safer Staffing Report	Reasonable	

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (102)

Title: Performance Brief December 2023

Category of paper: for assurance
History: Quality Committee – 22 January 2024
Business Committee – 24 January 2024

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

Executive Summary (purpose and main points)

This report seeks to provide assurance to the Senior Management Team, Business Committee, the Quality Committee and the Trust Board on quality, performance, compliance, and financial matters. It is structured in line with the Care Quality Commission (CQC) domains with the addition of Finance.

The report focuses on performance against the KPIs (Key Performance Indicators) agreed before the commencement of the fiscal year.

Performance Brief – December 2023

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 (Key Performance Indicators) agreed before the commencement of the fiscal year.

Committee Dates

- Quality Committee – 22/01/2024
- Business Committee – 24/01/2024
- Trust Board – 02/02/2024

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

- There were 437 LCH patient incidents reported with harm
- There were two Serious Incidents logged on StEIS (Strategic Executive Information System)
- There were 12 incidents which met the requirement for Legal Duty of Candour in November and December 2023, these were all managed appropriately
- There were four new Central Alert System (CAS) notifications in the period, all appropriate actions were taken, and three have since been closed. The remaining alert is being led by the Integrated Care Board (ICB). One existing CAS notification remains open and under review for completion of actions, this requires a co-ordinated LCH and Leeds Community Equipment Service (LCES) response. There is one historical alert open under review as part of NHS England's Enduring Standards.

Caring

- There were 20 new complaints received in the reporting period
- Percentage of respondents reporting a good or very good experience in Community care was 94.1%.

Effective

- This domain is not reported this month

Responsive

- The position is outlined in the report below
- The sustained rise in demand for Neurodisability Assessments and on-going challenges with Inter-Provider transfers to the Community Gynaecology service continue to be the primary cause for deterioration in performance against the RTT 18- and 52-week standards:
    - RTT 18-week performance fell to 43.8% by the end of December, against a target of 92%
    - Consultant-led pathways reported 711 breaches of the 52-week standard in November and December
- Attention is currently focussed on a targeted deep dive across the three Business Units to review the accuracy of the reportable service lines, understand and standardise the oversight and design of waiting list management processes, and provide assurance that there is standardised, accurate reporting in place.

Well-led

- Turnover continues to improve and stabilise and is reporting a healthy 9.5%.
- Turnover amongst staff declaring as BME was 11.6%, which is within the Trust's turnover tolerance, although higher than overall Trust turnover at 9.5%.
- Staff turnover of leavers with less than 12 months service continues within tolerance at 14% and remains consistent and stable.
- There has been a slight increase in overall sickness absence taking it to 6.7% in December 2023. Which compared to sickness rate in December 2022 which was 7.9% it has decreased significantly.

- Long-term sickness absence continues to be above the 3.5% target. ABU remains a concern having a long-term sickness rate of 6.2% and an overall absence rate approaching 10%. Operational leaders continue to focus on areas of concern. HR Business Partners continue to work with Business Units to focus on all long-term absence and have undertaken case reviews to ensure the necessary plans are in place.
- Short-term sickness absence has remained below the 3% target since last April 2022.
- Following the successful “Appraisal Season pilot” in ABU, further services and teams are being supported to roll out Appraisal Season pilots for 2024/25.
- Additional appraisal training is being scheduled in 2024.
- Overall BME representation in LCH is 12.8%, with representation at Band 8a and above at 6.76%.

Safe – December 2023

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	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Time Series (from Apr-21)
Patient Safety Incidents reported as Harmful (per 1K contacts)	SL	1.42 to 2.09	2023/24	2.47	2.10	2.14	2.33	2.54	2.54	2.05	1.69	1.49	2.15	
			2022/23	2.21	2.06	1.87	2.01	1.88	1.87	1.54	1.73	1.78	1.87	
Serious Incidents (per 1K contacts)	SL	0 to 0.1	2023/24	0.04	0.05	0.02	0.00	0.00	0.01	0.00	*0**	*0**	*0**	
			2022/23	0.00	0.01	0.02	0.01	0.02	0.04	0.02	0.03	0.04	0.02	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	8 per year	2023/24	1	0	1	0	*0**	*0**	*0**	*0**	*0**	*2**	
			2022/23	0	1	0	1	0	0	0	0	0	3	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	2023/24	0	0	0	0	*0**	*1**	*0**	*0**	*0**	*1**	
			2022/23	0	0	0	0	0	1	0	0	0	1	
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	10 per year	2023/24	0	0	0	0	*0**	*0**	*0**	*0**	*0**	*0**	
			2022/23	0	1	0	0	1	0	0	0	0	2	
Number of Falls Causing Harm	SL	No Target	2023/24	47	36	40	56	55	38	51	40	16	379	
			2022/23	46	55	46	51	34	42	25	22	37	458	
Number of Medication Errors Causing Harm	SL	No Target	2023/24	8	7	7	7	6	8	7	4	12	66	
			2022/23	5	5	6	5	0	8	6	4	10	60	
Attributed MRSA Bacteraemia - infection rate**	*SL*	0	2023/24	1	0	1	0	0	0	0	1	0	3	
			2022/23	0	0	0	0	0	0	0	0	0	*0*	

** Reported by exception

** These numbers are subject to revision pending completion of investigations*

Narrative

LCH Patient Incidents Reported as Harmful

There were 437 incidents reported as harmful within November and December 2023. In comparison there were 310 incidents reported with no harm. As the data is taken from a live system the incidents are continually updated which results in some variation in the reported numbers over time. The data included in this report is accurate as of the 02 January 2024.

Reported Level of Harm	Number of incidents
No Injury	310
Minimal	337
Moderate	54
Major	5
Unexpected death	32
Expected death	9
Total	**747**

Table 1: LCH patient incidents by degree of harm

The number of incidents with harm reported for the Specialist Business Unit (SBU) has reduced in November/ December (97 incidents), in comparison to previous months, September/October (142 incidents) and July/August (119 incidents). On review this reduction can be seen across all teams within SBU and December's reporting is significantly lower than previous months, December is below the mean however remains within the lower control limit. The number of incidents reported in December is comparable to the same month last year.

The overall number of incidents reported for Adult Business Unit (ABU) has also decreased, with December 2023 falling below the lower control limit, this is the first time over the last two years. There were 333 incidents reported in November/December, in comparison to 445 in September/ October and 433 in July/August. On review of the data Meanwood, Pudsey and Yeadon Neighbourhood Teams have reported considerably less incidents this reporting period, this will be monitored. The reduction in incidents reported in SBU and ABU will be monitored (see Chart 1)

The Children's Business Unit (CBU) reported five incidents in November and December 2023 which is consistent with the last nine months. The LCH patient incidents for CBU have been reviewed to determine whether they have gone below the lower control limit, and they have not, this will continue to be monitored. An SPC chart is now incorporated in the CBU monthly Governance report for this.

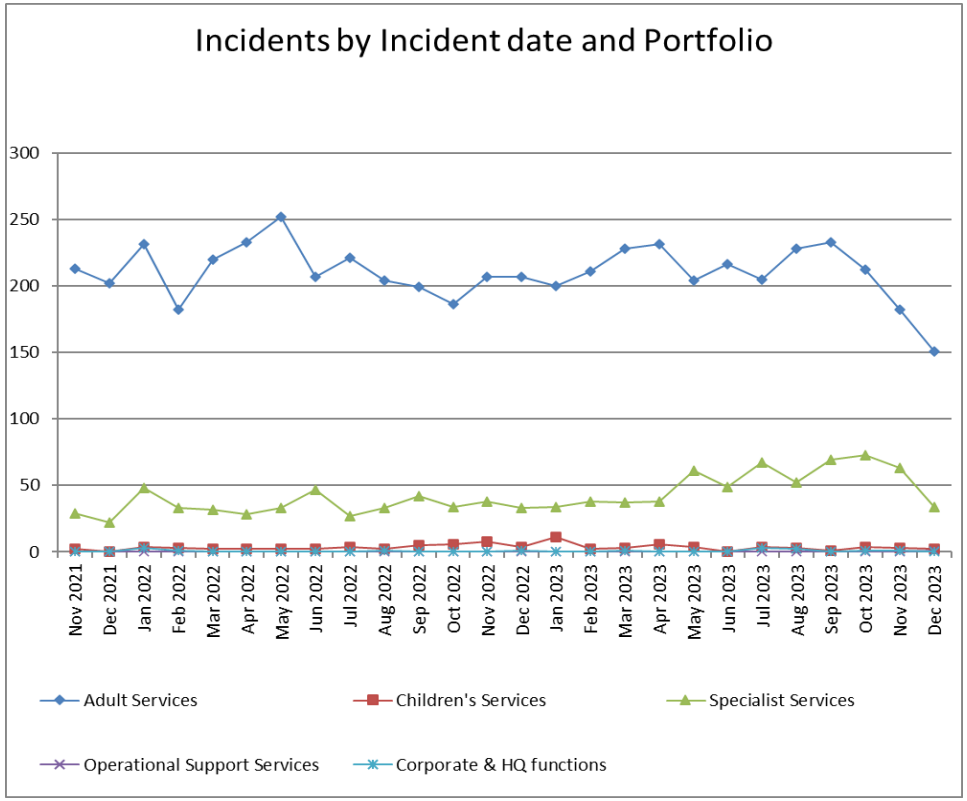


Chart 1: Incidents reported as harmful over two years by Business Unit

	Meanwood	Pudsey	Yeadon
September/October	36	34	54
November/December	17	21	23

Table 2: Neighbourhood Teams with reductions in Incident Reporting

Number of Falls causing Harm

There were 60 falls incidents causing harm in November and December 2023, compared to 88 in September/ October 2023.

	ABU	SBU	CBU	TOTAL
Sept/Oct 23	51	36	1	88
Nov/Dec 23	46	14	0	60

Table 3: Falls incidents causing harm by reporting period and business unit

There has been a decrease overall in this reporting period of falls incidents with harm. Major harm falls has decreased from 12 in September and October to 3 in November and December 2023, all three are awaiting Rapid Review. The peak identified in the last report for falls with harm in the Cardiac Team, Stroke and Community Neurology has reduced back to previous reporting norms.

The highest reporting teams for falls with harm across November and December 2023 were the Community Falls Service (13) and Armley NT, Middleton NT and the Cardiac team who reported five incidents each.

Community Falls Service

The Community Falls Service reported a total of 13 incidents in November and December 2023, the same as September and October 2023. Twelve incidents were reported as minimal harm, and the remaining fall of moderate harm is pending Rapid Review meeting.

Armley Neighbourhood Team

Armley Neighbourhood Team reported a total of five incidents in November and December 2023, this is an increase of four from September and October 2023. All incidents were reported as minimal harm.

Middleton Neighbourhood Team

Middleton Neighbourhood Team reported a total of five incidents in November and December 2023, this is a decrease of one from September and October 2023. All incidents were reported as minimal harm.

Cardiac Team

The Cardiac Team reported a total of five incidents in November and December 2023, this is a decrease of three from September and October 2023. Four were reported as minimal harm and one was reported as moderate harm. The moderate harm incident is pending Rapid Review meeting.

Updates from September/October

The major harm incident for the Community Falls Service concluded as no lapses in care.

The moderate harm incident for the Community Stroke Team and the major harm incident for the Cardiac Team is pending Rapid Review meeting, an update will be provided in the next report.

The learning from falls incidents will be shared in the quarterly Falls Report, six-monthly Safety and Serious Incident report and bimonthly Clinical Governance Report.

Number of Medication Errors Causing Harm

There were 17 medication errors causing harm reported, this is the same number of incidents as September and October 2023. Sixteen of these incidents were minimal harm, one is reported as expected death and under review.

Of the seventeen incidents, 13 were reported in the Neighbourhood Teams and six of these related to insulin administration. One incident was administration of insulin to the wrong patient in a care home who was not diabetic. This is similar to an incident that was reported in September/October 2023, both incidents were in the Middleton NT and the same care home. The incidents relating to the wrong patients receiving insulin were discussed at Rapid Review Meeting on 5 January 2024 and learning will be shared for consideration at the planned Insulin Working group.

The walkthrough to observe the insulin process from allocation to administration in the Neighbourhood Teams in real time to identify how the process could be made safer and reduce the risk of insulin errors and subsequent harm remains underway. The document for Neighbourhood Teams to work with care homes who are willing to support their residents with insulin administration has been completed and is awaiting Clinical Lead review and sign off.

The remaining four incidents were reported by Wetherby Young Offenders (two incidents) and Wharfedale Recovery Hub and the Community Dental Team (one incident each).

Pressure Ulcers

Validated Category 3 Pressure Ulcers

There were no validated category three pressure ulcers.

Validated Category 4 Pressure Ulcers

There was one validated category four pressure ulcer.

Team	Date of Incident	Date Validated
Yeadon NT	16/9/2023	17/11/2023

Table 4: Details of Validated Cat 4 Pressure Ulcer Incident

All learning for this incident had been identified at Rapid Review Meeting in line with PSIRF, as a proportionate approach to investigating and learning from incidents, an action plan was completed in place of a Serious Incident Investigation. Recommendations include earlier escalation to specialist colleagues, pressure ulcer prevention and management refresher sessions, improving the completion of safeguarding referrals and mental capacity assessments and effective case management.

Validated Unstageable Pressure Ulcers

There were no validated unstageable pressure ulcers.

The learning from pressure ulcer incidents will be shared in the quarterly Pressure Ulcer Report, six-monthly Safety and Serious Incident report and bimonthly Clinical Governance Report.

MRSA bacteraemia

One MRSA bacteraemia case was identified in October with the PIR meeting taking place in December. This case trialled a new form of documentation and review process in line with PSIRF. The process of aligning PIR's with PSIRF is still underway.

The case relates to a patient who was not known to LCH services but was known to the GP and practice nurse for routine leg wound dressings, they had also been identified as MRSA positive in September, but decolonisation treatment was not prescribed.

In October the patient sustained a fall and subsequent long lie requiring admission to hospital. On this admission they were found to have an MRSA positive blood culture.

Several examples of good practice were identified, including:

- The practice nurse contacting Tissue Viability for confirmation the correct dressings were being used.
- Following wound management and wound infection pathways.
- Referring to other services such as dermatology and podiatry in a timely manner and chasing these referrals when responses were not received.
- Photographing the wounds for future comparison.

However, learning from this case centred around the outdated community MRSA management policy on Leeds Health Pathways and the ambiguous wording in relation to decolonisation requirements. The updated MRSA community policy includes a risk assessment for decolonisation treatment, and it was felt that if this was available to the prescribing GP, decolonisation may have been more likely to be prescribed, potentially preventing this acquisition. There has been an action taken to identify who is responsible for uploading new policies to Leeds Health Pathways and ensure this is done as a matter of urgency to prevent further MRSA bacteraemia acquisition as a consequence of outdated advice. The patient also reported having an extensive long lie following their fall even though their property was monitored by a warden. An action has been taken to identify how often well fare checks are conducted by housing wardens and whether a risk assessment had been completed for the patient, taking into account his increased risk of falls due to bilateral leg wounds and bandaging potentially hindering mobility.

Serious Incidents

There were two incidents in the reporting period which met the criteria for Serious Incident Investigation (in line with the Serious Incident Framework 2015), both were reported on the Strategic Executive Information System (StEIS) within the 48-hour timeframe.

ID	Incident date	Category	Rapid Review	Date added to STEIS	Team
95300	28/05/2022	Moderate Harm Implementation of care	20/12/2023	21/12/2023	Armley NT
95367	02/11/2023	Unexpected Death	12/12/2023	12/12/2023	Integrated Wound Clinic

Table 5: Details of Serious Incidents reviewed during the reporting period

ID 95300 a retrospective Datix report was completed for this incident linked to an open claim, this was discussed at Rapid Review meeting in December 2023. A terms of reference meeting is scheduled to discuss progression of the incident. Early learning has identified that the correct policy regarding male catheterisation was not followed.

ID 95367 was discussed at Rapid Review meeting in December which identified learning related to a lack of case management, if this had been completed effectively the team could have highlighted the number of cancelled appointments for the patient.

Duty of Candour

There were 12 incidents which met the requirement for statutory Duty of Candour.

Eleven have been completed within the 10-day LCH standard, six letters were sent and the remaining five did not want a letter.

The remaining Duty of Candour is in the process of completion, although it has not been completed within 10 days this has been dealt with appropriately as contact details are being obtained.

Central Alert System (CAS) alerts outstanding

There were four Central Alert System (CAS) notifications during this period, three of these required a response on the CAS website. Two were not relevant to LCH and one alert was relevant to LCH. All were acknowledged, assessed, and actioned within the allocated timeframe. The remaining alert is being led at ICB level to meet the deadline of 31st January 2024.

The National Patient Safety Alert related to the risk of death from entrapment or falls from medical beds, trolleys, bed rails, bed grab handles and lateral turning devices. This is being coordinated by the Medical Device Safety Officer. Monthly strategy meetings are being held with partners across Leeds, as are required meetings with the business unit Clinical Leads and Clinical System Advisors. This alert requires input from LCH and LCES to meet the requirement of all actions to be completed by March 2024.

There is one alert which had historically been closed and is now reopened as part of NHS England's Enduring Standards, where Trusts are asked to ensure they remain concordant with historical alerts. This relates to the risk of harm from inappropriate placement of pulse oximeter probes and remains open. This alert is being reviewed and followed up by the Medical Devices Safety Officer to ensure compliance and provide assurance that appropriate actions have been taken, a new poster is under redesign prior to recirculation and an observational audit has been registered to assess concordance.

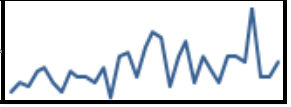
Alerts will be closed at a planned monthly meeting between the Head of Clinical Governance, Quality Leads, Medical Device Safety Officer, Medicines Safety Officer, and the Patient Safety Manager, as part of the collective approval process prior to closure.

Caring – December 2023

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	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Time Series (from Apr-21)
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%	2023/24	94.3%	92.9%	96.0%	95.6%	94.1%	91.9%	92.7%	92.0%	94.6%	93.4%	
			2022/23	92.8%	91.9%	92.9%	91.0%	94.4%	94.3%	93.3%	93.0%	92.6%	92.2%	
Total Number of Formal Complaints Received	SL	No Target	2023/24	9	7	12	12	11	22	8	8	11	100	
			2022/23	4	12	13	8	14	17	16	6	12	136	

Narrative

Complaints

Complaints this month are assessed to be within normal variation in consideration of the previous six months and is within the upper and lower control limits for monthly complaints received in the previous four years (which includes pre COVID data).

There were 20 complaints received in the period, this is a decrease in the numbers of complaints received over the last two months, and in comparison, to the previous four months, with 30 reported in September and October 2023, 24 reported in July and August 2023, 21 reported in March and April 2023 and 16 reported in May and June 2023.

Learning from Complaints

32 complaints were closed during the reporting period. A summary of the learning is presented below.

Adult Business Unit

An example of learning and improvement in this area comes from the Tissue Viability Team, where the complainant was unhappy with the service due to them not communicating the progress of his wound care with him. Service took this feedback on board and put a plan in place for wound measurement probes to be given to the Community Nurses to be used during visits, and to also be shared with this patient and for any future patients who may request or require this.

Children's Business Unit

Another example includes learning following a complaint around this subject with the ICAN Service. The complaint was regarding concerns around the questions asked by the Health Visitor and the way in which these were asked. As an outcome of the investigation the service will ensure the role of a Health Visitor is made clear prior to these visits, they will do this by developing a pack to be sent out prior to all antenatal contacts, this will consist of key public health information, the role of the Specialist Community Public Health Nurse and awareness of the structure of the visit.

Specialist Business Unit

Learning was identified from the Community Dental Service, a patient had not been reviewed within the timeframe of 3-4 months as agreed, due to an increase in the waiting lists the review was not planned. Following the increase, the service are now prioritising patients based on clinical need, the service is also providing safety advice to patients and carers including contact details advising if there are any concerns prior to their appointment to make contact with the service.

Friends and Family Feedback

Within the Friends and Family Test, 94.1% of feedback was good or very good. There has been a slight increase (0.5%) of good or very good reports from the previous reporting period (September- October 2023, 93.6%).

For responses that are rated poor/very poor we continue to see themes around access to the MSK service via telephone and service wait times.

Good/very good responses have highlighted positive experiences with staff, feedback has highlighted staff members being knowledgeable and understanding during appointments. Patients reported feeling reassured and listened to.

Effective – December 2023

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

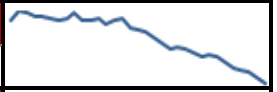
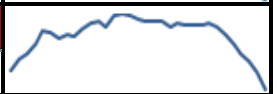
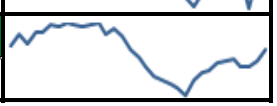
The Effectiveness Domain is not due for reporting this month, and so is not included in this report.

Responsive – December 2023

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	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Time Series (from Apr-21)
Percentage of patient contacts where an ethnicity code is present in the record	SP	100%	2023/24	97.0%	97.1%	97.1%	97.4%	97.4%	97.4%	97.4%	97.5%	97.4%	97.3%	
			2022/23	95.8%	95.6%	96.5%	95.8%	95.8%	95.6%	96.0%	95.8%	95.8%	95.7%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	2023/24	60.5%	61.4%	60.4%	56.9%	52.7%	52.0%	50.9%	46.6%	43.8%	43.8%	
			2022/23	80.6%	83.2%	83.4%	78.2%	77.0%	75.2%	71.8%	67.7%	64.4%	62.7%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	2023/24	9	23	38	71	158	199	268	343	368	368	
			2022/23	0	0	0	2	4	2	0	0	0	2	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	2023/24	42.0%	37.6%	37.4%	38.1%	31.8%	30.3%	32.4%	29.7%	28.7%	28.7%	
			2022/23	38.3%	49.4%	46.9%	47.5%	41.5%	44.3%	50.9%	57.8%	47.0%	50.3%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	2023/24	87.3%	88.0%	86.9%	84.6%	81.8%	79.1%	76.6%	73.4%	68.4%	68.4%	
			2022/23	86.4%	90.2%	90.6%	89.9%	89.0%	88.4%	88.6%	88.5%	86.5%	87.5%	
LMWS – Access Target; Local Measure (including PCMH)	SP	24456 by year end	2023/24	2,070	2,392	2,343	2,372	2,564	2,631	2,519	2,493	1,902	21,286	
			2022/23	2,312	2,699	2,570	2,536	2,716	2,781	2,867	3,088	2,013	30,963	
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	SP	No Target	2023/24	59.5%	65.3%	69.1%	77.9%	70.8%	76.9%	74.5%	74.5%	77.3%	71.9%	
			2022/23	59.7%	52.3%	43.9%	40.5%	39.0%	42.9%	40.1%	46.4%	58.4%	51.5%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	2023/24	98.1%	98.1%	98.0%	97.9%	98.2%	98.7%	97.5%	98.7%	98.7%	98.2%	
			2022/23	100.0%	99.4%	99.3%	98.9%	99.3%	98.4%	98.4%	98.5%	98.8%	98.7%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	2023/24	79.3%	79.7%	82.7%	83.3%	83.7%	81.0%	81.4%	83.3%	86.7%	82.3%	
			2022/23	92.1%	94.3%	91.2%	87.2%	84.5%	81.2%	77.8%	76.8%	75.6%	81.4%	

Narrative

As previously reported the sustained rise in demand for Neurodisability Assessments and on-going challenges with Inter-Provider transfers to the Community Gynaecology service continue to be the primary cause for deterioration in performance against the 18 and 52 week waits. Overall, the Trust receives approximately 240,000 referrals per year. In April there were 3167 people waiting over 18 weeks, this has increased with 8,400 people currently waiting over 18 weeks.

For school-aged children the capacity within the service enables us to deliver 120 Neurodevelopment Assessments per year. The current rate of referral is 102 per month. There are currently 1597 children on the waiting list. There are also a further 2662 neurodevelopmental referrals awaiting triage at MMSPA. Around 47% of all MMSPA referrals end up with CAMHS. There is ongoing work between the business unit and the ICB to identify solutions including advising children and their families on 'Right to Choose'.

In response to the continued challenges faced by clinical and administrative services in managing their waiting times, a workshop has been scheduled with each business unit to review the 'responsiveness' position in every service and make recommendations relating to the oversight, management, and reporting of waiting times. This approach is being supported by the Business Intelligence department and will result in a consistent understanding, management and reporting of the Responsive Domain. The workshops are due to take place during January 2024, with follow on work commencing from February 2024. The work will also address how to meet the request from Business Committee and Board for more detailed oversight and assurance at service level.

In addition to the extended waiting times in ICAN, CAMHS and Community Gynaecology there are pressures in other services and the report below contains actions and improvements being progressed in these services.

Consultant-led RTT Pathways

Whilst there are on-going challenges with the Inter-Provider Transfer for Community Gynaecology referrals there are some early signs of improvement (see Table 4).

As outlined above, demand continues to outstrip capacity across a range of ICAN Consultant-led clinics. This rise in demand is a significant factor in the increased number of people waiting more than 52-weeks for their first appointment. The number of people waiting over 52 weeks across the whole trust has increased from 199 patients at the end of September to 368 patients at the end of December, an increase of 85% in 4 months.

Both services are working closely with colleagues at the ICB to address changes to their pathways and make long-term, sustainable improvements.

ICAN consultant pressures (PND, CPC and CPMC)

The ICAN Service has now completed the first cohort of recruitment to Advanced Clinical Practitioner roles, reducing reliance on a medical model and increasing clinic capacity. A second round of recruitment is planned for January 2024. Waiting lists continue to grow, primarily due to increased demand across a range of clinics, including Paediatric Audiology which is now beginning to report patients waiting more than 52 weeks for assessment. The service continues to address these pressures by flexibly adjusting job plans where possible to ensure that all clinics can be covered. The service has been working with a full consultant compliment for the majority of the Financial Year.

Community Gynaecology

Although the service is continuing to receive referrals from LTHT for patients that have already waited more than 18 weeks, the responsiveness of our own service to care continues to be timely and of high standard. The average waiting time for patients once their care is transferred to LCH remains low at 8 weeks

However, due to the current challenges with the Inter-Provider Transfers, they continue to report a low level of formal RTT 18-week performance, as shown in Table 4, but there are early signs that this might be improving. As the service experiences a variability in the length of the existing waiting time for each person referred, this early trend should be noted with caution.

Month	ICAN Paediatric Neuro-Disability	Community Gynaecology
April 2023	37.1%	1.0%
May 2023	38.8%	0.0%
June 2023	37.0%	0.7%
July 2023	35.8%	0.0%
August 2023	31.0%	0.0%
September 2023	30.2%	4.0%
October 2023	29.4%	7.8%
November 2023	25.5%	16.4%
December 2023	23.9%	12.4%

Table 4 – RTT 18-week Performance in PND and Community Gynaecology

Non-Consultant Pathways

There are 3 non-consultant pathways highlighted in this report:

- MSK
- Respiratory
- Tier 3 Weight Management

MSK

The total number of patients waiting for First Assessment has grown to more than 8000 patients by the end of December, from 7046 at the beginning of April 2023. During this time period urgent referrals into the service have grown by approx. 100%, from 25 per month during the 2022/23 Financial Year, to 50 per month during the current Financial Year. These are primarily for Spinal Problems.

In response the service continues to explore phase 1 waiting list validation and a patient-initiated physio referral form.

Respiratory

The biggest waiting list for the service continues to be Pulmonary Rehab. This is a backlog from the pandemic and the service is working hard to address this. A third clinic venue has recently opened, with a fourth due to open soon.

Tier 3 Weight Management

The service continues to work with ICB commissioners on a timetable for a revised pathway model, however challenges remain within the service. The waiting list continues to grow and remains significantly above contracted levels. The service is commissioned to see 250 people per year with a caseload reaching 1121 in December 2023. The service remains closed to new referrals, following ICB agreement in July 2023. Improvements have been made in the interface between Tier 3 and Tier 4 pathways, leading to an increase of 6 additional patients per week transferring to Tier 4, which is improving flow.

New drug-therapies have been approved for use, however the ICB is concerned about the financial impact to the system of a large scale roll out, and so our service is working with the commissioners to deliver a phased approach. These new therapies could support approximately 660 patients who are currently awaiting treatment from the service, which equates to more than 50% of the caseload in December 2023.

ICB commissioners have also confirmed that additional monies provided to the service during 2023/24 (£192k) will not be available from April 2024. The loss of this additional income will lead to the loss of several staff from Band 7 to Band 2. The ICB has also indicated that a further 3% reduction is likely to be required during the upcoming year. The upcoming pathway review led by the ICB will be critical to addressing these pressures.

Urgent Community Response

As of the end of December 2023, the Trust had responded to 77.4% (against a target of 70%) of Urgent Community Response (UCR) patients within the required 2-hr timeframe, continuing its above-target performance for the 5th consecutive month.

Diagnostic Pathways (DM01)

The Audiology Service has now successfully completed recruitment to 2 posts at Band 2 and a Band 3 post. Due to the training requirements, these staff will be ready to undertake clinical work at the end of January 2024. Changes to the clinical model, and optimisation of clinic capacity has enabled the service to stabilise their waiting list, although this does not address the backlog created during COVID.

This now completes the staffing required to fully operate the new clinic structure, which is leading to greater flow into clinics, and increased face-to-face contacts. The service is now maximising the availability of soundproof rooms within LCH clinical estate. Additional locums had been brought in to help reduce waiting list sizes; these posts came to an end in December 2023. The service is also investigating their increasing DNA rate which has reached 14% in December 2023.

Although morale remains high there is limited time for service development or new learning opportunities for staff.

Currently, performance against this standard continues at low levels, with 32.4% of patient waiting less than 6 weeks at the end of October 2023, against a 99% target. The total number of patient waiting has increased 963 at the end of December.

Improving Access to Psychological Therapies

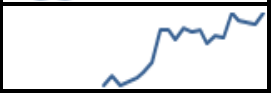
The Leeds Mental Wellbeing Service continues its improvement of Waiting List performance, achieving all targets during the reporting period. The recent reductions in Access numbers are being investigated by both the service and the Business Intelligence Department, to understand the causes and required solutions. It is likely that Access rates are in fact higher than reported locally, however, the service remains on track to achieve its end of year target.

Levels of activity within the service have been consistently high this year, averaging more than 500 face-to-face contacts per month more than 2022/23. This has been driven by the increases in recruitment during last year. Clinical Administration, Telephone contacts and Liaison have all remain stable, so this highlights a positive improvement in efficiency during this year.

CAMHS Access Measures

Significant progress has been made with clearing the backlog of referrals created during the migration to SystmOne, and data is being put through final preparations to be released during January 2024. Ongoing data quality concerns remain, that relate to the ongoing use of the EPR by the service, but a Data Quality Improvement Plan is in place with the service leadership team that is directing this work.

Neighbourhood Team Indicators

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	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Time Series (from Apr-21)
Neighbourhood Team Face to Face Contacts	SP	No Target	2023/24	44,473	47,652	47,732	48,112	49,334	46,164	49,027	46,959	47,051	426,504	
			2022/23	50,745	53,399	49,949	51,131	50,654	49,440	50,389	48,284	46,875	586,579	
Neighbourhood Team Referrals (SystmOne only)	SP	No Target	2023/24	2,191	2,545	2,641	2,460	2,478	2,570	2,590	2,593	2,585	22,653	
			2022/23	2,206	2,657	2,463	2,572	2,591	2,497	2,585	2,607	2,494	30,374	
Neighbourhood Team Productivity (Contacts per Utilised WTE)	SP	No Target	2023/24	97.2	101.4	98.8	98.1	100.7	96.3	109.9	100.3	129.1	129.1	
			2022/23	100.4	107.0	102.2	105.7	103.1	102.9	106.1	102.9	104.9	96.4	
Proportion of Urgent Community Response referrals reached within two hours	SP	70%	2023/24	71.7%	67.6%	69.7%	69.5%	77.5%	74.8%	74.5%	73.5%	77.4%	77.4%	
			2022/23	0.5	0.6	0.5	0.6	0.6	0.6	0.6	0.7	0.7	0.7	

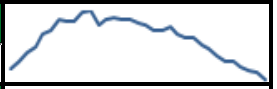
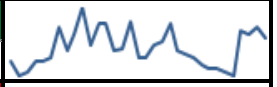
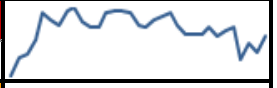
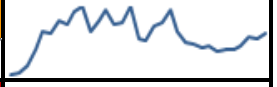
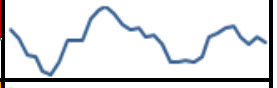
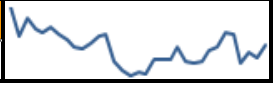
Referrals into Neighbourhood Teams have held steady at higher levels during the reporting period. Trends continue with more patients referred to Pathway 1 from Pathway 2. Contacts and productivity indicators are showing continued signs of improvement, however, as shown in well-led data tables, sickness and vacancy rates have returned to levels consistent with recent peaks, with a significant increase in vacancies reported in December.

Well-Led – December 2023

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	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Time Series (from Apr-21)
Staff Turnover	LS/JA	<=14.5%	2023/24	12.3%	11.9%	11.4%	10.9%	10.9%	10.5%	10.2%	10.0%	9.5%	9.5%	
			2022/23	14.4%	14.5%	14.4%	14.4%	14.1%	13.9%	13.4%	13.5%	13.7%	12.9%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	2023/24	14.1%	14.1%	14.1%	13.4%	13.6%	13.9%	13.1%	14.6%	14.0%	14.0%	
			2022/23	19.2%	19.5%	18.4%	17.6%	17.1%	17.2%	16.4%	15.2%	16.5%	14.3%	
Short term sickness absence rate (%)	LS/JA	<=3.3.0%	2023/24	1.6%	1.5%	1.5%	1.4%	1.3%	2.6%	2.5%	2.7%	2.4%	2.4%	
			2022/23	2.8%	2.0%	2.1%	2.9%	1.8%	1.8%	2.2%	2.3%	2.8%	1.8%	
Long term sickness absence rate (%)	LS/JA	<=3.5%	2023/24	4.4%	4.7%	4.3%	4.5%	4.6%	3.5%	4.1%	3.8%	4.3%	4.3%	
			2022/23	5.1%	5.2%	5.2%	5.1%	4.7%	4.6%	4.9%	5.0%	5.1%	4.4%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=6.5%	2023/24	6.0%	6.1%	5.8%	5.9%	5.9%	6.1%	6.6%	6.5%	6.7%	6.7%	
			2022/23	7.9%	7.2%	7.3%	8.1%	6.5%	6.4%	7.1%	7.3%	7.9%	6.2%	
AfC Staff Appraisal Rate	LS/JA	>=90%	2023/24	72.8%	75.2%	75.7%	76.3%	76.5%	75.1%	74.3%	75.3%	74.5%	74.5%	
			2022/23	79.0%	78.1%	76.7%	76.0%	76.3%	75.3%	75.5%	74.4%	72.0%	72.1%	
Statutory and Mandatory Training Compliance	LS/JA	>=90%	2023/24	86.2%	87.0%	87.2%	88.2%	88.1%	86.1%	86.8%	86.5%	87.3%	87.3%	
			2022/23	88.1%	86.2%	85.6%	85.3%	85.5%	85.4%	86.3%	86.4%	86.4%	86.1%	

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	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Time Series (from Apr-21)
'RIDDOR' incidents reported to Health and Safety Executive	BM	No Target	2023/24	0	0	0	0	0	0	0	0	0	0	
			2022/23	1	1	0	0	2	1	1	0	0	7	
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	LS/JA	No Target	2023/24	6.8%	6.6%	7.0%	7.3%	7.3%	6.9%	6.1%	6.7%	7.6%	7.6%	
			2022/23	7.8%	7.8%	7.8%	7.8%	7.6%	7.8%	7.8%	7.6%	7.5%	7.2%	
Total agency cap (£k)	BM	No Target	2023/24	417	362	376	307	485	312	314	-47	239	2765	
			2022/23	352	307	394	255	311	362	357	317	333	4133	
Percentage Spend on Temporary Staff	BM	No Target	2023/24	6.6%	6.2%	6.3%	5.9%	5.9%	6.1%	6.1%	1.1%	5.7%	5.7%	
			2022/23	6.3%	5.4%	6.3%	4.4%	5.4%	5.1%	5.6%	6.2%	5.7%	5.8%	
Neighbourhood Team Vacancies, Sickness & Maternity WTE	SP	No Target	2023/24	159	166	151	160	149	167	84	86	157	157	
			2022/23	110	100	106	119	114	117	122	134	156	139	
Neighbourhood Team Percentage of Funded Posts Utilised	SP	No Target	2023/24	78.2%	81.2%	83.9%	82.8%	83.8%	82.1%	92.0%	97.9%	78.1%	78.1%	
			2022/23	88.4%	88.6%	87.5%	85.9%	86.9%	86.4%	84.3%	83.3%	79.2%	83.2%	
Starters / leavers net movement	SP	>=0 in favour of starters	2023/24	13	15	16	30	4	9	13	7	5	112	
			2022/23	-2	-8	2	0	10	24	3	61	-6	17900.0%	

Narrative

Turnover

Turnover continues to improve and stabilise and is reporting a healthy 9.5%. Work to retain staff and achieve the right balance for the trust remains in focus and is now a standing agenda item at the trusts Resourcing Steering Group. A focus will be on understanding why and where turnover is happening and the impact on services and areas that are reporting low turnover as this may present unintended consequences for services. The latest Staff Survey results will help us target any areas highlighting workforce issues as well as a further review of a nursing retention self-assessment tool to help inform our work and how we can further support staff in their early, mid, and later careers.

"Stay conversations" are now being utilised across the trust, with some positive outcomes being reported and established Internal Transfer processes used to enable moves. Further work is starting to revisit the exit interview process, with the intention of "closing the gap" of "unknowns" and ensuring that appropriate actions are implemented. Instances of staff reporting reason for leaving as "Not Known/Other" remains one of the highest reasons for leaving. A reduction was seen following targeted communications in August and September 2023, but this has recently increased back to one of the main reasons for leaving (33.5% at December 2023) so ongoing work is required to address

this. It is anticipated that these should account for fewer than 20% of reasons for leaving, and ideally 10% or fewer considering that employees are under no obligation to share their reason for leaving.

As part of our Retention focus, we are now monitoring turnover by ethnicity and will be reporting this through the Performance Brief narrative. In December 2023 turnover amongst staff declaring as BME was 11.6%, which is within the Trust's turnover tolerance, although higher than overall Trust turnover at 9.5%.

We are continuing to see a month-on-month improvement across the staff net movement i.e. the number of starters –v- leavers, consistently since January 2023 and work continues on a range of resourcing initiatives to increase supply and enhance capacity.

Traditional recruitment methods continue to be supplemented by hyper local recruitment which reaches our local communities, narrowing inequalities and streamlining and speeding up recruitment processes for all roles. To address adult nursing vacancies, we have successfully recruited and inducted 32 international nurses of which 31 are now registered with the NMC.

Reduce the number of staff leaving the organisation within 12 months

Staff turnover of leavers with less than 12 months service continues within tolerance at 14% and remains consistent and stable.

In addition to the above retention initiatives, work to improve recruitment and induction processes has been a key focus to ensure that new recruits get the best possible experience during those first few crucial months of employment as we know poor practices and experience can impact on retention during this time. Work to introduce an Applicant Tracking system is underway and this will support improvement in recruitment processes and reporting.

The corporate induction has been revamped and feedback has been very positive. All new starters are also invited to attend a New Starters forum which meets monthly which helps us to understand what is working well and any areas for improvement.

Overall sickness absence

Since June 2023, the overall sickness absence has been below the organisational target of 6.5%. In the last two months there has been a slight increase taking it to 6.7% in December 2023. Which compared to sickness rate in December 2022 which was 7.9% it has decreased significantly. We are seeing high levels of colds, coughs and flu, which is causing significant pressure across all business areas. The vaccination programme has been widely promoted and encouraged throughout the organisation to mitigate the impact. We are seeing some improvements in both long-term and short-term sickness absence rates, including a small reduction in absence related to stress, anxiety, and depression.

Long-term sickness absence

Long-term sickness absence remains a concern in that all areas of the Trust remain above the 3.5% target with the exception to corporate areas which has been below the target for the last 2 months. ABU remains a concern having a sickness rate of 6.2%.

Anxiety/stress/depression/other psychiatric illnesses remain the highest reason for absence at 1.89%. The HR Business Partners continue to work with their Business Units to focus on all long-term absence and have undertaken case reviews to ensure the necessary plans are in place.

Short-term sickness absence

Short-term sickness absence for all areas, has remained below target for the last 12 months, the only area that is higher than the 3% target is ABU at 3.5%. The main reason for short term absence continues to be colds, coughs, and flu.

A focus is being placed on supporting managers to promote positive employment practices that we know help people to feel supported, effective, and well at work. These include encouraging regular support from their HR Business Partners, activating encouraging colleagues to use the support services available at LCH to not only support during sickness but to also prevent sickness absence like taking regular breaks and leave.

Appraisal

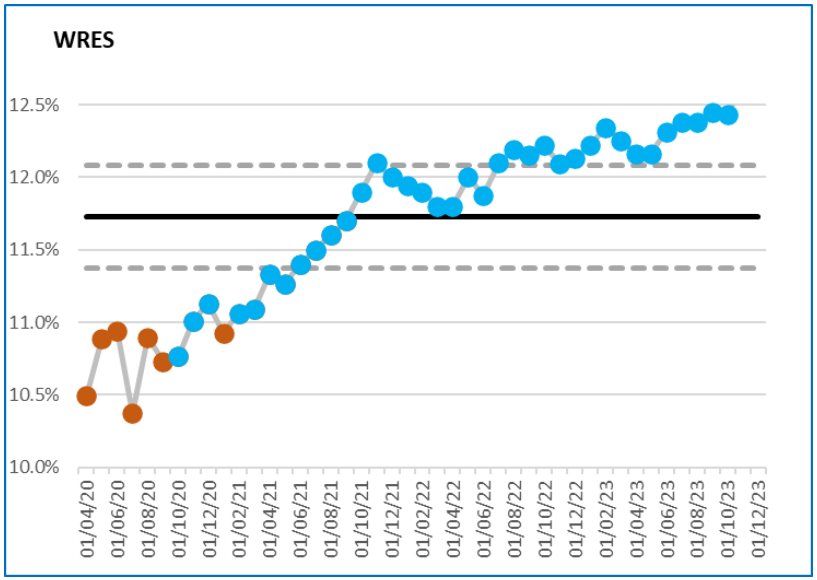
To improve appraisal compliance beyond the current rates further work is required to understand ESR hierarchies, reporting requirements and consider when would be a good time to introduce an appraisal season. In the meantime, appraisal training is being scheduled for 2024 and we are working locally with services and teams who want to pilot their own season following the success in ABU.

Statutory and Mandatory Training (MaST)

Nothing significant to report this month.

Workforce Race Equality Standard (WRES)

Overall BME representation has increased to an LCH all-time high of 12.8% which, together with an increase of BME representation at Band 8 > to 7.6%, is pleasing to see.

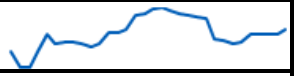


Finance – December 2023

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

Leeds Community Healthcare NHS Trust

Data

Finance	Responsible Director	Year End Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Time Series (from Apr-21)
Net surplus (+)/Deficit (-) (£m) - YTD	BM	1.0	2023/24	-0.2	-0.3	-0.5	-0.4	0.0	0.0	0.0	0.0	0.3	0.3	
Capital expenditure in comparison to plan (£k)	BM	4149	2023/24	-1344	159	-368	-358	28	-2110	536	1060	921	-1476	
CIP delivery (£k)	BM	3.03	2023/24	688	545	832	687	688	687	688	687	688	6190	

Narrative

National and West Yorkshire Context

At the time of writing this report there continues to be significant work ongoing across England to improve financial positions of ICBs and provider organisations. Trusts are also being asked to review their financial positions in the context of their aggregated place positions and the overall West Yorkshire position. Further information on the informal agreements reached across the Leeds Trusts' and the ICB in Leeds was reported to the Trust Board in December. The position agreed at Leeds Place includes the Trust's ICB income being reduced by £1m and is due to be transacted in quarter 4. There remains a £10m gap at West Yorkshire of which £4m relates to the Leeds place with work continuing across the system to identify opportunities to close this gap.

Income & Expenditure (I&E) Summary

At the end of December 2023, the Trust is reporting a surplus of £250k. The year-to-date position is mainly driven by substantive vacancies and a favourable variance in interest received, offset by contract penalties, and inflationary pressures. A breakdown of the variances by category are provided in the tables below. Forecast for the end of year is a surplus of £250k, the position agreed with WYICB in December, with the contract penalties and non-pay overspend being offset by underspends in pay and interest received.

Income & Expenditure Summary	December 2023			2023/24		
	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Forecast Outturn	Forecast Variance
	£k	£k	£k	£k	£k	£k
Income						
Income from Patient Care Activities	(154,352)	(154,319)	33	(205,845)	(205,716)	129
Other Operating Income	(9,817)	(9,859)	(42)	(13,124)	(13,147)	(23)
Total Income	**(164,169)**	**(164,178)**	**(9)**	**(218,969)**	**(218,863)**	**106**
Expenditure						
Pay	115,818	114,692	(1,126)	154,321	153,591	(730)
Non pay	48,201	50,188	1,987	64,448	66,264	1,816
Total Expenditure	**164,019**	**164,880**	**861**	**218,769**	**219,855**	**1,086**
Operating (Surplus) / Deficit	**(150)**	**702**	**852**	**(200)**	**992**	**1,192**
Public Dividend Capital	346	346	0	461	461	0
Profit/Loss on Asset Disp	0	(8)	(8)	0	(8)	(8)
Interest Payable	507	491	(16)	676	658	(18)
Interest Received	(691)	(1,784)	(1,093)	(922)	(2,353)	(1,431)
(Surplus) / Deficit	**12**	**(253)**	**(265)**	**15**	**(250)**	**(265)**
Less: Donated Asset Depreciation	(12)	(12)	0	(15)	(15)	0
Less: Capital Donations and Grants	0	15	15	0	15	15
Adjusted (Surplus) / Deficit	**0**	**(250)**	**(250)**	**0**	**(250)**	**(250)**

Income From Patient Care Activities

The year-to-date small adverse variances of £33k and full year variance of £129k mainly relates to contract penalties for Police Custody due to nursing shifts not being filled. All contracts for this financial year have been signed apart from the Leeds Equipment Service contract with Leeds City Council. This is due to be signed in February 2024.

Other Operating Income

The small year to date and forecast favourable variances largely relate to additional lease car income.

Pay

The year-to-date favourable variance is (£1,126k), this is comprised of favourable variances in substantive staff of (£1,509k) due to vacancies partially offset by a £383k adverse variance from the cost of bank and agency staff covering substantive vacancies.

The pay forecast favourable variance continues however at a reduced rate due to assumptions on increased recruitment in quarter 4 including frontline line digitisation and the cost of the real living wage at £165k.

	December 2023			2023/24		
Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Budget £k	Forecast Outturn £k	Forecast Variance £k
Substantive Staff	109,170	107,661	(1,509)	145,471	144,114	(1,357)
Bank Staff	2,740	3,808	1,068	3,655	5,105	1,450
Agency Staff	3,450	2,765	(685)	4,600	3,777	(823)
Sub Total	**115,360**	**114,234**	**(1,126)**	**153,726**	**152,996**	**(730)**
Apprenticeship Levy	458	458	0	595	595	0
Total	**115,818**	**114,692**	**(1,126)**	**154,321**	**153,591**	**(730)**

There are 150 vacancies as at December 2023 (November 2023: 155 vacancies).

Non-Pay including Depreciation and Interest

The overall year to date position is £879k adverse to plan. The adverse variances in other non-pay of £1,936k relate to inflationary pressures and £1,154k in general supplies and services relate to expenditure with the local authority. These are partially offset by a non-recurrent favourable variance of £1,093k in interest received due to the higher-than-expected interest rates, clinical supplies, and services £769k for services provided by our partners due to vacancies and depreciation of £350k.

The annual **f**orecast adverse variance is expected to reduce to £367k due to additional expenditure controls and non-recurrent expenditure with the local authority included in the year-to-date position not expected to continue in quarter 4.

	December 2023			2023/24		
	YTD Plan	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
Non Pay Costs	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Drugs	706	760	54	941	1,014	73
Clinical Supplies & Services	21,269	20,500	(769)	28,562	27,404	(1,158)
General Supplies & Services	4,432	5,586	1,154	5,870	7,040	1,170
Establishment Expenses	3,147	3,192	45	3,998	3,956	(42)
Premises	6,726	6,644	(82)	9,054	8,897	(157)
Depreciation	7,430	7,080	(350)	9,908	9,451	(457)
Other Non Pay	4,491	6,426	1,935	6,115	8,502	2,387
Total Non Pay Costs	**48,201**	**50,188**	**1,987**	**64,448**	**66,264**	**1,816**
Public Dividend Capital	346	346	0	461	461	0
Profit/Loss on Asset Disp	0	(8)	(8)	0	(8)	(8)
Interest Payable	507	491	(16)	676	658	(18)
Interest Received	(691)	(1,784)	(1,093)	(922)	(2,353)	(1,431)
Total Non Pay	**48,363**	**49,233**	**870**	**64,663**	**65,022**	**359**
Less: Donated Asset Depreciation	(12)	(12)	0	(15)	(15)	0
Less: Capital Donations and Grants	0	15	15	0	15	15
Total Adjusted Non Pay	**48,351**	**49,236**	**885**	**64,648**	**65,022**	**374**

Delivery of Efficiency Plans

The Trust has £8,252k of planned efficiencies to deliver during 2023/24 of which £5,000k is a non-recurrent saving (£4,400k vacancy factor and £600k interest receivable). At the end of December, £6,189k of savings have been delivered which is in line with plan. The forecast assumes that the efficiency programme will be delivered in full.

	December 2023			2023/23		
Savings Scheme	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Plan £k	Forecast Outturn £k	Forecast Variance £k
Vacancy factor	3,300	3,300	0	4,400	4,400	0
Incremental Drift	1,042	1,042	0	1,389	1,389	0
Interest receivable	450	450	0	600	600	0
Contribution from developments	636	636	0	848	848	0
Procurement - management of price increases	761	761	0	1,015	1,015	0
Total Efficiency Savings Delivery	**6,189**	**6,189**	**0**	**8,252**	**8,252**	**0**
Recurrent	2,439	2,439	0	3,252	3,252	0
Non-recurrent	3,750	3,750	0	5,000	5,000	0
	6,189	**6,189**	**0**	**8,252**	**8,252**	**0**

Capital Expenditure

The Trust's plan for 2023/24 is to spend £16.9m on capital of which £2.8m is in respect of operational capital expenditure and the balance is to fund Right of Use Asset leases following the adoption of IFRS 16.

At the end of December 2023, the Trust has spent £12.7m compared to a plan of £11.2m. The main year-to-date expenditure on owned assets is £1.4m on the HQ project. On the lease expenditure, the year-to-date and forecast variance relates to increased costs for RPI following the remeasurement of the right of use leases, lease car additions and the addition of the Trust HQ Lease in September. The year-to-date variance for the HQ additions is due to the phasing of the plan, whilst the total cost has been capitalised in September. A refurbishment contribution has also been received towards the HQ fit out costs of £0.142m.

The Trust is forecasting to spend £16.3m by the end of March 2024. This is an underspend of £0.7m. The underspend consists of a £2.8m underspend relating to leases not starting as planned in 23/24 for Killingbeck and St Georges, offset by £1.6m of increased IFRS 16 costs from the remeasurement of Wharfedale and additional frontline digitisation costs of £0.5m from the successful bid for additional funding from the national underspend.

The initial business case for frontline digitisation is awaiting approval from NHSE. In September the Trust bid for some additional PDC Frontline digital funding. Confirmation has been received that £0.5m has been approved and been included in the forecast.

	December 2023			2023/24		
Capital Scheme	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Plan £k	Forecast Outturn £k	Forecast Variance £k
Estate Maintenance	222	123	99	443	443	0
Estates - HQ Project	1,433	1,292	141	1,433	1,292	141
Clinical Equipment	174	8	166	350	350	0
IT Hardware	100	103	(3)	200	200	0
IT - National Cyber Security	199	0	199	400	400	0
Hannah House Garden Charitable Fund Donation	0	(15)	15	0	(15)	15
Sub-Total	***2,128***	***1,511***	***617***	***2,826***	***2,670***	***156***
PDC Capital - Frontline Digitisation	*0*	*0*	0	*1,194*	*1,748*	(554)
Sub-Total Capital Expenditure	***2,128***	***1,511***	***617***	***4,020***	***4,418***	***(398)***
Lease Cars IFRS 16	225	398	(173)	300	475	(175)
Property Leases IFRS 16 - Additions	2,734	3,203	(469)	6,524	3,733	2,791
Property Leases IFRS 16 - Remeasurement	6,128	7,637	(1,509)	6,128	7,726	(1,598)
Lease Disposals	0	(48)	48	0	(48)	48
Sub-Total Finance Lease Expenditure	***9,087***	***11,190***	***(2,103)***	***12,952***	***11,886***	***1,066***
Total Capital Expenditure	**11,215**	**12,701**	**(1,486)**	**16,972**	**16,304**	**668**

Statement of Financial Position (Balance Sheet) and Cash

The Trust Statement of Financial Position is shown in the table below. As at the end of December 2023 the Trust is reporting Total Equity of £60.9m compared to a planned position of £61.2m.

Statement of Financial Position	December 2023 YTD Plan £m	YTD Actual £m	YTD Variance £m
Property, Plant and Equipment	34.7	33.7	(0.9)
Intangible Assets	0.1	0.1	0.0
Right of Use Assets	60.0	62.4	2.4
Trade and Other Receivables	0.0	0.0	(0.0)
Total Non Current Assets	**94.7**	**96.2**	**1.5**
Current Assets			
Trade and Other Receivables	9.3	13.7	4.5
Cash and Cash Equivalents	48.2	40.3	(7.9)
Total Current Assets	**57.4**	**54.0**	**(3.4)**
Total Assets	**152.2**	**150.2**	**(1.9)**
Current Liabilities			
Trade and Other Payables	(30.7)	(26.0)	4.7
Borrowings	(7.0)	(7.2)	(0.3)
Provisions	(0.6)	(0.6)	(0.0)
Total Current Liabilities	**(38.3)**	**(33.8)**	**4.4**
Net Current Assets/(Liabilities)	**19.2**	**20.2**	**1.0**
Total Assets less Current Liabilities	**113.9**	**116.4**	**2.5**
Non Current Borrowings	(52.7)	(55.1)	(2.4)
Non Current Provisions	(0.0)	(0.4)	(0.3)
Total Non Current Liabilities	**(52.7)**	**(55.5)**	**(2.8)**
Total Assets less Liabilities	**61.2**	**60.9**	**(0.3)**
TAXPAYERS EQUITY			
Public Dividend Capital	0.8	0.8	0.0
Retained Earnings Reserve	27.7	24.9	(2.8)
General Fund	18.5	19.5	1.0
Revaluation Reserve	14.2	15.7	1.5
Total Equity	**61.2**	**60.9**	**(0.3)**

Better Payment Practice Code

The Trust's cumulative Better Payment Practice Code performance has exceeded the 95% target for paying invoices within 30 days for non-NHS invoices at the end of December 2023 and for the value of NHS invoices as shown in the table below.

The NHS invoices by number figure is lower than target at 92.4%. This is an improvement since November (91.3%). The shortfall is due to the delayed payments of some small value invoices at the beginning of the financial year with the NHS Business Services Authority because of delayed supplier set up by NHS SBS. There have also been delays with the approval of invoices within the Trust and the finance team have introduced additional monitoring measures to try and ensure the timely approval of due payments going forward.

	December 2023		
BPPC Measure	**YTD**	**Target**	**RAG**
NHS Invoices			
By Number	92.4%	95.0%	**A**
By Value	99.4%	95.0%	**G**
Non NHS Invoices			
By Number	95.5%	95.0%	**G**
By Value	98.0%	95.0%	**G**
Total			
By Number	95.5%	95.0%	**G**
By Value	98.5%	95.0%	**G**

Appendix 1

Measures with Financial Sanctions

Measures with Financial incentives/Sanctions	Responsible Director	Threshold	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Potential Financial Impact
LMWS – Access Target; Local Measure (including PCMH)	SP		2021/22	1927	1839	1802	1838	1465	1868	1665				
			2020/21											
T3WM - Percentage of patients currently waiting under 18 weeks	SP	>=92%	2023/24	97.2%	96.7%	98.5%	89.7%	74.7%	50.9%	23.1%	0.5%	1.4%	1.4%	
0-19 - % of infants who had a face to face newborn visit within 14 days of birth.	SP	>=87%	2023/24	88%	91%	88%	90%	88%	91%	88%	87%	86%	89%	
0-19 - % of 6-8 week reviews completed within 12 weeks of birth.	SP	>=83%	2023/24	89%	88%	91%	90%	90%	87%	86%	88%	86%	88%	
0-19 - % of 12 month reviews completed within 12 months.	SP	>=80%	2023/24	87%	87%	86%	91%	88%	88%	87%	88%	88%	88%	
0-19 - Number of PBB Programmes commenced	SP	0	2023/24										66	0.25% of contract value (annual)
0-19 - Number of HENRY Programmes commenced	SP	0	2023/24										58	0.25% of contract value (annual)
0-19 - Percentage of actual staff in post against funded establishment	SP	>=95%	2023/24										94.3%	
0-19 - % of 0-19 staff (excluding SPA) co-located in Children's Centres	SP	43%	2023/24										0.0%	
PolCust - % of calls attended within 60 minutes	SP	>=95%	2023/24	84.9%	87.5%	84.9%	86.1%	86.6%	85.2%	87.0%	86.3%	84.9%	85.9%	0.50% deduction from monthly invoice
PolCust - Provision of a full rota	SP	>=90%	2023/24	98.5%	99.2%	98.6%	99.1%	99.0%	99.4%	99.2%	99.5%	99.0%	99.1%	£350 deduction per missed shift

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (103)

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

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Category of paper: for assurance
History: Senior Management Team 17 January 2024

Responsible director: Chief Executive
Report author: Risk Manager

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.

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 8 out of the 10 strategic (BAF) risks during November and December 2023, all of which received reasonable assurance (see appendix A). There is further commentary regarding BAF risk 3 in the body of the report.

Risk themes
The strongest theme found across the whole risk register is demand for services exceeding capacity, the second strongest theme is related to patient safety. There is also a theme concerning compliance with standards and/or legislation.

Risk movement
There are three risks on the Trust risk register that have a score of 15 or more (extreme), two of which have been recently escalated and one is new:

- Reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand
- Mind Mate Single Point of Access (SPA) increasing backlog of referrals (system-wide risk)
- Patient safety concerns relating to capacity in Yeadon Neighbourhood Team

There are a total of six risks scoring 12 (very high), none of which have been recently escalated:

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 risk 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 (December 2023), 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 8 out of the 10 strategic (BAF) risks during November and December 2023, all of which received reasonable assurance. Sections 2.5 and 2.6 below address the varying assurance levels allocated for BAF risk 3 as a result of all three Committees currently having oversight of that strategic risk. Details of the assurance levels 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 3 (Failure to invest in digital solutions) received limited assurance from the Audit Committee in December 2023. Following

several discussions regarding this strategic risk the agreement was reached that the Audit Committee would no longer have oversight of this risk as the Committee's scope did not provide sufficient opportunities for sources of assurance to provide an opinion to the Board. The Quality and Business Committees would continue to share oversight of Risk 3.

2.6 It should however also be noted that in November 2023 the Quality Committee determined that there had been no items on the agenda providing assurance against BAF risk 3, and a conversation was required regarding the role of the Chief Clinical Information Officer and the new Associate Director of Digital Transformation once in post to determine if further assurance is required on how well the risk is being mitigated from a Quality Committee perspective.

3 Risks by theme

3.1 For this report, the 46 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:

Theme One: Demand for Services

The strongest theme across the whole risk register is demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals

Specifically, twelve risks relate to an increase in referrals and service demand[1]

Theme Two: Patient Safety

The second strongest risk theme is patient safety due to staff working outside their role, lack of incident management, workload pressures, capacity to complete clinical supervision, clinically essential training and safe operation of medical devices [2].

Theme Three: Compliance with Standards/Legislation

There is also a risk theme relating to compliance with standards/ legislation[3]
This includes: the limited completion of health needs assessments, compliance with information governance, and waste management across the Trust.

3.3 Risk theme correlation with BAF Strategic Risks

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.

[1] Risks: 836, 904, 954, 957, 984, 994, 1015, 1043, 1047, 1048, 1072, 1112
[2] Risks: 877, 1070, 1109, 1139, 1171
[3] Risks: 902, 1089, 1126, 1149

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

Risk register theme: Demand for Services
BAF Risk 2 Failure to manage demand for services
BAF Risk 8 Failure to have suitable and sufficient staff resource (including leadership)

Risk register theme: Patient safety
BAF Risk 1 Failure to deliver quality of care and improvements
BAF Risk 2 Failure to manage demand for services
BAF Risk 4 Failure to be compliant with legislation and regulatory requirements

Risk register theme: Compliance with standards/ legislation.
BAF Risk 4 Failure to be compliant with legislation and regulatory requirements

4 Risk register movement

4.1 There are three risks scoring 15 (extreme) or above on the risk register as of 10 January 2024.

- **Risk 877**: Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand (this has been recently escalated see section 5.2 below)
- **Risk 1048**: Mind Mate SPA increasing backlog of referrals (system-wide risk) (this has been recently escalated see section 5.2 below)
- **Risk 1171**: Patient safety concerns in Yeadon Neighbourhood Team (new risk, see section 5.1 below)

5 New or escalated risks (scoring 15+)

5.1 There is one new risk scoring 15+ that has been added to the risk register since December 2024.

Risk 1171	Initial risk Score **15** (extreme)	Current risk score **15** (extreme)	Target risk score **6** (medium)
Title: Patient safety concerns in Yeadon Neighbourhood Team **Description:** As a result of known capacity and demand challenges coupled with senior clinical and operational leadership gaps the team have raised concerns regarding the level of care that is able to be delivered to patients which could have an impact on patient safety / patient harm. **Controls in place:** • Business Unit and Trust leadership meetings with the team to hear concerns and continued visibility and presence in the team • Temporary movement of staff in from other areas to provide a safe clinical skill mix and level of seniority to support delivery of safe care is now being formalised and made permanent			

- Management of staff with performance / development needs and ensuring this is facilitated in the appropriate place as the priority in the team is ensuring patient safety
  Review of specific clinical cases of concern and liaison with patient safety team to facilitate rapid review process

Action Planned:

- 3x band 5 experienced Registered nursing Staff to move to team on a permanent basis.
- An experienced wound care nurse is now based within the team and will link with the Team.
  An additional senior Community Matron will provide weekly support and clinical oversight of caseload management.

Rationale for risk score: Likelihood 5 = Almost Certain due to known capacity and demand.
Impact 3 = Moderate impact in relation to patient harm, examples could be an adverse event which impacts on a small number of patients / Category 3 pressure ulcer.

The risk has been previously recorded under risk 877, however it was agreed that as this has become an extension to risk 877, with patient safety concerns specific to Yeadon Neighbourhood Team, this would be reported separately so that additional mitigating actions over and above those reflected in risk 877 can be accurately captured and monitored.

Date to reach target: 31/03/2024.
Risk Owner: Clinical Lead for the Adult Business Unit
Lead Director: Executive Director of Nursing

5.2 There are two risks escalated to 15 since December 2024.

Risk 877	Previous risk score **12** (high)	Current risk score **15** (extreme)

Title: Risk of reduced quality of patient care in neighbourhood teams (NT) due to an imbalance of capacity and demand

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 escalation:
The level of risk has been reviewed with the Executive Director of Nursing on the 15/12/23 and the decision taken to raise the risk level to 15. Due to ongoing capacity and demand pressures coupled with increasing levels of community referrals and level of clinical and social complexity.

The service remains in Business Continuity daily and escalating to silver command frequently.

New mitigating actions:

- Daily capacity and demand meetings continue.
- Commenced project with Newton Europe to develop a systems dashboard with NT to provide more robust oversight of capacity / demand to manage referral management, monitor where core work is moved to be delivered.
- Guidance circulated regarding allocation of visit based on clinical need and to follow BCP if unable to achieve this.
- Work in triage teams to map planned / unplanned activity and project underway with senior leadership team to plan this approach within clinical teams
- Ongoing conversations with ICB regarding contracted outcomes

Expected date to reach target: 31/03/2024.
Risk Owner: Clinical Lead for the Adult Business Unit
Lead Director: Executive Director of Nursing

Risk 1048	Previous risk Score **12** (high)	Current risk score **15** (extreme)

Title: Mind Mate Single Point of Access (SPA) increasing backlog of referrals (system wide risk)

Description: As a result of a marked increase over time in routine, complex and urgent referrals into Mind Mate SPA there is a significant backlog in mental health and emotional wellbeing and neurodevelopmental referrals, waiting times are significantly exceeding standards. Urgent referrals are prioritised but there is a risk that complex and routine mental health and ND referrals will not be triaged in a timely way; resulting in deterioration in patient's needs/mental health, increased acuity and risk of harm to self and others.

Reason for escalation:
A new risk assessment has been completed in December 2023. The risk has been increased from 12 to 15 given the numbers of children and waiting times for children to be triaged for mental health and neuro-diversity referrals. The risk is high due to the limited availability of support for children whilst waiting and the risk of harm arising which could be significant.

New mitigating actions:

- Prioritise MH referrals for clinical triage
- Letter to ND referrals on waiting list will signpost to Right to Choose.
- Review of Mind Mate SPA transformation plan and link with ICB re options. Options need to include system working into/with Mind Mate SPA.
- ICB pathway integration lead identified to support this review.

Expected date to reach target: 31/03/2024.
Risk Owner: Head of Service for CAMHS
Lead Director: Executive Director of Operations

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

6.1 No risks have been de-escalated below 15 since December 2023.

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)
836	CAMHS waiting list for follow-up appointments	12
874	Sickness levels – Neighbourhood Teams	12
913	Increasing numbers of referrals for complex communication assessments in Integrated Children's Additional Needs Service (ICAN)	12
957	Increased demand for the Adult Speech and Language Therapy service	12
981	Application of constant supervision at WYOI	12
1070	Capacity pressures in Neighbourhood Teams impacting on ability to deliver full range of clinical supervision and annual appraisals	12

8 New or escalated risks (scoring 12)

8.1 No new risks scoring 12 have been added to the risk register since December 2023

8.2 No operational or clinical risks have been escalated to a score of 12 (high) since December 2023

9 Risk profile - all risks

9.1 The total number of risks on the risk register is currently 46. Of these there are 17 open clinical risks on the Trust's risk register and 29 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	1	0	0	1
4 - Major	0	1	0	0	0	1
3 - Moderate	1	7	16	6	2	32
2 - Minor	0	1	7	2	2	12
1 - Negligible	0	0	0	0	0	0
Total	1	9	24	8	4	46

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. Reminders are sent to risk owners to update their risks where a review date has passed. The Risk Manager produces a monthly quality assurance report and if the risk remains outstanding, further reminders are sent personally by the Risk Manager. Any risk reviews 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 risk themes identified in this report
- Note that the Audit Committee would no longer have shared oversight of BAF Risk 3 (Failure to invest in digital solutions).

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				
Strategic Goal(s)	Risk	Responsible Director(s)	Responsible Committee(s)	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Additional Information
Deliver outstanding care	**Risk 1 Failure to deliver quality of care and improvements:** If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm.	DoN	QC	4	4	**16**				✓		
Deliver outstanding care	**Risk 2 Failure to manage demand for services:** If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage.	DoO	QC/BC	4	3	**12**				✓		
Deliver outstanding care. Use our resources wisely and efficiently	**Risk 3 Failure to invest in digital solutions:** If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable and the impact will be delays in caring for patients and less than optimum quality of care.	DoF/MD	QC/BC/AC	3	3	**9**		✓	✓	✓		Dec 2023 Audit Committee: Limited assurance received. See assurance report. It has been agreed that the Audit Committee would no longer oversee this risk as the Business and Quality Committee agendas provided more opportunity for assurance against this risk. Nov 2023 Quality Committee determined that there had been no items on the agenda providing assurance against this risk, and a conversation would be held between the Chief Clinical Information Officer and the new Associate Director of Digital Transformation once in post.
All four strategic goals	**Risk 4 Failure to be compliant with legislation and regulatory requirements**: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention.	SMT	QC/BC/TB	3	3	**9**				✓		
Use our resources wisely and efficiently	**Risk 5 Failure to deliver financial and performance targets:** If the Trust does not deliver key financial and performance targets, agreed with NHS England and the ICB, then it will have adverse consequences for financial governance and cause reputational damage.	DoF	BC	3	4	**12**				✓		

Use our resources wisely and efficiently	**Risk 6 Failure to have sufficient resource for transformation programmes:** If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.	DoO	BC	3	3	**9**				✓		
Use our resources wisely and efficiently. Ensure our workforce is able to deliver the best possible care in all of the communities that we work with.	**Risk 7 Failure to maintain business continuity (including response to cyber security):** If the Trust is unable to maintain business continuity in the event of significant disruption then essential services will not be able to operate, leading to patient harm, reputational damage and financial loss.	DoO/DoF	BC/AC	3	4	**12**				✓		
Ensure our workforce is able to deliver the best possible care in all of the communities that we work with	**Risk 8 Failure to have suitable and sufficient staff resource (including leadership):** If the Trust does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, then the impact will be a reduction in quality of care and staff wellbeing and a net cost to the Trust through increased agency spend.	DoW	BC	4	3	**12**				✓		
Ensure our workforce is able to deliver the best possible care in all of the communities that we work with	**Risk 9 Failure to involve and engage staff:** If the leadership of the Trust does not engage with and involve staff and create and embed a culture of equality and inclusion based on available evidence, then the impact will be that it will fail in its ambition to attract and retain a diverse and committed workforce, there will be low morale, a less representative workforce and a loss of trust and confidence in the communities we serve.	CEO/DoW	TB	2	4	**8**						
Work in partnership to deliver integrated care, care closer to home and reduce health inequalities	**Risk 10 Failure to collaborate:** If the Trust does not work in partnership with other organisations, then systems will not provide a single offer for patients or achieve the best outcomes for all.	CEO	TB	2	4	**8**						

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (104a)

Title: Freedom To Speak Up Guardian Report February 2024

Category of paper: for assurance

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

Executive summary

This report covers the period of 4th August 2023 to 2nd February 2024. It offers a record of the work of speaking up at Leeds Community Healthcare NHS Trust (LCH) and wider work across the health and care system.

There were seventy-two concerns overall. Fifteen concerns were raised formally by LCH staff members concerning LCH or LCH services through the Freedom To Speak Up Guardian (FTSUG). Fifty-four concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had three concerns.

The Freedom To Speak Up Guardian service has:

- Worked across the trust with key partners to share and embed the work.
- Shared the LCH model of speaking up regionally and nationally.
- Offered to all staff who approach the FTSUG a programme of pastoral support whether they wish to raise a concern or not at the time.
- Sought to ensure we align with all national work, learning and guidelines.

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 4th, 2023, to February 2nd, 2024.

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 for our staff.

3 Current position

3.1 The FTSUG work receives strong ongoing support from the Interim Chief Executive, the executive and non-executive directors, the Chair, the Non-Executive Director with responsibility for speaking up work, the trust's Race Equality Network (REN) and the wider Trust. A clear form of work has been established and operates well. This work has several forms principally where staff approach the FTSUG and the Race Equality Network Speaking Up Champions to discuss concerns. Other forms include managers inviting the FTSUG to work with their teams so staff voices can be heard to enable better team cultures, conversations, and change.

3.2 Work with the Race Equality Network Speaking Up Champions and the Clinically Extremely Vulnerable (CEV) Staff Group continues. Work with the Disability, Neurodiversity and Long-Term Condition Network has started. Career development work is offered to any staff member from an ethnic minority community who contacts 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. This career development offer now extends to staff who are CEV and have a disability.

3.3 The FTSUG works at local, regional, and national levels. The local work at LCH continues to develop and evolve. The learning and outcomes include work linking to the WRES, initiatives around mental health, leadership development, staff health and wellbeing 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 and NHS England in developing speaking up in the wider health and care system.

3.4 Different NHS Trusts and national NHS bodies have had consultations and conversations with LCH about our work and approach to speaking up in the period covered in this report. The FTSUG has offered 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 the LCH work and approaches.

3.5 The FTSUG attends the New Starters Forum with the Chief Executive and Director of Workforce to hear and support those new to the trust.

3.6 The work supporting Leeds GP Confederation and Leeds GP practices to build speaking up work is ongoing. This work involves the Leeds Integrated Care Board.

3.7 The work supporting Leeds City Council (LCC) and its Freedom To Speak Up work continues.

3.8 A regional NHS organisation has asked us to work with them to help them create the model we use across their trust.

3.9 Presenting on the LCH speaking up work has taken place since last August at conferences and sessions including the national NHS People Promise in Action
Conference and the national Duty of Candour conference.

3.10 Work from the FTSUG with our new International Nurses is ongoing and work with the Clinical Education Team facilitating a forum for clinical students which has a special focus on wellbeing support and students being able to raise concerns. Work with Preceptorship is also ongoing.

4 Activity data

4.1 The table below shows the volume and type of activity with which the FTSUG has been engaged between August 22nd, 2022, and February 4th, 2023. 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	Culture, leadership, recruitment issues, patient care
Children and Families Business Unit	2	Culture, leadership, wellbeing support
Corporate Services	3	Recruitment issues, religious and cultural sensitivity and understanding
Specialist Business Unit	2	Culture, leadership, recruitment issues, behaviours.

4.3 Twelve concerns were raised formally by LCH staff members concerning LCH services through the FTSUG. One concern was raised formally concerning LCH regarding an App we use. Two other concerns were also raised about both LCH and the staff member's service around their experience and the behaviours they reported.

Fifty-four issues were informally discussed or resolved through the FTSUG. Three of these were LCH staff raising issues about partner agencies.

The Speaking Up Champions had three issues raised with them.

This brings the overall concerns raised to seventy-two cases in the period this report covers.

4.4 Twelve staff colleagues who informally discussed concerns with the FTSUG are from Black, Asian and minority ethnic communities and one of these were related to issues of race. There were three formal concerns raised by staff from Black, Asian and minority ethnic communities and one involved race. One involved religious and cultural sensitivity. There was thirteen informal and six

5. Themes

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

5.1 We see a significant number of staff using the FTSU mechanism in the last period. Staff report being supported and heard.

5.2 We are seeing more cases resolved or supported informally which fits with our ambition that concerns are addressed via local conversations and team / service changes.

5.3. Leadership, culture, and behaviours in teams are ongoing key factors that have featured historically. Health and wellbeing, ways of working, changes in services and workloads are areas mentioned in recent concerns. Race, disability, and health issues are featuring in the concerns. Patient care is appearing more in concerns.

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

5.5 The model we have created shows itself to easily apply to a wide range of work and needs. The trust has supported the work to flow into many organisational terrains which have had positive results for staff and changes.

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. The FTSUG is meeting staff from across all business units of the trust and at different roles and levels. 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 agree the national board planning tool and start to act on its highlighted actions
- To review the FTSUG service in the light of the Staff Survey results we receive
- To work with the FTSUG at Leeds City Council and Leeds Health and Wellbeing Board on supporting speaking up in our systems in Leeds
- To continue to build the work and ensure its development.
- To continue to focus on staff with protected characteristics in the trust to see how speaking up can support these staff when needed.

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

8.1 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: 2 February 2024

Agenda item number: 2023-24 (104bi)

Title: Freedom to Speak up – reflection and planning toolkit

Category of paper: For a decision
History: N/A

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

Executive summary (Purpose and main points)
The senior lead for Freedom To Speak Up (FTSU) in the organisation should take responsibility for completing the reflection tool, at least every 2 years.

This improvement tool is designed to help the organisation identify its strengths, and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to the senior leadership team and board the progress made in developing your Freedom to Speak Up arrangements.

The self-reflection tool is set out in three stages, set out in the document attached. Under stage 2 there are three options for a high-level action for the Board to decide. These are:

- To undertake how we as a trust work best with detriment / reported negative impact for staff who speak up.
- For the FTSU training to be mandated for all new starters
- For a review of how the FTSU links with patient care / patient safety issues in the trust

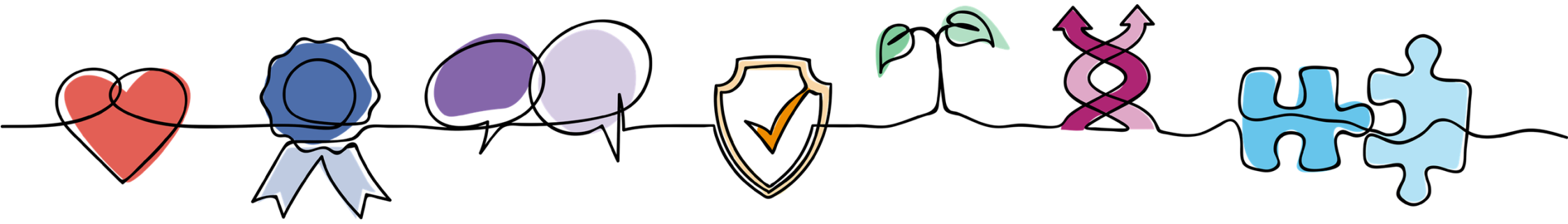
Recommendations
The Board should
- look at and identify the action or actions (all three are an option)

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5*
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5
Enter summarised commentary to support your score. **Freedom to Speak Up is well embedded in the organisation** ***The previous Chief Executive ensured this took place prior to August 2023. This review is the first since that time.** **Monthly 1:1s in place – evidence available through 1:1 notes and email exchange**	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	5
I challenge the board to develop and improve its speaking-up arrangements	5
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	4
Enter summarised evidence to support your score. The FTSUG arrangements at LCH are both mature and constantly evolving when improvement opportunities or national imperatives are identified.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to challenge whether we are encouraging patient safety concerns to be escalated.	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	5
We regularly and clearly articulate our vision for speaking up	5
We can evidence how we demonstrate that we welcome speaking up	5
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	5
We regular discuss speaking-up matters in detail	5
Enter summarised evidence to support your score. Good culture, managers referring staff to FTSU services, good stories of change	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1 To develop thinking and practice plan on detriment	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes
Enter summarised evidence to support your score. There is an embedded culture of speaking up in LCH, staff are aware of who to approach and this is validated historically by our Staff Survey results and the previous National Guardian Office Index while it operated.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	5
We have reviewed the ringfenced time our Guardian has in light of any significant events	5
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	5
Enter summarised evidence to support your score. The board has created and shaped the role including the hours and time, There has been a recent change in this to best reflect the work in the last two years. The FTSUG controls his own diary and is fully supported. He has never made a request for help or assistance that has been refused.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	Yes
Enter summarised evidence to support your score. We have used national policy and our own approach in the policy. The policy was peer reviewed by a FTSUG at another trust. It has also gone through consultation with key stakeholders including staff who have spoken up.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 weblink to actual national policy in policy. Change some features that no longer exist.	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	5
We have an annual plan to raise the profile of Freedom to Speak Up	5
We tell positive stories about speaking up and the changes it can bring	4
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3
Enter summarised evidence to support your score. Regular Communications, high visibility of the Guardian and the work	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 need to share more stories of positive change across the trust.	
2	

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	No
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes corporate but locally varied
Our HR and OD teams measure the impact of speaking-up training	No

Enter summarised evidence to support your score.

Everyone goes to corporate induction. Also new starters have a forum with the Chief Executive, FTSUG and Director of Workplace and clinical student forum, preceptorship and International Nurses..

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1
To consider making the FTSUG training mandatory for all new starters. To consider whether when serious issues in a team occur there is an insistence that all staff have done the staff training and all managers the manager training.

2 To look at measuring training.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	No
We have enabled managers to respond to speaking-up matters in a timely way	Yes
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes
Enter summarised evidence to support your score. There is a good culture of speaking up. Managers support this and refer staff to the service. We work with managers to ensure they work with speaking up. We have seen in the last seven years a real development of how managers work and learn from cases.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes

Enter summarised evidence to support your score.

Our FTSUG regularly raises potential areas of concern and we have supported him to work with staff where there were potential issues such as unvaccinated staff refusing the Covid vaccine and staff who are Clinically Extremely Vulnerable and who were shielding during the pandemic. The FTSUG flows into ODI, HR, leadership, PSIRF and other trust work.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	Yes
We share the good practice we have generated both internally and externally to enable others to learn	Yes
Enter summarised evidence to support your score. We have an improvement approach. This listens to all concerns. We use gap analysis and this feeds into FTSU practice. We share information internally for services. We share good practice in the wider system including the local authority. The FTSU service is continually reflecting and acting on what we see and learn.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes
Enter summarised evidence to support your score. Advertised and Staff assessment and interview used. FTSUG has done training and refresher training and is registered.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes
Enter summarised evidence to support your score. We have an informal plan and objectives. We have culture of many doors to speaking up which allows cover for absence. Support is given and psychological supervision is enacted via the ICS. Regular co-mentoring with another FTSUG in place. Regular data to NGO	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes
Enter summarised evidence to support your score. Record kept. Learning and new approaches for managers on speaking up. Confidentiality maintained (no cases in last seven years of breach in confidentiality). We strive to work in timely ways. The positive experience will be being heard and understood as we cannot guarantee what someone speaks up will be the organisational answer. There can be delays in timings for some cases usually due to complexities.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 written briefing with the Chief Executive, NED and FTSUG on how we document.	
2	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	Yes
We know who isn't speaking up and why	Yes (often)
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	Yes

Enter summarised evidence to support your score.

Work on barriers. Horizon scanning work. Looking at protected characteristics – work with networks would helps with who isn't speaking up.

Increase in race, disability, mental health concerns.

Its difficult to totally know who isn't speaking up and why unless we know who they are and they find a way to share their concern with us.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	Yes
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	Yes
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes
Enter summarised evidence to support your score. Monitored by the FTSUG. We inform and involve the NED. We have some ways in place to respond to detriment. We do need to deepen and create best practice in this area.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 joint paper on detriment and repairing what has happened. Joint paper to be prepared by LCH FTSUG and FTSUG's from LCC, Locala and LTHT .	

2

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Yes
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	Yes
Our improvement plan is up to date and on track	Yes
Enter summarised evidence to support your score. We have a strategy linked to the LCH Workforce strategy. We work on improvements to enhance speaking up.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	Yes
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	Yes
Our speaking-up arrangements have been evaluated within the last two years	Yes
Enter summarised evidence to support your score. We use the PDSA cycle for developing speaking up. We had a peer review by another NHS organisation several years ago and we are planning an independent peer review in 2024. LCH evaluates the service and offers recommendations and changes.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Peer review to be arranged for 2024.	
2	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes
Enter summarised evidence to support your score. We have created organisational assurances. The FTSUG is doing a new evaluation of the report and the guide and other factors.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 FTSUG to undertake new evaluation.	
2 Look at how we measure training	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1 Work on Detriment / reported negative impact	June 2024	Director of Workforce, Head of HR and FTSUG
2 Reflection on the FTSU link with clinical care issues	March 2024	Executive Medical Director, Executive Director of Nursing and AHPs and FTSUG
3 Look at mandatory training for all new starters on speaking up E learning.	June 2024	Director of Workforce FTSUG and Head of Learning and Development
4		
5		
6		
7		

8		

Development areas to address in the next 12–24 months	Target date	Action owner
1 Developing FTSU champions work	December 2024	FTSUG
2 Completing, sharing and embedding any learning from the peer review	March 2025	FTSUG
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 Weblink to actual national policy in policy	January 2024	FTSUG
2 Peer review to be arranged for 2024.	Details to be agreed March 2024and completed by end of 2024	FTSUG
3 To develop thinking and practice plan on detriment. joint paper on detriment and repairing what has happened. Joint paper to be prepared by LCH FTSUG and FTSUG's from LCC, Locala and LTHT . Written briefing with the Chief Executive, NED and FTSUG on how we document	March 2024	FTSUG
4 FTSUG to undertake new evaluation of annual report and national guide and other national learning	June 2024	FTSUG
5 Considerations around mandatory nature of FTSU training in the trust	June 2024	FTSUG
6 Sharing positive stories of change	June 2024	FTSUG
7 Peer review	September 2024	FTSUG
8 Work on how we measure training	September 2024	FTSUG

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Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (105)

Title: Safe Staffing report

Category of paper: For assurance

History: Business Committee 24 January 2024

Responsible director: Executive Director of Nursing and AHP's

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Report author: Executive Director of Nursing and AHP's and Clinical Leads from the Business Units.

Executive summary

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.

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. This report continues to attempt to address the concept of delivery of effective care in the context of gaps in staffing etc. as well as addressing the safe staffing which is more about minimum staffing levels. There has been a lot of work over the last 6 months to enable this approach but there are some final steps to this and the next 6 monthly report is expected to be able to articulate the full triangulation of data to describe this.

Safe staffing has been maintained across both inpatient units that the Trust runs for the time period. The paper sets out the mitigation in place and also triangulates elements of patient safety data to the staffing numbers where this is possible.

Recommendations

Board is recommended to:

- Receive the report.
- Note the further planned work around effective care delivery.
- Agree the level of assurance provided.

Safe Staffing Report

1 Introduction

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.

In addition to reporting on the in-patient areas which is what is mandated by the NQB, of which the Trust has two, the paper also provides information on all the Trusts services.

Details of impact of staffing levels on patient safety and staff retention and morale is included, alongside information about future initiatives to increase staffing levels.

This report continues to attempt to describe the delivery of effective care in the context of knowing we have staffing gaps. There has been a lot of work over the last 6 months to enable this approach but there are some final steps to this and the next 6 monthly report is expected to be able to articulate the full triangulation of data to describe this.

Tables are provided in Appendices 1-3 to show the full staffing picture in each business unit and the narrative in the paper attempts to address any issues and challenges within the business unit.

2 Background

We continue to use a set of principles to monitor safe staffing in our in-patient beds and wider teams in the absence of a national definition of community safe staffing.

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

3 Specialist Business Unit (SBU)

The table at Appendix one provides more detail on each specific area of the business unit.

Services continue to monitor waiting lists, record risks and monitor concerns, complaints, and incidents to identify if staffing levels have been an issue in any reported and when needed appropriate actions are taken to mitigate further problems arising. In this period there have been no incidents or complaints relating to safe staffing.

The health and wellbeing of staff continues to be of paramount importance to leads within the business unit and absence levels continue to be closely reviewed.

Where services are being remodelled or re tendered staffing levels are revised and the required competency / skill mix reviewed to try to ensure safe staffing levels are in place.
Discussions have taken place with Business Intelligence (BI) regarding the safety dashboard which is going live at the time of completing this report, going forward this should help in the future as all the information should be in one place and

seeing the whole picture should be easier and enable us to articulate effectiveness of care delivery related to the staffing.

4 Children's Business Unit (CBU)

The table at Appendix Two provides more detail on each specific area of the business unit.

Safe staffing continues to be a priority for the Childrens Business Unit where staffing levels are monitored alongside data on PIP to create a meaningful narrative. Risks are recorded where there are concerns regarding staffing levels in relation to the demand on the service. There continue to be a number of services where demand is at a higher level than capacity, mainly due to an increase in referral numbers and/or vacancies.

Some teams have temporarily reduced their offer as described in the table in Appendix Two for occupational therapy and pre-school autism assessments due to vacancies. Many of our services have waiting lists where children are waiting longer than we would like including audiology, neurodevelopmental assessments, CAMHS therapy interventions, MindMate Single Point of Access and paediatrician clinics.

Other teams including speech and language therapy have been able to reinstate elements of their mainstream offer to provide intervention for a cohort of children rather than assessment only. The 0-19 PHINS are using a phased approach to increase the antenatal offer to families by a health visitor through skill mixing and focusing on areas of most need in the city. Innovative pilots such as Baby Bubble - Leeds deliver high quality care via a closed Facebook group for mums to be that begins at sixteen weeks of pregnancy up to six months after the baby is born. In partnership with Leeds Teaching Hospitals dedicated support and advice is offered alongside the opportunity for peer support.

The Business Unit has welcomed our first registered nurse who undertook an apprenticeship with the Childrens Community Nursing Service and has started work in the inclusion nursing team. There are two further nursing apprentices who are expected to qualify this year. The Integrated Children's Additional Needs Service have successfully recruited two Advanced Clinical Practitioner trainees who will study at Sheffield Hallam, both are physiotherapists. Alongside this they are looking to recruit an Advanced Clinical Practitioner who will work with children on the complex communication assessment pathway. These posts are in line with the workforce strategy to create clinical leadership roles and will in time support a reduction in locum paediatricians. CAMHS is also considering where Advanced Clinical Practitioners would be well suited within their service and approaching NHS England regarding the funding for training posts. These are exciting developments for the Business Unit to ensure that the professionals with the right skills are able to respond to children and young people, there is also an eagerness to collaborate and share learning across services.

There have been some delays within the recruitment process and services have worked alongside the Trust recruitment team to prioritise some posts, for example to mobilise the school aged immunisations service who have been awarded the contract for delivery of the flu vaccination. There have been occasions where appointable staff have found employment elsewhere due to the lengthy delays

between being offered a job and agreeing a start date. The recruitment team now have a tracker system and the onboarding time is being monitored.

There is currently one rapid review that has commenced in the 0-19 Public Health Integrated Nursing Service following an incident. The review will consider staffing levels, the IT outage and were processes in place and correctly followed. There have been no other incidents and no complaints relating to safe staffing.

To measure effectiveness the Childrens Business Unit strives to use Goal Based Outcomes with children, young people and families. Training is provided for all CBU staff on the use of Goal Based Outcomes including how to set appropriate goals. Therapeutic services use these in a clinically meaningful way with families to ensure interventions work towards the wishes of the child, young person or family and to support decisions around discharge. It is not possible with the way goals are currently recorded to provide an aggregate score for services/pathways. There is a pilot within the infant mental health service to use a new SystmOne questionnaire template where we understand these aggregate scores will be able to be reported. Further information will be provided in the next six monthly report.

5 Adult Business Unit (ABU)

The table at Appendix Two provides more detail on each specific area of the business unit.

Progress has been achieved within several key priorities in our 23/24 business plan that are specifically focused on improving our demand and safe and effective staffing position – this includes the planned and unplanned work in NTs, self-management, Integrated Clinics, progressing the review of staffing establishments and skill mix to enable efficiency and effectiveness work across ABU teams, and the work Newton Europe have supported in the Home First workstreams.

Our recruitment position is improving, although remains challenging across some teams and roles – specifically registered nurses, advanced clinical practitioners, and therapists, which reflects the national picture. We are seeing reduced agency usage and are expecting this to reduce further going forward. We are reducing our dependence on non-NHS providers (i.e. the Marie Curie contract in the Neighbourhood Nights Service, as this is no longer required and managed inhouse which will contribute to service cost savings in the new financial year.

Historically the staffing position in the Neighbourhood Teams has been of the most concern, this is reflected on the Trust's risk register and some of the figures in the table in Appendix Three.

- **Recruitment**:
1. ABU have established a recruitment lead for all roles, Job adverts have been rewritten to make them more noticeable and appealing to optimise candidate interest.
2. Work is underway by the ABU Recruitment Team to widen access to entry level roles by partnering with third sector organisations such as Gipsil, system partners like Leeds City Council, local colleges, and universities we are recruiting to NCA roles through this initiative.
3. The Applicant Tracking System, TribePad, has been procured and is in the implementation phase. Simplifing the application process, improving the onboarding

process and reduction in the time to hire, resulting in vacancies being filled more quickly.
4. ABU will widen their reach by social-media campaigns to increase the pool of candidates for roles. Specific campaigns already confirmed for newly Qualified Nurses and AHP recruitment as well as regular 'A Day in the life' posts to increase potential applicants understanding of the roles available in Adult Community Services.
5. Working proactively with students on the new Final Year Pathway from the University of Leeds and Leeds Beckett University to explore within a careers conversation during their placement re opportunities being offered at LCH and to discuss the benefits of working with us. A simplified application and interview process for these potential candidates is also being explored by the Recruitment Team, with successful candidates being given a conditional offer of employment dependant on them successfully passing the course. This would provide an ongoing pipeline of newly qualified nurses who have community experience joining us each year.
6. An apprenticeship plan is being established for Nursing Associates, Nursing and District Nursing apprenticeships as well as Advanced Practice. This will provide opportunities for career development, and also a support worker workforce planning, with a clear map of how many people will be on the programme at any one time and how many people will qualify each year.
7. A Resourcing Dashboard is in initial development. The aim is that this will provide an at a glance look at vacancies at Business Unit, Service and Team level, by role, also using ESR and Health Roster data to forecast future capacity – e.g. retirement, maternity leave, leavers. The dashboard will again support workforce planning and will be a more reliable tool to identify recruitment needs and hotspots.
8. We continue to support international recruitment within NTs and the Recovery Hubs We have learned a significant amount from the first cohort in terms of the support needed when moving cross-continent to new roles.

Retention:
We acknowledge that retention of staff is the biggest priority for ensuring safe staffing levels. 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.
1. A standardised services Welcome Booklet for staff joining ABU has been developed. Providing new starters with answers to common questions and information about the different roles and services delivered by the Business Unit.
2. Work undertaken with procurement to trial a central store for uniform and new systems for ordering IT equipment meaning that new starters will have everything they need on day one, improving their introduction to the trust.
3. The Clinical Training offer has been refreshed and dates set with Clinical Skills Week for Staff Nurses and NCAs monthly – the first 2 days are also suitable for AHP colleagues. Line care training will also be offered monthly. Regular bowel and catheter care training sessions also now available. This training will ensure that colleagues have the skills their teams need to deliver care, increasing capacity, but will also ensure staff feel confident and competent in doing their job, increasing job satisfaction.
4. Line management structure within NTs is being reviewed to ensure that line managers have an appropriate and manageable number of direct line reports. This will mean capacity for 1:1s, appraisals and reviews, and improving the support to staff and their experience of working within ABU.
5. After a successful roll out of 'Stay Conversations' in CBU this will be trialled in the Yeadon NT. The purpose of this is to identify staff issues which may not currently be

known by local leadership to reduce any avoidable leavers and subsequent vacancies. If successful, this will be implemented in other teams with the aim of improving retention.
6. Staffing Budgets: Work is progressing in ABU to align staffing budgets, and this will continue to be reflected in the 2024/25 reports. With vacancies in some areas but over establishment in others – this budget review is enabling an improved understanding of the overall ABU position; this will be essential during the coming financial year where budgets will be constrained.
7. Our service offer continues to develop with a planned programme of increasing bed numbers within the Home Ward. The Active Recovery programme continues to be tested in the Seacroft and Chapeltown Neighbourhood Team areas, with patients being supported by Neighbourhood Team Therapy and LCC Reablement. We are continuing to expand our ambulatory care offer with the Integrated Clinics and self-management hubs to support patient's independence and offer care outside of the home environment.
8. Work has commenced in Q3 to establish a new model to deliver the unplanned and planned elements of the Neighbourhood Team offer. This will offer a more attractive job and career development opportunity due to greater definition in the roles and responsibility in their day to day working.

Phase 1 and 2 of the of the ABU leadership review was completed in Q3 2023 and has resulted in some significant changes, with investment in additional senior clinical leadership roles. With postholders now established in role; good progress is being made, in clinical pathway review and development (e.g. Falls Community Pathway, the community catheterisation of patients on IV diuretics), also with aspects of nursing care practice, advanced clinical practice and senior clinicians' roles. Work has been completed to manage the enhanced scope of practice for Therapy Assistant Practitioners– with clinical competencies now being tested. Clinical leaders all now have an established regular time in practice and/or clinical research– which is proving beneficial in how they clinically lead teams in ensuring they have a current working knowledge of our practices, and this is enabling improvements in clinical effectiveness across services.

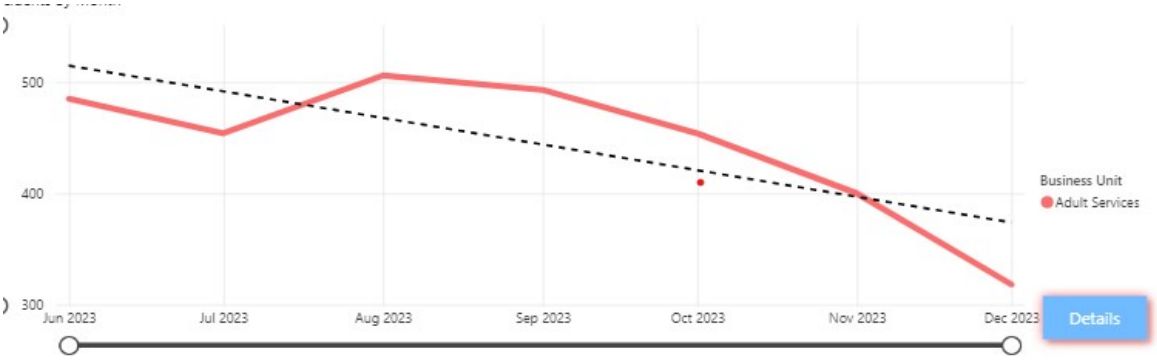
Staffing is monitored and managed on a twice daily basis through the capacity and demand reporting tool with senior clinical and operational oversight seven days a week. With the ongoing system pressures a new system visibility dashboard is being developed to enable system level reporting out of pressures within Neighbourhood Services and UCR capacity. Staffing levels continue to be reviewed within the ABU monthly performance process and any additional actions required are considered by the ABU senior leadership team. produced using data from the e-roster system and distributed on a weekly basis.

Workforce reports demonstrate the significant amount of internal movement in the ABU which reflects the development and progression we offer.

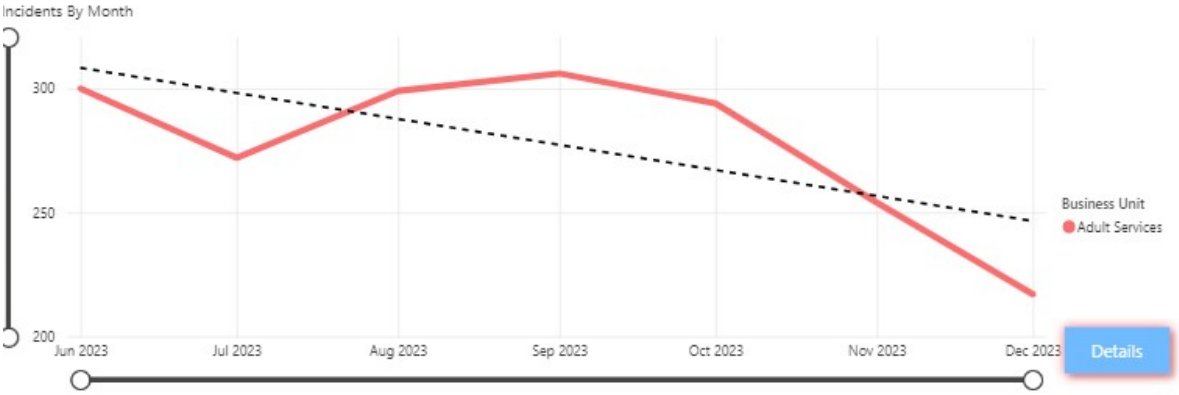
Monitoring patient and staff safety incidents that are related to staffing issues or concerns constitutes a key area for review. Based on learning from the last period we have maintained additional support with incident investigation and learning. We have continued to monitor ABU incident investigations, mortality reviews and any complaints raised by patients, families and staff as always and any issues related to staffing levels will be escalated to SMT. The last periods incident data is showing that fewer incidents over all are being reported. We are monitoring this closely to understand the reason for this, and which factors could be contributing to the change. (e.g. PSIRF, improvements in the sharing of learning from incidents).

The following 2023 graphs show this recent change. Whilst the numbers are reducing there is variation in the level of this change across the city which is a key line of enquiry and scrutiny.

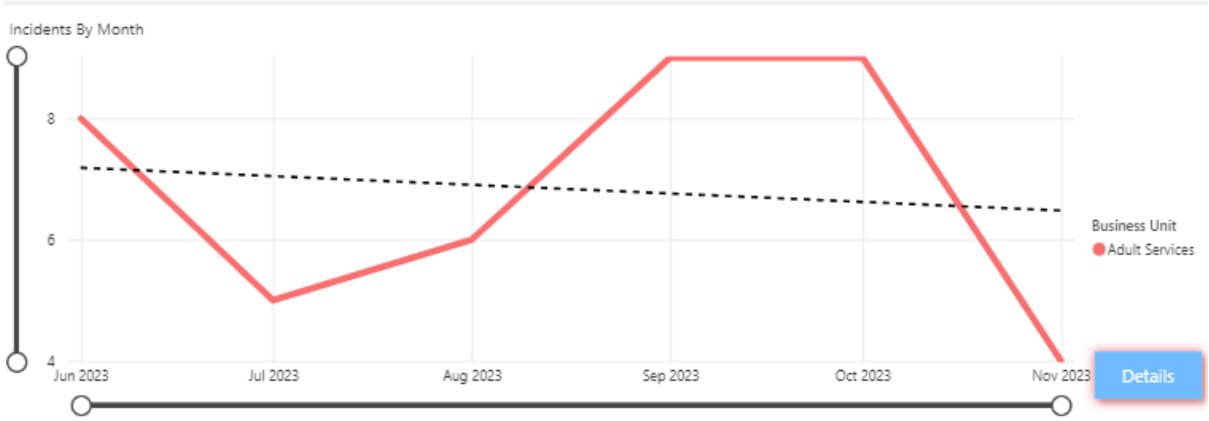
1. All ABU Incidents



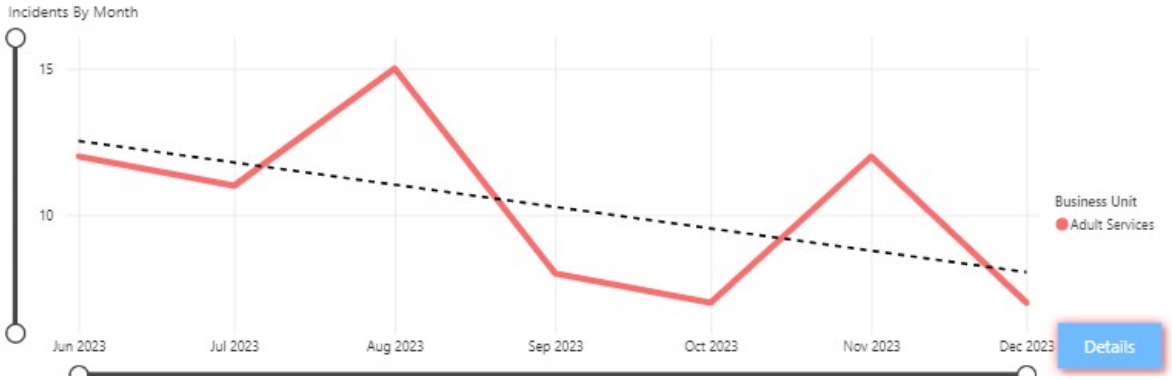
2. All clinical harm incidents



3. Avoidable Harm Incidents



4. Staff Incidents



6 Conclusion

This paper presents the six-monthly review to Committee and Board in relation to safe staffing. It is clear that there are many challenges in relation to staffing across a range of services and it is a daily challenge to maintain patient safety. The paper demonstrates that the Trust has maintained safe staffing in the six-month reporting period, despite the many challenges. This paper continues to attempt to articulate the effectiveness of care delivery in the context of staffing gaps. This is not easy to do, and this has been recognised. There have been a number of meetings including a deep dive into this at QAIG, with the intention to improve reporting of effectiveness of care delivery in the next 6 monthly paper. BI are working with us on this to produce dashboards to triangulate the information to be able to describe this more accurately. This will include things such as are we able to deliver all aspects of care – holistic person-centred care or are we delivering in a task focussed way. It will also consider triangulation with other factors e.g., cancelling or re-prioritising visits.

7 Recommendations

Committees and Board are asked to receive this report, note the plans for further work on how effective care delivery is and agree the level of assurance provided.

Appendix One

The following table provides specific information regarding staffing levels within services in the SBU. The data was pulled at the end of December 2023.

The data within the table continues to be shared/ reviewed monthly at the SBU Senior leadership team (SLT) meeting and information from services is shared at performance panels.

Name of service	Budget WTE	Contracted WTE May 2023	Vacancy	Comments
Portfolio1				
Cardiac Services	33.69	32.02	1.67	B3 0.3 – plan to skill mix B7 0.3 pharmacist – service has queried what this relates to with Finance as they already have pharmacy provision within the budget. 1x B5 nurse commenced in post 04/12/23.
CIVAS	12.76	9.40	3.36	1x clinical lead starts 02/01/23 1x staff nurse starts 02/01/23 1x staff nurse - waiting for pre-employment checks Plan to go back out to advert for staff nurse in January 2024
Community Gynae Beeston	2.04	2.70	-0.66	Over established (B7 Nurse)
Homeless and Health Inclusion Team (HHIT)	7.19	6.74	0.45	Staffing levels maintained since July 2023.
Liaison and Diversion Humber	19.80	14.80	5.00	2xB4 – L&D – currently out for recruitment, will be interviewing in January 2xB6 – RECONNECT – 1 in post, 1 onboarding 1xB4 - RECONNECT – 1 onboarding
Leeds Long Covid Rehabilitation Service.	28.37	25.55	2.82	LCH is likely to have to meet a cost pressure from April 2024 due to changes to funding therefore active recruitment is not taking place.
Police Custody - Y and H	121.50	113.54	7.96	Improved picture from July 2023. The service has not actively recruited to these vacancies due to the loss of the North Yorkshire Police Custody contract.
Respiratory Service	27.68	26.93	0.75	Employee is on secondment and will return to the role on 01/04/23
Respiratory Virtual Ward	8.84	6.85	1.99	2 vacancies: CSW – this has been skill-mixed and is funding 0.5 WTE B7 pharmacist from within the Trust

				Physio – this is being used to fund a physio within the core team (which now provides cover for HWR)
Sexual Health Service	50.91	49.58	1.33	Vacancies improved from 3.2 in July 2023. Service successful in retender but model will change from June 2024 with reduced budget. Recruitment to vacancies paused until we understand impact of new model.
TB Nursing	8.19	5.60	2.59	2 x staff nurse vacancies. Appointed to – waiting for start dates. Other vacancies are for non-recurrent funding – no plans to recruit to.
Wetherby YOI Primary Care	35.87	25.90	9.97	Primary Care Manager has recently left post, this is currently vacant and work ongoing to determine the needs of the service. This post will then be advertised January 2024. Band 6 Primary Care Team Leader has had a successful internal transfer from another LCH service. Due to commence post week commencing 4th March 2024. Band 5 Staff Nurse post currently out to advert and shortlisting to take place w/c 18 Dec. Band 3 HCA post currently out to advert and shortlisting to take place w/c 18 Dec. Admin posts and pharmacy technician have been recruited to and currently undergoing pre-employment checks. Work underway to consider structure of health promotion team to consider needs and development of the service. Use of regular bank and agency staff to fill any vacancies and the number of staff on duty on a night were increased to meet the needs of the young people and to ensure safer staffing is maintained. The service is part of the prison nurse recruitment campaign, work to commence with local universities to advertise the role and ensure awareness is raised regarding opportunities available.
Portfolio 2				
Adult Dietetics	21.88	20.90	0.98	The service completed another successful round of recruitment of trainee Dietitians in Q4 of 2022/23 and successfully onboarded them throughout Q1 and Q2 of 2023/24 before they joined the team in Q3. Meaning the service is almost fully established with Band 5 Dietitians (5 wte in post, 5.36 wte in budget). The remaining vacancies factor is made up of small % of wte of a number of roles in the service.

Community Neuro Rehab Service	43.52	40.58	2.94	As part of the service redesign project the service has recruited to a number of posts which has significantly improved their vacancy factor. Remaining posts the service are currently recruiting to are Band 8A Clinical psychologist due to turnover and Band 5 and 6 Occupational Therapists. The service has experienced difficulties recruiting to OT posts and have explored alternative recruitment techniques to fill these posts throughout 2023.
Dental	42.09	32.96	9.13	The service has several vacancies that are either in recruitment or the service is having active conversations about how to recruit to fill them as they have not been filled in a previous round of recruitment. This includes a full Leadership Team redesign that have been designed in consultation with the service.
Diabetes Counterweight	0.00	1.70	-1.70	Diabetes Counterweight is fully funded by the ICB. The service is checking data with Finance Manager to ensure this is accurately reflected. All remaining vacancies are being actively recruited to.
Diabetes Service	21.17	17.89	3.28	
Dietetics Childrens	7.23	6.60	0.63	Vacancy rate is <10%. Ongoing recruitment will further improve this position.
First Cont. Practitioner	5.04	5.04	0.00	Vacancy rate is 0%.
LCH Pain Service	8.74	8.59	0.15	Vacancy rate is 2%.
LMWS	101.26	91.98	9.28	Vacancy rate is <10% for the first time since the contract commenced. This is due to several recruitment drives and diversifying workforce, including a focus on CBT Trainee posts, and introducing Mental Health Practitioners post to increasing support for Helpful Conversations.
MSK Service	64.52	60.26	4.26	Vacancy rate is <10%. The vacancy rates have significantly improved due to the service skill mixing hard to fill vacancies into new roles, such as the Engagement Lead post, to address the current issues they are aware of and where appropriate and safe to do.
Podiatry	49.35	40.84	8.51	The vacancy rate in Podiatry has deteriorated due to higher than usual numbers of leavers. The service has tried to actively recruit to these roles but there is a national shortage of Podiatrists and

				delays in pre-employment checks has resulted in 1 person giving backword. The ICB Planned Care Board has recently signed off on a change to the service model and offer which will allow the service to address the increased demand which should in turn address the poor staff morale which is leading to reduced staff capacity. In addition, the new service offer will also have a significant focus on workforce diversification. Specifically, the introduction of non-registered workforce will offer education and foot health reviews as part of the discharge package for some and annual passport for others who are more vulnerable.
SLT Adult	14.75	11.66	3.09	Organisation agreement to over recruit due to increased demand and long waits. However, the service continues to experience difficulties recruiting to Band 5 and 6 SLT posts both permanently and through agency. The service is now advertising 2 Band 6 SLT posts to make them more attractive, but it is likely that these will be recruited to internally leaving further gaps at the Band 5 level.
Stroke Pathway	32.74	33.48	-0.74	All posts are filled with a slight over recruitment. The service will ensure this is addressed in future turnover/recruitment.
T3 Weight Mgmt Service	9.53	7.40	2.13	The service is reporting no vacancies. The discrepancy is likely due to the additional non recurrent funding the service has received from the ICB not being captured correctly on budget lines. The service will pick this up with their Finance Manager. The service has worked hard to recruit and retain staff in temporary posts funded by non-recurrent monies and this figure is not an accurate reflection of that.

Appendix Two

The following table provides information regarding staffing levels within services in the CBU. The data was pulled at the beginning of December 2023.

Service/Team	Funded WTE	In Month Contract WTE (Nov 2023)	Vacancy WTE	Comment
Speech and Language Therapy				
Speech and Language including Traded, Youth Justice Service, Therapeutic Social Work Team.	62.7	67.8	-5.0	2.8WTE using backlog monies and employed as part of waiting list initiative. Plans for staff is that they will move to new Traded contracts in Q1. Over staffed 0.8WTE with dysphagia due to clinical risk and an increase demand – on Trust Risk Register. 0.8WTE cost pressure due to One Adoption West Yorkshire who reduced the value of the contract.
Integrated Children with Additional Needs Service (ICAN)				
ICAN	66.16	63.22	2.94	3.0WTE Band 5 OTs have been recruited -currently going through onboarding process. 0.53WTE Band 6 OT vacancy awaiting ECF sign off. 0.6WTE Band 6 nurse out to advert 1.0WTE Band 5 nurse out to advert for second time. 0.6WTE Consultant ECF being prepared following vacancy in December.
ICAN Consultants	0.80	0.00	0.80	Locum until March 2024.
ICAN Management	6.26	6.25	0.01	
Audiology	7.46	6.98	0.48	
Total	80.68	76.45	4.23	

Areas to highlight:

ICAN have successfully recruited 2 x 0.8WTE trainee Advanced Clinical Practitioner roles ensuring we have the right professional to see the Children and Young People at the right time and developing the clinical career pathway for nursing and allied health professionals.

There continues to be high levels of maternity leave in physiotherapy and we have been unable to recruit to maternity leave cover posts. There is a reduced service offer for occupational therapy (C3 aspects of the service are paused) due to 3.0WTE Band 5 vacancy which has now been recruited to with the new staff currently going through the onboarding process and awaiting a start date. Until the new staff have been inducted, children with mild to moderate motor problems remain on the waiting list; families have been informed of the delays and provided with resources to support self-management.

We are delivering safe, effective care when families see our clinicians and have good FFT feedback to reflect this. We are unable to meet the demand of the number of referrals to the service with the

current staffing levels and current service offers. We plan to amend the occupational therapy service offer to improve access to families via group sessions(EQIA pending) and are considering similar amendments to the constipation and daytime wetting offer. Autism assessments have been stopped (December 2023 – March 2024) due to not being able to provide NICE compliant assessments because of psychology vacancy. ICAN health visitors and speech and language therapists continue to offer interventions to families of children with autism/suspected autism who have the greatest need. Therapy and nursing teams use Goal Based Outcomes with children, young people and families in sessions to ensure care is client centred and effective. Currently we are unable to report this on a service level through SystmOne reporting. We are exploring using a SystmOne questionnaire which would allow data to be collated on a service/pathway basis. Additional admin support will be required to transfer Goals to the new Questionnaire so matched pair outcomes can be measured.				
Community Children's Nursing Service (CCNS) .				
Child Continuing Care and Core Respite	40.73	32.13	8.60	3.00WTE due to start in the next 3 months. 70% of Health Short Breaks delivered in November (this has been the best figure all year) rising from 30%. This has increased in line with children known to continuing care dying and that capacity being used for health short breaks. Over 90% of CC packages delivered. An increase in the administration team and having a Management Support Officer has also released clinical staff (B6s) to deliver more clinical care and more holistic reviewing of cases for better clinical care management. 1 child on the Health Short Breaks waiting List (reduced from 6) Diabetes training has been delivered to registered nursing staff to allow a parent more 'true respite' following a raised concern. This is now up and running with further training being delivered to HCSWs to allow further quality respite and better holistic care (parent was still providing diabetic care during respite previously). New employees starting have been hampered by significant delays in the recruitment processes. Following a summer recruitment event attended by the team manager five candidates were successful at interview. However this reduced to securing three staff members due to the recruitment delays.
Hannah House Respite unit	21.26	19.15	2.11	1 WTE appointed but not yet started. One cancelled night only in this reporting period which was due a covid outbreak. The cancelled night was replaced for the

				family and parents had choice around this date. Good collaboration work between Hannah House and Continuing Care on One Page Profiles for Children – these are person centred and reflect the child's individual needs, views and personalities. Stable staffing over Christmas Bank holidays allowing children to stay as planned over this period. Fortnightly staffing meetings are held between the leadership team and the Management Support Officer to enable smoother running of the service. Complexity profiles of children are being created to better plan appropriate staffing according to children's needs. Interviews are being held imminently for two Caseload Coordinators for better coordination and oversight of care across the Community Childrens Nursing Service. This will include checking of care plans amongst other outstanding care such as Purpose T assessments. 5 children on the HH waiting list. Families contacted to organise introduction. Change in team manager who is currently within an acting up post and is also managing the Continuing Care Team
Children's Nursing Team	16.89	14.20	2.69	All staff now appointed (last one started 8/1/23) so now no vacancies. Staffing has been increased in readiness for the imminent commencement of the Children's home antibiotic service. Plans are being constructed to review and improve diary management on SystmOne to maximise efficiency of care and visits. Waiting list have been cleared for children waiting for a Sleep Study. First newly qualified nurse in post. Plans to collaborate with this staff member and gain feedback to help steer improvements to build upon and tailor our support on offer.
Inclusion Nursing Service	17.31	16.00	1.31	1.0WTE now appointed but waiting start date. During this period every team has had vacancies or staff on long-term sick, this is an improving picture.

				Waiting lists in all teams being reviewed as a number of children waiting for Nurse Led reviews/interventions. Movement from within Inclusion Teams and wider teams within CCNS have supported gaps with success. Processes have been reviewed for new starters into school. Increased admin support has also freed clinical staff to do more clinical work.
Total	96.19	81.48	14.71	
Areas to highlight: Meeting planned with Business Intelligence for January with the aim of being able to pull better quality reports and useful data for service planning and quality of care within Childrens Community Nursing Service.				
Child and Adolescent Mental Health Service (CAMHS)				
Community CAMHS	45.40	44.06	1.34	Vacancies are managed in a timely way as they occur across the service to minimise disruption in service delivery. Waiting Lists remain of concern. Currently on the risk register. As reported last time Partnership Executive Group and Children and Young People's Population Board are sighted on the increase of referrals for neurodevelopmental assessment (preschool and school age) and that significant investment would be required to manage these. The ICB is leading work on whole system response to this increasing need.
Transitions	3.91	4.47	-0.56	New team manager starts 8th January. Secondments are being used to help provide maternity leave cover.
Doctors In Training	7.36	4.00	3.36	Deanery led. Ongoing rotational allocation of trainees, limited notice as to when these posts will be filled.
MindMate SPA	10.46	7.96	2.50	1.6WTE clinical vacancy to be advertised again as unsuccessful in last round. All referrals screened for risk and urgency within 48 hours. Increase in the waiting times for routine referrals to be triaged therefore a delay in children and young people being referred to the correct service. This is on the LCH risk register. ICB are leading a review of MindMate SPA commencing January 2024.
CAMHS Psychology	5.31	6.50	-1.19	
Learning Disability Team	5.14	5.64	-0.50	

Eating Disorders Team	11.02	10.35	0.67	All emergency and urgent referrals seen within Assessment and Waiting Time standards.
Crisis Helpline	8.64	9.00	-0.36	
Crisis	13.89	14.40	-0.51	Liaison Band 6 being moved across from crisis team, evidence of shared resources to best support teams and promote safe staffing.
Youth Justice Team	2.91	2.91	0.00	
CAMHS Outreach Service	3.51	3.31	0.20	New band 4 started 1st January.
CAMHS Medical Consultant	6.90	5.19	1.71	Long standing vacancies, Locums currently being used.
CAMHS Management	6.34	6.28	0.06	
MindMate Support Team	42.13	41.97	0.16	New funding aligned to support team 4.
Total	174.72	167.64	7.08	
Areas to highlight: There are significant waiting lists in many areas of the service and these risks are on the Trust risk register. Work is ongoing to mitigate these risks and support young people and families whilst waiting including signposting to information, what to do if concerns increase and online support services.				
Healthy Child Pathway/ 0-19 Public Health Integrated Nursing Service				
0-19 Integrated Service	195.05	180.67	14.38	The service continues to manage high numbers of Band 6 vacancies mainly within Health Visiting This has been impacted further in November and Dec with higher levels of service sick leave. There is a continued rolling programme of recruitment and Bd6 staff training to become differing fields practitioners to work flexibly across 0-19 service. The commissioned flexible approach to skill mix supports service delivery and has developed further following EQIA. During times of low capacity and sickness the capacity tool has been essential in supporting cross team working for all bandings to support teams with very low staffing capacity. We continue to maintain extra Staff Nurse, Family Health Workers, and Healthcare Support Worker capacity to support some of the universal and universal plus work. To support service delivery, we promote additional hours within the service and continue to use B6 registered CLASS staff. There were 769 additional hours delivered in Dec.

				One incident has gone to Rapid Review to consider where process were not followed, whether safe staffing was a factor and the impact on IT outage.
Infant Mental Health	6.97	7.20	-0.23	IMHS budget currently has 0.18WTE B6, and 0.09 WTE B8c underspend. The vacancy factor has been met. Cancelled appointments are not a result of low staffing and predominately at families' request. The service has been challenged to see infants referred for direct work within 12 weeks owing to an increase in referrals and resources needed to develop direct work for over 2 year olds. However, the vast majority of families are seen under 12 weeks, and those who were not were offered appointments under 12 weeks, but later cancelled and rearranged. Outcomes measured by goals demonstrate interventions received are effective in improving infant-parent relationships.
Health Visitor /School Nurse Trainees	11.00	11.00	0.00	Health Visitor and School Nursing SCPHN students continue with their placements and will qualify in September 24 when we are hopeful that they will expand 0-19 service band 6 numbers.
Children's Community Eye Service	2.60	2.60	0.00	LCH continues to work with LTHT Orthoptists and Optometrists to ensure effective delivery of the Children's Community Eye Service. Service manager delivering on this work is on extended leave at present. Eye service review continues.
School Immunisation	16.83	13.96	2.87	Team cohesion improving due to new starters, involvement and supportive management. Ongoing flu scheduling & planning – challenges faced with positive creativity. Staff training running alongside delivering HPV Fixed term contract staff and CLaSS staff met as a team which improved team dynamics. Band 3 consent coordinators meeting with schools to discuss consent processes and introduce role Mobilisation meeting evaluation session held in November Photoshoot was a success using team and children from the after school club at Meadowfields primary school for LCH Kids Flu Campaign

				First flu vaccinations ordered and delivered Admin supporting unpacking and transportation to Woodsley maintaining cold chain due to lack of fridge storage at Woodhouse. Admin managers more engaged in admin support for service and providing additional staff to support transition
Total	232.45	215.43	17.02	

Appendix Three

The following table provides information regarding staffing levels within services in the ABU. It includes details of the budget, staff in post, number of vacancies within the service and further notes regarding vacant positions. The data was pulled at the end of Q3 and reviewed at the beginning of January 2024. Due to these timescales, some positions will have changed at the point of this report's dissemination.

Name of ABU service		Budget WTE	Contracted WTE December 2023	Vacancy	Comments January 2024
Neighbourhood and Citywide Services	Armley NT	41.30	41.84	-0.54	Overspent 0.54 TCM and DN uplifts have impacted on no. WTE and vacancy factor across all NT's.
	Pudsey NT	37.47	29.32	8.15	Ongoing recruitment and good success with responsiveness to hyperlocal recruitment. Locally in the west the teams are supporting one another in the 5 NTs. TCM and DN uplifts have impacted on no. WTE and vacancy factor across all NT's.
	Holt Park NT	25.08	23.86	1.22	
	Woodsley NT	35.60	32.29	3.31	
	Yeadon NT	46.85	36.21	10.64	Due to challenges move permanent/experienced staff from across West to support. New starters are being directed to west team to support with inducting. Locally in the west the teams are supporting one another in the 5 NTs.
	Chapeltown NT	36.71	33.06	3.65	
	Seacroft NT	40.30	35.06	5.24	
	Wetherby NT	24.75	16.18	8.57	Locally North teams are supporting one another in the 4 NT's.
	Meanwood NT	43.80	30.76	13.04	
	Beeston NT	20.56	18.30	2.26	
	Middleton NT	58.87	43.00	15.87	Ongoing recruitment and good success with responsiveness to Hyperlocal recruitment. Locally in the South the teams are supporting

					one another in the 4 NTs.
	Morley NT	32.59	35.21	-2.62	Overspent 2.62
	Kippax NT	32.99	29.22	3.77	
	North Triage Hub	5.09	5.03		Money from the NT budget needs to be moved into the triage hubs.
	South Triage Hub	2.18	6.19		Money from the NT budget needs to be moved into the triage hubs.
	West Triage Hub	4.30	8.05		Money from the NT budget needs to be moved into the triage hubs.
	North Therapy	28.75	22.94	5.81	
	South Therapy	35.73	31.12	4.61	
	West Therapy	29.51	31.65	-2.14	Overspent – MWB to be moved to cover overspend.
	Neighbourhood Nights	67.71	61.69	06.02	Often struggle to recruit due to the nature of working nights, though a more positive response recently and added into the hyper-local recruitment campaign. 22wte were added from additional monies (20 NCAs, 2 nurses) staff are actively being recruited to reduce the reliance on agency spend to support night sits and assessments.
	Virtual Frailty Ward (Home Ward)	41.31	28.04	13.27	The Home Ward will move into 3 cost centres as we progress into business as usual as some staff still appear on the NT staffing reports. This will be managed on an area level by the Operational Service Managers. A workforce plan is under review to determine our succession planning into the roles to support clinicians to obtain their Advanced Practice qualification to safely manage acutely unwell patients on the ward. Additional pharmacy

					roles have also been introduced.
	Integrated Clinics	0.00	4.41	-4.41	Overspent 4.41 – We are reviewing the staffing need of the clinics as currently NT staff are rotating in. For continuity of patient care we are looking at increasing our permanent resource into the clinics as the demand from the Neighbourhood Team referrals grows.
	Palliative Care Service	10.31	11.00	-0.69	Overspent by 0.69
	CUCS	14.27	15.21	-0.85	Overspent by 0.85
	Tissue Viability	6.08	6.16	-0.08	Overspent by 0.08
	Community Falls Service	8.96	8.10	1.67	
	Self-management	25.50	24.20	0.86	Money move from NT budgets into SMF following this being made into a separate budget
	CCSS	06.00	04.20	1.80	Service is being de-commissioned. Staff are currently being supported through redeployment
Patient Flow Services	Transfer of Care	23.00	17	-6	Ongoing recruitment but may not recruit into some admin posts – no issues
	SPUR	5.39	0.00	-5.39	Now admin only. The remaining budget and clinical staff will be transferring to the triage hubs
	Bed Bureau	5.25	4.5	-0.7	Out for recruitment – no issues
	CDAT	25.28	16.64	-3.92	Using the budget to support movement of staff between bandings, staff increasing hours and work around therapy input. No major concerns at this time as recruitment is ongoing. The bed bureau, TOC and CDAT cost centres have been merged to allow more flexibility.

	Therapy Supported Discharge	3.08	10.36	-2	Budget previously dispersed across Neighbourhood Team but currently carrying 2 vacancies and maternity leave.
	Health Case Management	43.74	42.00	1.00	No issues, good response to any vacancies.
	Community Care Beds	31.82	31.82		Contract with Villa Care terminates by end of January 2024, Workforce now fully recruited. Hope to work more collaboratively across bed bases including Wharfedale.
	Wharfedale Recovery Hub	43.20	48.93	5.73	Conversations taking place with ICB re. contract and funding. Current staffing is safe for the current 30 open beds.
	East Leeds Recovery Hub	2.41	2.50	0.09	LCH provide physiotherapy input only

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (106)

Title: Patient Experience Six Monthly Report.

Category of paper: For assurance

History: Quality Committee 22 January 2024

Responsible director: Executive Director of Nursing and Allied Health Professionals.

Report author: Patient Experience and Engagement Lead.

Executive summary

Purpose:

1. This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH) between 1 July 2023 and 31 December 2023.
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 six-month period 1 July 2023 to 31 December 2023; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years.
4. The report includes Friends and Family Test (FFT) information.

Main points:

1. There has been an increase in complaints (76 complaints) received between July and December 2023, compared to the 65 complaints received between January and June 2023. There has been a slight decrease of in complaints received from the same period between July and December 2022, where 79 complaints were received.
2. Two of the themes were clinical judgement and treatment and attitude, conduct and cultural and dignity issues
3. LCH has received 3 possible claims between 1 July and 31 December 2023, 3 claims were also reported for reporting period between 1 January and 30 June 2023.
4. Work continues to focus on review of the process of managing 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. INTRODUCTION

This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH) between 1 July 2023 and 31 December 2023. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).

2. BACKGROUND

LCH collects patient experience feedback through a variety of channels, and this is recorded centrally between two different systems. Complaints, concerns, enquiries and compliments are 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 the Membership Engagement System (MES) provided by Civica.

3. COMPLAINTS, CONCERNS & COMPLIMENTS

3.1. From 01 July to 31 December 2023, LCH received 76 complaints which were managed under the 2009 regulations. There has been an increase in complaints received (from 65 to 76) since the period between 01 January and 30 June 2023.

3.2. There has been a slight decrease in complaints received, from 79 to 76 complaints from the same period in the previous year, between 01 July 2022 and 31 December 2022.

3.3. Work has now been completed to capture complaints acknowledged within 3 working days, 73 complaints out of the 76 complaints made have been acknowledged and responded to within 3 working days in this period . 3 complaints out of the 76 complaints made have been acknowledged and responded to within 7 working days.

3.4. The highest number of complaints were from services in the Specialist Business Unit 33% (25), followed by 32% (24) from the Children's Business Unit and Adult Business Unit 31% (24). Community CAMHS (9), Leeds Sexual Health (5), Mindmate (6), ICAN (6). Corporate services received 3 complaints in the period (4%).

3.5. Of the 76 complaints received between 1 July and 31 December 2023, 42 have been closed. All closed complaints were responded to within 180 days of receipt. One complaint was closed and passed on to another organisation (not for LCH). 2 complaints were withdrawn, 2 complaints were duplicates. Since data was provided for this report 2 complaints were found to have been created as tests for functionality of Datix system.

3.6. The average length of time to provide a response to a complainant was 44 days. Several complaints were responded to well within the internal 40-day timeframe, 48% (20/42) of closed complaints were closed within 40 working days of receipt, the Trust standard. Of the 22 complaints closed after 40 days all timeframes were negotiated and agreed with the complainant, and were either due to staff leave within services, the record being re-opened and closed, time for the service to meet with or speak to the complainant in line with best practice, the complaint being on hold for some time or on the request of the complainant.

3.7. The Trust has received 149 concerns between 1 July to 31 December 2023, this is lower than the number of concerns received in the same period in 2019 (pre-pandemic) when 219 concerns were received.

3.8. The Trust has received a total of 468 compliments between 1 July and 31 December 2023. This shows a similar reporting pattern to our previous report where we received 465.

3.9. Work has been completed to capture the health equity data for patient experience, complainants are encouraged to use the survey shared via QR code and link by the Patient Experience Team to capture demographic data. Current data gives an insight into the demographic characteristics of complaints, on review, Patient Experience Team are considering whether the results accurately represent the diversity of the complainants and ongoing work is required to encourage the uptake completing the survey.

4. PATIENT EXPERIENCE (COMPLAINTS) TRAINING

4.1. Complaint training took place externally and was delivered to members of the Clinical Governance Team and Clinical services. The training focused on Process, Procedure and Information Gathering and Responding to Complaints - Letter and Report Writing. There is a clear plan to revise the Managing Concerns and Complaints Training package, which will be developed following these sessions and will be delivered by the Clinical Governance Team going forward. The Complaints, Claims and Patient Experience Officer is liaising with the Parliamentary Health Service Ombudsman regarding their training package, and looking into organising some tailored sessions for LCH.

4.2. Support continues to be provided to teams where needed and guidance given; bespoke training sessions are offered where requested. The Complaints, Claims and Patient Experience Officer will be joining the ABU leadership in February 2024 to present and update on our complaints and concerns processes.

5. OVERARCHING THEMES FROM CLOSED COMPLAINTS

5.1. The top three subjects for LCH’s complaints closed during period 1 July – 31 December 2023 were: Clinical judgement/treatment, attitude, conduct, cultural and dignity issues and appointments.

Two of the three themes are consistent with the previous six months and the same period last year; however, appointment appears as the second highest subject for complaint between 1 January- 30 June 2023.

6.2 Complaints citing Clinical judgement and treatment

6.2.1 "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 July– 31 December 2023, 33% (25 out of 76) of complaints received were due to issues around clinical judgement and treatment.

6.2.2 The most complaints citing clinical judgement and treatment were closed within the Specialist Business Unit with 36% of the complaints (9/25). Children's Business Unit accounted for 32% (8/25) of the complaints closed citing clinical judgement and Adult Business Unit 28% (7/25) of these complaints.

6.2.3 An example of learning in this theme can be found in Appendix 1

6.3 Complaints citing attitude, conduct, cultural and dignity issues

6.3.1 Of received complaints between 1 July- 31 December 2023, 14.5% (11 out of 76) cited issues concerning attitude, conduct, cultural and dignity, and was the second most common area for complaints received.

6.3.2 The Adult Business Unit and Specialist Business Unit both had 36% each (4/11) of complaints citing Attitude issues, and Childrens Business Unit had 27% (3/11) of these complaints.

6.3.3 An example of learning in CBU for this theme can be found in Appendix 2

6.4 Complaints citing Appointment issues

6.4.1 For the period 1 July- 31 December 2023 10.5% (8 out of 76) of all complaints received highlighted appointment issues, this was the third most common area for complaints received.

63% (5/8) of complaints citing appointment issues were in the Specialist Business unit. These ranged across Specialist Weight Management, Leeds Sexual Health, Leeds Mental Well-being Service, Dental and Community Neurology Services.

6.5

6.5.1 An example of learning in this theme can be found in Appendix 3

6. CLAIMS

6.1. LCH has received 3 potential claims between 1 July and 31 December 2023.

6.2. Of the three new claims two are being handled by the Clinical Negligence Scheme for Trusts and are related to clinical care provided by MSK and Chapeltown Neighbourhood Team.

6.3. The third potential claim is a request for records to IG by a solicitor.

7. FRIENDS AND FAMILY TEST

During the reporting period of 01 July and 30 December 2023 there have been 5524 Friends and Family Test (FFT) responses, this is a 72.7% increase on the previous six months (3198). The overall percentage of patients or their carers reporting a very good or good experience was 94.6% this is a 1.1% increase in satisfaction from the previous reporting period (93.53%). 2.5% of responses reported the experience was poor or very poor and 2.5% neither good nor poor. 0.4% answered 'Don't know' to this question.

8.1 The increase in FFT is linked to a focused piece of work within the MSK service, sending FFT links via system one. This good practice is being shared with the Trusts engagement champions for future use across other services.

8.2 We continue to receive comments within the FFT that praise staff members for the care and support provided, examples of these comments can be found in Appendix 4

8.3. 78.1% (4314) of our FFT surveys were completed online from 1 July- 10th December 2023, and 21.3% (1180) were completed in paper/postcard form either via post or in service. Work is ongoing to support services to increase accessibility when using the FFT.

8.4 The FFT is available in a variety of languages and easy read, and services are supported to follow Trust interpretation and translation procedures if requiring language translation and interpretation.

8.5 Services continue to develop specific surveys relating to their care offer and seek feedback and development ideas. A total of 622 responses have been received during the reporting period of 01 July and 30 December 2023 from service specific surveys outside of the Friends and Family Test, this is a 14.3% increase from the previous 6 months (544). Patient Engagement Team (PET) continue to develop the proforma for staff to outline what support they need with an engagement project/idea and how to track outcomes. The document itself is continually improved, and staff are encouraged to look at their community demographics to identify who currently does and does not access the service when developing engagement requests.

8.6 Children's Speech and Language Therapy Service (SLT) have collaborated with the Audiology team in their engagement work. The aim is for SLT to support Audiology primarily in their assessment of preschool children awaiting assessment or children with complex needs. These children sometimes need multiple appointments for a hearing test to be completed so the service have advised on social story and visual information that can be sent before the appointment to prepare families on what to expect, how the session runs and to introduce the use of visuals into the session to increase understanding of the tests and increase compliance in assessments. The Audiology service have

shared useful documents and ideas from the service on how they have streamlined their reports and letters, how they arrange their booking system and triage which has been useful in terms of sharing with SLT as the service are currently making changes in these areas.

8.7 The Patient Engagement Team have continued to work in partnership with the 3rd Sector and attend various services for engagement opportunities, see further examples in Appendix 5

8.8 The Patient Experience Team have begun benchmarking LCH complaint processes against the Parliamentary and Health Service Ombudsman (PHSO) Complaint Handling standards (2022).

Two surveys have been produced and shared to capture feedback on patient/carer and staff experiences of the complaint process, to help inform the benchmarking and areas for improvement.

8.9 Work to support the implementation of the Health Equity and Third Sector Strategies is ongoing and will include a review of process and systems to help improve access and experience of vulnerable communities and those at highest risk of health inequalities.

9 RECOMMENDATIONS

The Board is recommended to:

- Receive this report
- Note the updated information

Appendix

Appendix 1

An example of learning is within a complaint made to the Children and Young Peoples Mental Health Service (CYMPHS) regarding a young person's mother receiving appointment notifications with insufficient notice. The service has since added a notification to the front page of the young person's records to highlight their communication preferences, by doing this they can ensure future appointments details will be sent via their preferred method of communication in advance.

Appendix 2

An example of learning following a complaint around this subject with the ICAN Service: The complaint was regarding the types of questions asked by the Health Visitor and how they were posed. As an outcome of the investigation the service will ensure the role of a Health Visitor is made clear prior to these visits, they will do this by developing a pack to be sent out to all antenatal contacts, this will consist of key public health information, the role of the Specialist Community Public Health Nurse and awareness of the structure of the visit before it takes place.

Appendix 3

An example of learning and improvement in this area comes from the Tissue Viability Team, where the complainant was unhappy with the service due to them not communicating the progress of his wound care with him. Service took this feedback on board and put a plan in place for wound measurement probes to be given to the Community Nurses to be used during visits, and to also be shared with this patient and for any future patients who may request or require this.

Appendix 4

Staff member is always very friendly and kind with her help and checks in and offers reassuring support for both me and my baby on her visits. I feel like I can turn to her when I need to, even though I haven't specifically needed to as yet. Thank you for being there for us to keep us feeling that reassurance on this new journey together" – Comment from 0-19 PHINS East Health Visiting Team

"The sessions were very interactive, and the therapists were very patient and explained everything fully, they allowed open discussion which also helped us patients speak with each other as well as the staff, this allowed us to offer advice to each other, I found the sessions very valuable in regards to coming to terms with chronic pain." – Comment from the Pain Management Team - Armley Moor Health Centre

"Very prompt on time for all appointment - clear with instructions for exercises - book in exercises very useful - professional and gentle instructor Helen - great improvement overall"- Comment from the Community Falls Service.

Appendix 5

PET have worked in partnership with LCH staff, Leeds City Council, Carers Leeds and NHS England to develop a carers roadshow event which took place on Friday 8th December at Leeds Kirkgate Market. The aim of the event was to highlight the fantastic partnership work Leeds has developed to support carers and to provide information and advice to unpaid carers about support that is available. Stall holders included student nurses providing health checks, Healthwatch Leeds, Family Action, Carers Leeds, LTHT, Johns Campaign Ambassadors, Care and Repair and many more. 377 members of the public attended stalls with 100 referrals made to services for further support. The partnership hopes to repeat this event annually.

During the reporting period of 01 July and 30 December 2023 PET have completed two Engagement Drop in's, one drop in being linked to the new Patient Safety Incident Response Framework. The drop in involved Patient Engagement Team and a Patient Safety Partner. The drop involved asking patients their thoughts on the new priorities set and discussed lived experience of patient safety. Themes from speaking to a patient included, communication throughout care, knowing who to speak to and how to raise concerns around safety and patient felt being involved in their care was of importance.

When speaking to a second patient, feedback themes included, patients having a key point of contact regarding raising concerns about safety, importance of removing blame culture and empowering patients to voice concerns without feeling their care would be different.

As a consequence of this feedback, the PSIRF engagement task and finish group for are planning more engagement sessions with Patient Safety Partners to continue hearing the voice of patients/family members/carers who have experienced incidents.

PET have completed an engagement drop in at the Mindmate SPA Service. The drop-in included discussing engagement/involvement work and opportunities for the team to engage service users. The service want to complete 'virtual reality' type videos of entering the building and introducing staff members. This is to support patients who may be anxious about attending an appointment by making surroundings and staff familiar. The service also discussed having a tablet/iPad for patients, to encourage to complete the Friends and Family Test and to be used by patients during appointments, when feeling overwhelmed or overstimulated. The

Charitable Funds Officer has been involved in these conversations, with a request for purchase of the tablets via LCH Charity, the service are exploring this with our. Feedback received following engagement drop-in has identified services have found the drop-ins useful and have provided services further insight into engagement and involvement of patients through feedback/focus groups/involvement opportunities. PET continue to contact services to plan engagement drop-ins for the future.

PET have supported engagement around a newly developed accessible communication letter for appointments. This has involved discussion with Karl Proud from BID Leeds a 3rd sector organisation that supports people who have hearing and sight loss, he was able to give feedback from his own perspective of being blind/visually impaired. Further engagement included attending Being Well Task Group, a group that focuses on health and wellbeing outcomes for people with learning disabilities in the city. Positive feedback from the group indicated that the new appointment letter was a big improvement on previous appointment letters and would give people the essential information they needed in plain English to help make it easier and therefore more likely to access appointments.

Trust Board meeting held in public: 2 February 2024

Agenda item number: 2023-24 (107)

Title: Trust Priorities 2023/24 – Q3 Exception Report

Category of paper: For Assurance

History: Trust Leadership Team January 2024

Responsible director: Executive Director of Nursing and Allied Health Professionals and Executive Director of Finance and Resources

Report author: Business & Planning Manager, Head of Clinical Governance and Head of Strategy, Change and Development

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Executive summary

This report provides an update by exception of progress against the Trust's 2023/24 priorities at the end of Q3 2023/24.

Recommendations

The Board is recommended to:

- Receive the report and note the updates against the Trust's 2023/24 priorities at the end of Q3 2023/24.

Trust Priorities 2023/24 – Q3 Exception Report

1. Introduction

The BCDS (Business Change and Development Service) continue to lead and support several projects throughout 2023/24 to underpin the achievement of the Trust Priorities. The following provides exception reporting for each Trust Priority. Please see Appendix 1 for further information.

2. Priorities Exception Report

Strategic Goal - Work with communities to deliver the right quality care

Trust Priority: We will be responsive to the needs of our populations as we deliver safe and effective care on our journey to outstanding care.

Key focus 1: How we engage with our patients, carers, families and communities, is fundamental to the achievement of this and other priorities: our Engagement principles will be developed and ratified this year by LCH Board.

The Engagement Principles have been ratified and the Clinical Governance Engagement Co-ordinator and Engagement Officer are supporting the Principles. Progress during the first six months was not as anticipated due to staffing changes, however, work is continuing towards achieving the Principles in lieu of the planned update to Board in March 2024.

Key focus 2: We will 'make stuff better' by embedding learning from incidents, complaints, and general feedback from the communities we serve, and drawing on best practice/clinical evidence through our development of the LCH Patient Safety Incident Response Plan, over the next 12 – 18 months. The LCH 2023/24 Change Programme projects will drive continuous improvement. For example, the review of planned and unplanned care in the Neighbourhood Teams, the Community Gynaecology Service Review and the CAMHS EPR transition.

The LCH Patient Safety Incident Response Plan was finalised and launched on 2 January 2024. Quarter Four is protected for transition from the previous processes. A joint Quality Committee and Quality Assurance and Improvement Group (QAIG) workshop was held in 2023/24 and an action plan developed to better identify, share and embed learning. The action plan is held by QAIG.

We continue to see high waits for our **Colorectal and Urinary Continence Service** (CUCS).

We have seen a reduction in the total **Occupational Therapy and Physiotherapy** waiting lists since October 2023 (from 1577 patients to 1417 in mid-December 2023).

The December ICB Planned Care Board signed off a new delivery model for the **Podiatry** service which will reduce the demand for the service and change the offer using workforce diversification.

The project to expand our **Community Gynaecological** service and move more interventions into the community from LTHT has been indefinitely paused in agreement with commissioners.

Key focus 3: We will work with system partners to increase capacity and improve patient flow to enable us to maximise the number of referrals into urgent community response and strive to consistently meet or exceed the 70% 2-hour urgent community response standard.

The **unplanned care project** has progressed at pace. A pilot separating out nursing planned and unplanned care in the North Neighbourhood Teams will start the week commencing 19 February 2024. This aims to improve the allocation of work and have a positive impact on patient care and staff satisfaction.

Following previous **data quality** issues, we continue to meet the national quick response standard.

Strategic Goal - Use our resources wisely and efficiently

Trust Priority: We will aim to use our resources wisely, delivering efficiencies required to meet our financial targets or to reinvest in our services, while ensuring we maintain a focus on quality and safety

Key focus 1: Work with services, patients, and partners to identify changes to service provision and/or pathways (both within LCH, across Leeds and across the ICB) to more effectively manage patients and therefore help to reduce waits. This will be achieved through the LCH Change Programme, Third Sector Partnerships and Primary Care Integration.

Ongoing, no exceptions to report.

Key focus 2: We will adopt a standardised approach to waiting list management through the Improving Patient Flow and Prioritisation (IPFP) Programme

The Design and Test phase of the IPFP Programme has been completed for a standardised process. The delivery phase is paused while Business Units explore this alongside service priorities for next year as part of the business planning process.

Key focus 3: Establish and deliver an efficiency programme that contributes to Trust, place and system financial sustainability whilst maintaining safe and effective care and, through Equity and Quality Impact Assessments, ensures no detriment to health inequalities.

North Yorkshire Police Custody - Following the North Yorkshire decision to exit the regional Police Custody contract and subsequent unsuccessful LCH bid the service has now commenced demobilisation ahead of 25 March 2024 contract end.

Liaison and Diversion – Humberside. Pre-tender work has started with the service supported by BCDS ahead of tender process in 2024-25.

The **Digital Allocation Project**, aiming to introduce allocation software into the Neighbourhood Teams, continues to be on pause while issues with system integration are resolved.

'Go live' on the new **Wharfedale Recovery Hub** EPR unit has been delayed due to risks flagged. A migration risk assessment was completed with input from Co-formation, clinical leads and clinical systems teams and was presented to TLT on 13 December 2023.

The outcome of the **Long Covid** options appraisal regarding the future of the service remains unclear. The Long-Term Conditions Board has supported the recommendation of Option 2 (Reduction of 30% funding) which is a £340k cost pressure to LCH but is more likely to be approximately 10% reduction in staffing from 1 April 2024 due to the current financial position of the service.

Strategic Goal - Enable our workforce to thrive and deliver the best possible care

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

Key focus 1: We will focus on the retention of our existing talent

The Trust has seen a sustained improvement in its turnover, which currently stands at 9.5%, well within the current threshold of 14.5%.

Key focus 2: We will carry out locally targeted recruitment and reduce barriers to entry to widen our talent pool and diversify our workforce

A significant Talent Development programme for LCH BME staff is being launched Mid-January which includes leadership training programme and an accredited Coaching and Mentoring course.

5 x Neurodiversity and Wellbeing awareness sessions are being run "virtually" by an external provider – over 400 staff have joined the first 2 sessions, with positive feedback

BME Diverse recruitment panels – over 20 staff have come forward to be part of a pool of people who would like to be actively involved in the full recruitment and selection process for all posts at Band 7+.

Hyper local recruitment continues to be an area of focus and success for the Trust, and we are up to almost 200 recruits from our hyper local approach in the 18 months of this initiative running.

Key focus 3: We will induct our second cohort of international community nurses

The Trust is currently inducting a third cohort of international community nurses.

Key focus 4: We will continue to use our workforce data and planning methodology to both understand our longer-term workforce gaps and develop interventions to address our future needs.

Ongoing, no exceptions to report.

Strategic Goal - Working together to enable people to live better lives

Trust Priority: We will work pro-actively across the system with all the communities we serve to improve health outcomes, improve patient flow and continue to drive integration.

Key focus 1: Continue to work with communities and partners to create equitable care and pathways in line with LCH's Health Equity Strategy, identifying and addressing inequity in access, experience and outcomes.

A review of LCH's 2021-4 Health Equity strategy is underway to develop the next phase in identifying and addressing inequity in our care and pathways from May 2024.

Key focus 2: Continue to engage with and support the intermediate care redesign.

The **Home Ward (Frailty)** offer has developed over time, supporting the highest ever number of referrals received in October 2023 – 387. The context in which the service is working has also changed, including national requirements and other system offers.

ABU is working closely with partners in the **Home First** intermediate care programme to design and develop plans for 2024, including commissioning models.

Due to capacity and staffing challenges, conversations are being explored with primary care regarding the future model for the **Integrated Clinics.**

A further year of **Enhance** funding for 2024/25 was approved in December, with agreement to develop a business case for ongoing funding following this.

Key focus 3: Continue to work with partners to drive integration. A key focus here being CAMHS and working with primary care and schools in line with the ambitions set out in the NHS Long term plan.

MindMate Support team - Eight trainees for Team 4 have been approved to start and will primarily work with the South Leeds schools.

3. Recommendations

The Board is recommended to:

- Receive the report and note the updates against the Trust's 2023/24 priorities at the end of Q3 2023/24.

Appendix One – Additional information re Trust Priority Progress

Strategic Goal - Work with communities to deliver the right quality care

Trust Priority: We will be responsive to the needs of our populations as we deliver safe and effective care on our journey to outstanding care.

Key focus 2: We will 'make stuff better' by embedding learning from incidents, complaints, and general feedback from the communities we serve, and drawing on best practice/clinical evidence through our development of the LCH Patient Safety Incident Response Plan, over the next 12 – 18 months. The LCH 2023/24 Change Programme projects will drive continuous improvement. For example, the review of planned and unplanned care in the Neighbourhood Teams, the Community Gynaecology Service Review and the CAMHS EPR transition.

We continue to see high waits for our **Colorectal and Urinary Continence Service** (CUCS). CUCS have seen some successful recruitment recently, with several colleagues starting in post in October and November, however staff sickness continues to impact waits, particularly at band 5 level. A quality improvement project concentrating on waiting lists with the ODI team is commencing in January 2024.

We have seen a reduction in the total **Occupational Therapy and Physiotherapy** waiting lists since October 2023 (from 1577 patients to 1417 in mid-December 2023), demonstrating the positive impact of the significant work going on. This includes greater local ownership of therapy waits, use of the capacity tracker, and locums, CLaSS, STaR and extra hours made available to increase capacity. A waiting list workshop which generated further ideas was held in December 2023 and a focus on waiting times has been introduced to the ABU performance process.

The December ICB Planned Care Board signed off a new delivery model for the **Podiatry** service which will reduce the demand for the service and change the offer using workforce diversification. This will ensure viable and sustainable service that offers a robust service to patients with the greatest risk of complexity and vulnerability and maximising the skills and opportunities for non-registered and registered workforce. Next steps are to setup the project governance structure and complete the associated Equity and Quality Impact Assessments. A resource request has been submitted to the BSCD allocation group.

The project to expand our **Community Gynaecological** service and move more interventions into the community from LTHT has been indefinitely paused in agreement with commissioners. It is recognised by the system as the future for the service, but funding is currently unavailable to the changes and expansion.

Key focus 3: We will work with system partners to increase capacity and improve patient flow to enable us to maximise the number of referrals into urgent community response and strive to consistently meet or exceed the 70% 2-hour urgent community response standard.

The **unplanned care project** has progressed at pace. A pilot separating out nursing planned and unplanned care in the North Neighbourhood Teams will start the week commencing 19 February 2024. This aims to improve the allocation of work and have a positive impact on patient care and staff satisfaction. A decision was taken, following engagement with therapy leads, to keep therapy out of scope for the initial pilot due to their differing ways of working, many of which align with this model already. Running the pilot in the North, the same location as the Active Recovery pilot, aims to focus on the interdependencies between both pieces of work.

Following previous data quality issues, we continue to meet the national quick response standard. In October 73% of people assessed as requiring a response within 2 hours were seen within 2 hours, in September this was 74% and in August 78%.

Strategic Goal - Use our resources wisely and efficiently

Trust Priority: We will aim to use our resources wisely, delivering efficiencies required to meet our financial targets or to reinvest in our services, while ensuring we maintain a focus on quality and safety

Key focus 3: Establish and deliver an efficiency programme that contributes to Trust, place and system financial sustainability whilst maintaining safe and effective care and, through Equity and Quality Impact Assessments, ensures no detriment to health inequalities.

North Yorkshire Police Custody - Following the North Yorkshire decision to exit the regional Police Custody contract and subsequent unsuccessful LCH bid the service has now commenced demobilisation ahead of 25 March 2024 contract end. Demobilisation meetings to begin fortnightly in January 2024 and weekly in February and March.

Liaison and Diversion – Humberside. Pre-tender work has started with the service supported by BCDS ahead of tender process in 2024-25. Bidders event is expected early 2024 and it has been indicated the next contract will be regional from March 2025. A business case is also being written to provide mental health treatment requirement within the service. This is a current gap in the Humberside L&D pathway and the next step to add to the offer available to those entering the criminal justice system in need of support or diversion. NHS England have requested this business case and indicated this will be a requirement of the next contract.

The digital allocation project, aiming to introduce allocation software into the Neighbourhood Teams, continues to be on pause while issues with system integration are resolved. Work is ongoing, and an options paper was reviewed by Trust Leadership Team (TLT) in November. TLT requested that before a decision is made on how to progress, testing of the integration should be carried out along with an exploration of extending the contract with RL Datix, however this is limited due to the procurement framework. The ICB have agreed to host the integration which will allow testing to commence – costs and logistics associated with this are now being

explored. The options paper will be updated following testing and re-submitted to TLT in February 2024.

'Go live' on the new Wharfedale Recovery Hub EPR unit has been delayed due to risks flagged. A migration risk assessment was completed with input from Co-formation, clinical leads and clinical systems teams and was presented to TLT on 13th December. Following this a decision was taken to progress with the 'big bang' migration option where all patients are pre-loaded onto the new unit which is then switched on and the old one closed, rather than a phased approach of having two units running concurrently. Intended go live is now mid-February. In the meantime, development and optimisation work continues in agreed areas. Phase 2 optimisation after migration will slip into 24/25 – proposed likely to be completed by end of Q1 24/25.

Long Covid - The outcome of the Long Covid options appraisal regarding the future of the service remains unclear. The Long-Term Conditions Board has supported the recommendation of Option 2 (Reduction of 30% funding) which is a £340k cost pressure to LCH but is more likely to be approx. 10% reduction in staffing from 1 April 2024 due to the current financial position of the service. The ICB is coordinating EQIAs for the above option and option 3 (a Single Point of Access / Coordination function) in the event that funding from NHS England is not confirmed.

Strategic Goal - Enable our workforce to thrive and deliver the best possible care

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

Key focus 2: We will carry out locally targeted recruitment and reduce barriers to entry to widen our talent pool and diversify our workforce

A significant Talent Development programme for LCH BME staff is being launched Mid-January which includes leadership training programme and an accredited Coaching and Mentoring course. The intention is to increase diverse and inclusive representation across all leadership hierarchies, ensuring that the future staffing model better reflects current staff diversity and the communities in which we deliver patient care.

5 x Neurodiversity and Wellbeing awareness sessions are being run "virtually" by an external provider – over 400 staff have joined the first 2 sessions, with positive feedback

BME Diverse recruitment panels – over 20 staff have come forward to be part of a pool of people who would like to will be actively involved in the full recruitment and selection process for all posts at Band 7+. A session has taken place with the volunteers outlining roles and expectations and escalation/support process put into place. The process will be implemented from early February.

Hyper local recruitment continues to be an area of focus and success for the Trust, and we are up to almost 200 recruits from our hyper local approach in the 18 months of this initiative running.

Strategic Goal - Working together to enable people to live better lives

Trust Priority: We will work pro-actively across the system with all the communities we serve to improve health outcomes, improve patient flow and continue to drive integration.

Key focus 1: Continue to work with communities and partners to create equitable care and pathways in line with LCH's Health Equity Strategy, identifying and addressing inequity in access, experience and outcomes.

A review of LCH's 2021-4 Health Equity strategy is underway to develop the next phase in identifying and addressing inequity in our care and pathways from May 2024. The Board workshop in October agreed a specific Health Equity strategic goal which will be further developed to identify success measures, informing the next phase of health equity activity.

Key focus 2: Continue to engage with and support the intermediate care redesign.

The Home Ward (Frailty) offer has developed over time, supporting the highest ever number of referrals received in October 2023 – 387. The context in which the service is working has also changed, including national requirements and other system offers. A decision has therefore been made to review and refine the Home Ward (Frailty) offer to ensure it offers the best possible outcomes in the changing context of the Leeds health and care system - the review will be completed between December and the end of March, with the aim of implementing a revised operating model from April 2024. The review will consider, amongst other objectives, the cost benefit of our current model based on provision to date, and the most appropriate workforce and operating model.

ABU is working closely with partners in the Home First intermediate care programme to design and develop plans for 2024, including commissioning models.

Due to capacity and staffing challenges, conversations are being explored with primary care regarding the future model for the integrated clinics. A recent audit of 30 patients attending clinic demonstrated that 60% of clinic time was spent with patients referred from GP/Practice Nurses. This patient group made up 63% of the patients, had longer clinic times and were reviewed more often. Neighbourhood Team referrals had a shorter time on the caseload. This suggests the patients referred from primary care are more complex. Currently the clinics are staffed solely from LCH, which may not be sustainable going forward. However, analysis of Primary Care referrals to Neighbourhood Teams prior to and since Integrated Clinics were established suggests that the Clinics are diverting a significant proportion of referrals from Neighbourhood Teams.

A further year of Enhance funding for 24/25 was approved in December, with agreement to develop a business case for ongoing funding following this. Going forward Enhance third sector partners will support patients referred by a wider range of LCH services, targeting services and people where we will maximise time savings for LCH clinicians. LCH and LOPF are proud of this partnership approach – investing in Leeds's rich third sector, using their skills and networks to keep people well and socially connected, and through doing so reducing the pressures on LCH, the hospitals and other health and care services.

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in Public: 2 February 2024

Agenda item number: 2023-24 (108)

Title: 3rd Sector Strategy Progress Update

Category of paper: Assurance

History:
Progress Update to January 2024 Business Committee

Responsible Director: Interim Executive Director of Operations

Report author: LCH Partnership Development Manager, Volition Director (on behalf of Forum Central), Head of Strategy, Change and Development

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Executive Summary (Purpose and main points)

The paper provides an update on progress over the past 6 months in implementing LCH's 3rd Sector Strategy.

The paper refers to recent strategic developments including the launch of:

- the city Third Sector Strategy which sets out a shared vision for how the third sector in Leeds should work, and what we need to do to get there in the next five years.
- the Healthy Leeds Plan and refreshed Leeds Health and Well-Being Strategy 2023-2030, in which the 3rd sector has a central role in delivering on the city's ambitions, left shift and reducing health inequalities.

The paper flags notable areas of progress over the past 6 months including:

- Sexual Health service: extensive engagement and co-production with the third sector in developing the tender, and a third sector co-ordination role for Forum Central to ensure the service is as accessible as possible.
- Board approval of a 3rd year of funding for the Enhance programme with a view to longer term funding dependent on evidencing cost benefit analysis. Over half of the people supported to date live in the most deprived areas of Leeds.
- CBU continuing to develop links with the 3rd sector including informing the recent review of the Community Eye Service and improving service accessibility for the Gypsy and Traveller communities.
- The first LCH–Third Sector networking event took place in November at John Charles Centre in collaboration with Forum Central, providing opportunities to celebrate excellent 3rd sector partnerships, enable connections and better understanding and navigation of LCH and the 3rd sector and inform development of future partnership working through discussions.
- strong commitment to more partnership working with the third sector as part of service development at the December Board workshop on organisation strategy, reflected in key organisational workstreams supporting planning for 24/25: the 24/25 Quality and Value Programme and the review of LCH's 'core offer' and services / service elements that could be devolved to the third sector.

A key focus in quarter is reviewing priorities and plans for 2024/25 informed by discussion at the LCH 3rd sector networking event in November 2023.

Purpose

The paper provides an update on progress over the past 6 months in implementing LCH's 3rd Sector Strategy.

Background

The 3 year LCH Third Sector Strategy, co-produced with Forum Central (partnership of Volition and Leeds Older People's Forum) which represents and provides a collective voice for Leeds' third sector in health and care, was approved by LCH Board in August 2020. The Strategy Steering Group agreed the year 2 implementation plan in November 2022 and in quarter 4 is reviewing the strategy and priorities for 2024/25. The Strategy aim and objectives are set out in Appendix 1

Third Sector Context and Background

The last report provided an overview of

- the very significant shifts and developments (in Leeds and beyond) over the last five years that have changed the way that the third sector operates, both in itself and within the wider system in the city, including:
  - The current funding challenges and cost of operating
  - The impact of COVID-19, and the way the third sector mobilised to work in new ways and was recognised as a key and critical partner.

  and reflected in the State of the Sector which describes what the third sector looks like in Leeds.
- Forum Central's work with system partners to develop sustainable funding for the Health and Care VCSE sector and ensure reach to people not supported elsewhere in the system. The WY ICB 2023/4 financial position meant that only partial funding for one year was approved, £309k allocated to Leeds. Half will resource Neighbourhood work/ Locality Models and culturally diverse and faith groups and consortia/partnership working to increase sustainable and strategic approaches, the other half will fund work on third sector representation, engagement and system change, including work on sector visibility, workforce, digital and developing third sector proposals for cost-saving schemes.
- Some third sector organisations will lose staff, services or even fold – small, non recurrent grants from this allocation will not prevent that from happening in all cases but will at least enable some to weather the current challenges.

In November the The Leeds Third Sector Strategy, developed by Third Sector Leeds, was launched. The strategy sets out a shared vision for how the third sector in Leeds should work, and what we need to do to get there in the next five years (2023 – 2028). It recognises that the previous decade has involved growing trust and understanding between the third sector and public sector partners, businesses, schools and universities. It is not a strategy for the third sector – it's a strategy for the whole city to better understand, support and work in partnership with the sector to

continue playing a vital role in supporting communities in Leeds to thrive. We call on all partners to work with us to deliver this.

Key Local Leeds Strategic context includes the Inclusive Growth Strategy, Healthy Leeds Plan – launched in December along with the Refreshed Leeds Health and Wellbeing Strategy 2023-2030, Home First - Hospital Discharge and the Leeds Marmot partnership in which the role of 3rd sector will be significant - see link https://linktr.ee/fairerleeds

Third Sector Strategy Implementation

The Steering Group has continued to provide a valuable channel for understanding the challenges, concerns and risks that both LCH and 3rd sector organisations face in the current climate of financial pressures, increased and more acute demand and the impact on staff health and well-being, recruitment and retention and the potential to address those challenges through partnership working bilaterally and with system partners remains a key focus of the Steering Group.

In 2023 all except one Steering Group meeting were held in a 3rd sector organisation premises and invited to give an overview of their organisation at the meeting, which supports 3rd sector resilience and widening links with 3rd sector organisations.

Notable developments over the past 6 months include:

- **Co-Production workstream - Co-produce Leeds Sexual Health service.** We engaged with 18+ third sector organisations both ahead of and following release of the specification to explore opportunities to develop links and how best to work together, with a focus on accessibility and outreach. Third sector partners helped co-produce pathway elements to enable access, reach and ensure we meet the needs of specific populations. Forum Central will lead on the management of the third sector network in the new Leeds Sexual Health Service which we have established to ensure third sector partners have a voice throughout the lifetime of the contract and ensure the service is as accessible as possible. Forum Central will sit on the partnership board. This approach reflects objectives 1, 2, 4, 6 and 7 in action.

- **Connect Better workstream –** the Enhance programme is an example of LCH advocating in the system for investment in 3rd sector capacity to deliver on the left shift ambition, investing LCH resource to ensure continuation of the project and ensuring that our own contracts with the third sector are more viable and sustainable. December ’23 Board approved a 3rd year of funding for with a view to longer term funding dependent on evidencing cost benefit analysis. Enhance is reaching the people most in need: to date 53% of people supported by Enhance live in the most deprived areas of Leeds, IMD1 & IMD2 areas. Over recent months links with wider ABU services have been developed. In 24/25 Enhance support will be targeted to support SBU and ABU services where Enhance support will maximise time saved for LCH clinicians and further develop the focus on reducing health inequalities.

The Enhance project was prominent at the well attended launch of the Healthy Leeds Plan and refreshed Health and Well-Being Strategy in December where a short film of people supported by Enhance talking about the transformational impact of Enhance on their quality of life and physical and mental health and well-being was shown and the Chief Exec of the ICB, Tim Riley, flagged Enhance as an excellent example of the left shift ambition and the Healthy Leeds Plan in action. Reflects objectives 1,2,4,5,6,7

- **Develop Inclusive, Accessible Services Workstream -** CBU have developed further inclusion work with GATE including projects around raising awareness of mental health support and contacting families in a timely and safe manner. Young Lives Leeds helped the review of the Community Children's Eye Service reach a wider audience by including surveys in the Young Lives Leeds bulletin and the Doing Good Leeds website. Reflects objective 2.

- **Develop Inclusive, Accessible Services Workstream – Integrated Clinic Social Model**

  Integrated Clinic provision transitioned from project to BAU in October. Due to continued capacity and staffing challenges, conversations are being explored with primary care regarding the future model for the integrated clinics which to date have been staffed solely by LCH. Because of the staffing challenges, 1 of the 2 weekly wound clinics run together with Forward Leeds for people who are homeless, sex workers and/or have an addiction has been stopped. The Neighbourhood Team is working creatively to find a solution. The service isn't commissioned to provide wound care for these populations however these populations have high incidence of severe wounds, face very significant additional challenges in managing their wounds and risk not being able to access effective wound care. This supports objectives 1 and 2.

- **Develop a 'one health system infrastructure'** - since the last update LCH Forward Leeds staff who are in roles created as part of the Community Mental Health Transformation new service model have been given access to LCH systems. This was processed through a framework that the LCH IG lead has developed to allow non LCH staff access to our systems where there is not a BAU type reason for access. The 3rd sector organisation has to be DSPT accredited.

  There is work in progress to develop a Recovery Plan on the LTHT PPM system for people post discharge from hospital which will enable info sharing initially across LCH and LTHT, and if successful, follow on stages planned are to connect it to the Primary Care Anticipatory Care Framework assessment, potentially RESPECT and enable access to 3rd sector partners working with NHS to provide multidisciplinary care.

  These support objective 5.

- **LCH 3rd sector networking event** – the first LCH–Third Sector networking event took place in November at John Charles Centre. The event aimed to celebrate our many excellent 3rd sector partnerships, enable connections and better understanding and navigation of LCH and the 3rd sector, inform

development of future partnership working through discussions and inspire further partnership development. Event planning and delivery was done jointly by LCH and the Forum Central with input from all 3 Business Units. The event showcased partnership working in each of the 3 Business Units and had over 20 stalls. The event was very well attended with over 140 delegates, many of whom asked for future networking events. The key points from table discussions have been shared with the Steering Group and quick wins and priorities identified which are being further tested in teams. This will inform the review of plans for 2024/25 at the February Steering Group meeting. This supports all objectives.

- **LCH intranet: partnership content** – work has progressed on developing the 3rd sector partnership intranet pages with input from Forum Central. It was not possible to launch the pages to coincide with the networking event; we will launch the pages in February. The pages will enable navigation and connection with 3rd sector networks and organisations through links to directories and networks, inspire and support culture change through case studies and vlogs, and promote volunteering by sharing staff experience and the personal and professional impact, highlight specific Trustee vacancies and provide a link to the city volunteering website. This supports all objectives.

- The December Board workshop on organisation strategy included focus on partnership working with the third sector to deliver on our ambition to provide the best possible care, with strong commitment to more partnership working with the third sector as part of service development. This commitment is reflected in key organisational workstreams supporting planning for 24/25:
  - Potential for developing partnership working with / a greater role for the 3rd sector will be considered when redesigning service offers as part of the 24/25 Quality and Value Programme whether to make services more inclusive and accessible, better support prevention, self efficacy, wider health and well-being and / or mitigate workforce challenges.
  - agreeing to review LCH's 'core offer' leading to decisions about what services and/or service elements could be devolved to the third sector: to start at a Board workshop in May 2024

A key focus in quarter is reviewing the strategy and plan for 2024/25 informed by discussion at the LCH 3rd sector networking event in November 2023.

Recommendations

The Board is asked to consider whether it is assured about progress in implementing the 3rd Sector Strategy.

Appendix 1:

The aim of the LCH Third Sector strategy is:

to deliver outstanding care to the people we serve by developing effective partnership working with the third sector, maximising use of their expertise and contribution, achieve a culture change in LCH where our people fully recognise their value and support third sector resilience.

The strategy has 7 objectives:

- **Objective 1**: develop integrated working and co-delivery between LCH and the 3rd sector
- **Objective 2:** use the health inequalities expertise of the third sector to support the poorest to improve their health the fastest
- **Objective 3:** develop shared agendas to maximise effort and impact on improving health outcomes
- **Objective 4:** develop an LCH offer that helps develop a resilient, thriving and successful third sector
- **Objective 5:** champion a 'one health system' where infrastructure is aligned to enable all partners, including the third sector to successfully contribute
- **Objective 6:** design a fair and equal approach to business development, contracting and partnership working that supports growth, sustainability and viability in the third sector with a diverse range of organisations
- **Objective 7:** LCH and the third sector to work with other system partners to improve how we enable clear navigation of the health system in Leeds

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (109)

Title: Mortality Report Quarter 3 2023-24

Category of paper:	**For assurance**
History:	**Quality Committee 22 January 2024**
Responsible director:	**Executive Medical Director**
Report author:	**Executive Medical Director**

Executive summary

Purpose of this report:

To provide the Board with assurance regarding the Mortality figures and processes within LCH NHS Trust in Quarter 3 23-24.

Main points to note:

- Quality Assurance & Improvement (QAIG) Group have met regularly and are quorate. The last business meeting was on the 9th January 2024.
- Business Unit Learning from Deaths meetings have taken place regularly and have been quorate throughout the quarter.
- Due to timing of meetings data for Q3 had to be reported early this year therefore numbers may appear artificially low and will have to be assessed fully as part of the Q4 and annual review.
- The tender ready review of services in SBU planned as part of the Quality & Value Program will include governance and mortality processes for all services in order to ensure the process previously established remains appropriate for 24.25.
- Identification of Serious Mental Illness remains lower than anticipated and will be reviewed as part of the mortality pilot analysis ahead of 24.25.
- An overall lack of deaths reported in patients with autism over a time period of several years has been noted and is being investigated by the LD Lead.
- Timing of data reporting to QAIG and Quality Committee will be considered again as part of a review of quality governance processes by the new Company Secretary; in the absence of live data the correct balance between timely reporting and discussion against data availability and business unit capacity remains a challenge.
- Timely review of Child Deaths remains a capacity issue, but immediate learning is noted and child deaths are subject to comprehensive and robust oversight and review processes as part of CDOP.
- The Executive Medical Director has been asked to contribute to the new ICS Mortality Oversight group to bring a community perspective.

Recommendations:

- Trust Board is recommended to receive this assurance regarding Trust mortality processes during Q3 of 23-24

1. Adults & Specialist (Appendix 1)

- The NT element of the mortality pilot has finished, this will be assessed and reviewed during Q4 and rolled out across ABU for 24.25 if effective. The pilot appears to have decreased the volume of mortality reviews whilst increasing the timeliness and effectiveness of those that require a more indepth review but a full analysis is planned to ensure the new process is effective before full implementation.
- No increased identification of SMI has been seen to-date with introduction of the pilot or change to the datix reporting field; this is being kept under review.
- A sustained increase in patients dying in a care home has been noted and appears to be sustained. This continues to be monitored, no key themes have been identified.

2. Equity

- Equity figures for Q3 of 23-24 continue to show similar patterns and trends as identified previously. The work reported during Q2 is not yet at a point that learning or progress can be reported to Quality Committee, but is anticipated for the end of Quarter 4 in line with the annual mortality report.
- It has been noted that the Adults flash report makes reference to White and Non-White deaths, which incorrectly clusters White patients from an ethnic minority and this will be appropriately reported moving forwards.

3. Children (Appendix 2)

- 9 deaths were seen in Quarter 2, of which 4 were SUDIC, which is just higher than the average of 7 seen for the previous 24 months.
- The National Child Mortality Death (NCMD) database Child Death Data Review for the year ending 31st March 2023 has been received and the Trust figures will be reviewed for 23.24 in the context of this report for the end of Quarter 4.
- Data for patients with an LD was unavailable this quarter due to a system error but will be included in the Quarter 4 report.

4. People with a Learning Disability

- The LD lead is conducting a review of all deaths for patients with an LD during 23.24.
- Between Q1 and Q3 there were seven deaths in patients with an LD, but only two of these appear to have had a Level 2 mortality review completed: work is underway to understand why this was the case, and the findings will be fed into the mortality pilot for inclusion in the processes for 24.25.

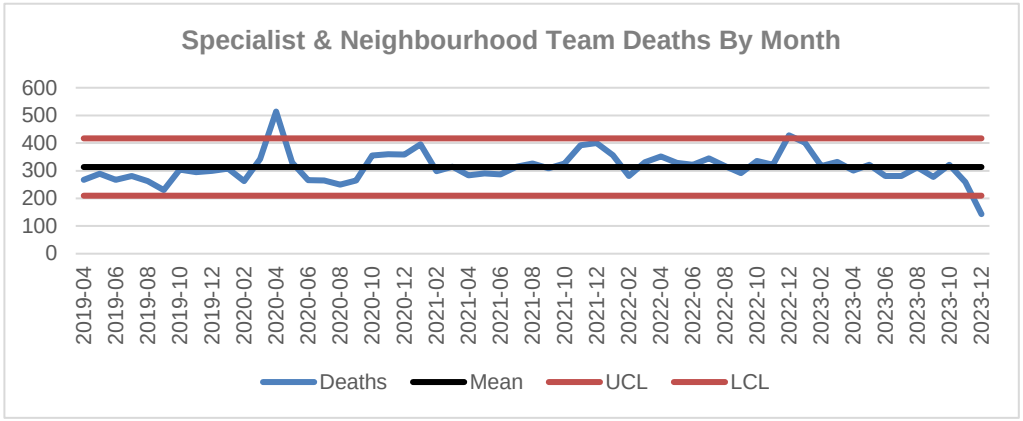
5. Recommendations:

- Quality Committee is recommended to receive this assurance regarding Trust mortality processes during Q3 of 23.24

[Adult Mortality Report – QAIG], Q[3] 2023/24 (October – December 2023)

NB * BI data was captured earlier than usual on 20.12.2023 It is usually captured on 3rd of month; brought forward to ensure submission deadline can be met. Please be aware it will impact on Dec data.

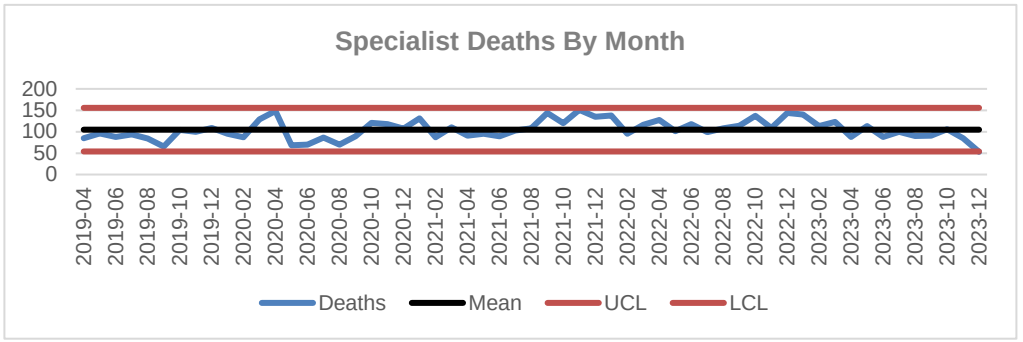
Quantitative data

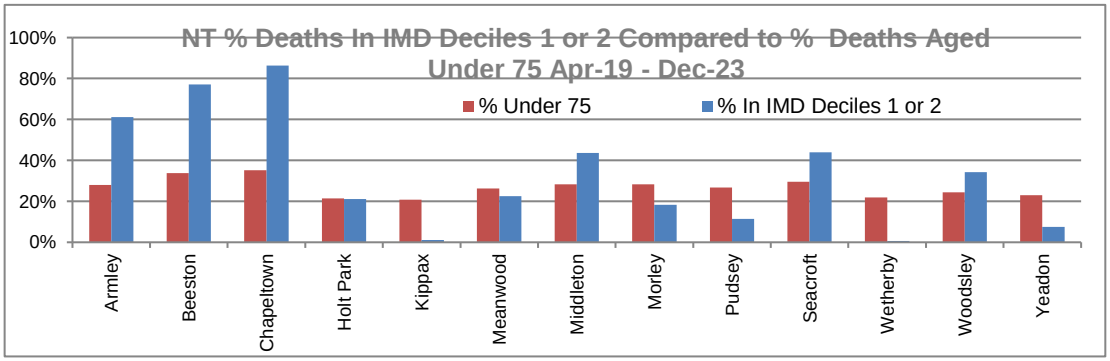


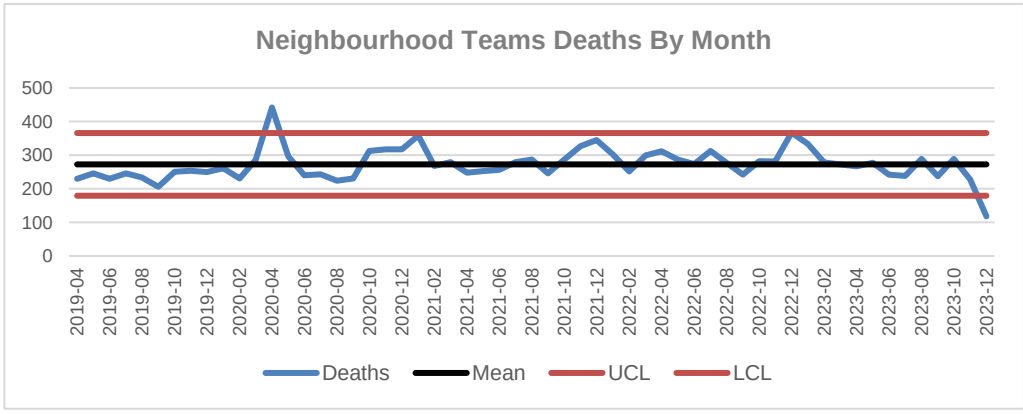
Oct - Dec 23 Mortality Figs for NTs & Selected Specialist Services

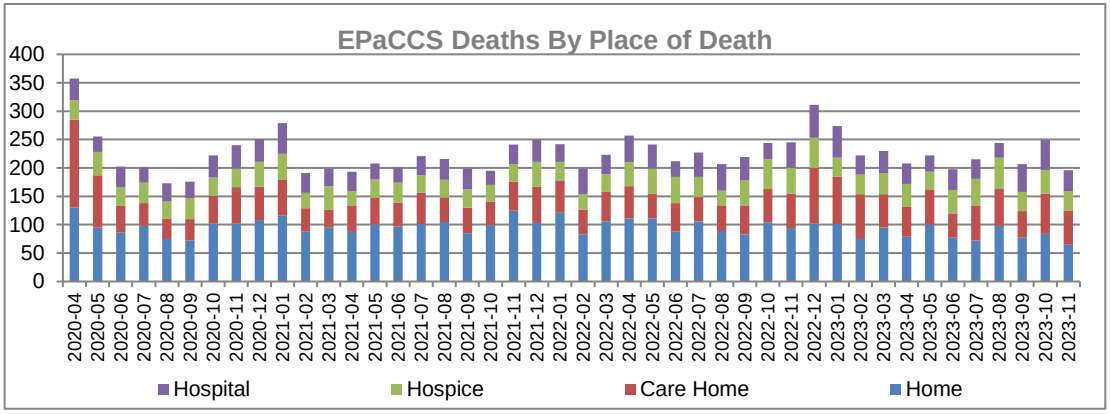
Deaths	Oct-23	Nov-23	Dec-23	Q3
Total	322	259	143	**724**
NT	289	228	118	**635**
Specialist	106	85	53	**244**
Specialist not in NT	33	31	25	**89**
In NT & Specialist	73	54	28	**155**
Specialist Deaths in Multiple Units	9	13	2	**24**
VFW	2	0	0	**2**
LD	1	0	1	**2**
NT Deaths in Multiple Units	1	0	1	**2**

Adult data (deaths)	Q3 * 23/24	Q2 23/24	Q1 23/24	Q4 22/23
Level 1	637	356	492	691
Level 2	121	94	146	224
Unexpected deaths	47	64	86	100
Expected deaths	282	289	477	450
Alliance CCB	5	4	5	3
Virtual ward	2	3	4	5
LeDeR (LD deaths)	2	4	2	5
Serious MH	0	0	0	0









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[3]2023/24 (October – December 2023)

NB * BI data was captured earlier than usual on 20.12.2023 It is usually captured on 3rd of month; brought forward to ensure submission deadline can be met. Please be aware it will impact on Dec data.

Analysis:

- Total adult deaths in Q3 2023/24 = **724** (Q2 (July – Sept 2023) = 784, Q1= 832, Q4 (2022) = 962, Q3=961, Q2=868, Q1=938). The total is the **lowest** in the last year.
- ABU deaths Q3 2023/24 = 637 (Q2=678, Q1=720, Q4=800).
- SBU deaths Q3 2023/24 = 267 (Q2=258, Q1=262, Q4=339)
- All ABU and SBU mortality data for this quarter sits within control parameters; the trend is towards the lower control this quarter and will be monitored.

Serious Incidents as a result of patient deaths

- There have been three patient safety investigation as a result of deaths in ABU during Q3
- There have not been any patient safety investigations as a result of deaths in SBU during Q3

Themes / Trends:

- There is a gradual increase in the number of people who died in a care home over the last 3m. The number of people who died in hospital in last 3m appears to be consistent with prior quarter. Data indicates average rates of dying at home were: 34% in 2019/20, 42% in 2020/21, 47% in 2021/22, 40% in 2022/23. Data for 2023/24 is incomplete: 37%.
- Two LD patients died (decrease from 4 in Q2 2022.23 and 2 in Q1). The LD Lead has initiated a data review based on Q3 LeDeR data. Of the two deaths one had a Level 2 mortality review completed by LCH. Between Q1 and Q3 there were seven LD deaths; Level 2 mortality reviews were completed for two of them. Further investigation underway to clarify why the other five did not have Level 2 review.

Equity:

- In NTs in 2023/24 YTD 80% patients died in their preferred place of death (PPD) compared to 78% in 2022/23. Since 04.2019 80% total white and 81% total non-white achieved their PPD.
- The % of Non-White on EPaCCs with PPD & APD recorded is 7.6%

Learning from ABU Mortality Review meetings:

I. Excellent holistic care was provided to a patient who was agitated, e.g. nicotine patches were prescribed as they became too unwell to continue their smoking habit.
II. Bariatric patient was not weighed regularly despite a significant weight loss (7st) and their LTC not monitored (BP not taken as bariatric cuff unavailable). Staff are encouraged not to become complacent about holistic care when patients have been known to service for protracted periods of time. Bariatric cuffs are available from all health centres.
III. Further training for staff to understand LPOA regarding Advanced Care Plans to be established.
IV. Concern shared by hospital and community staff in ensuring the most recent version of the RESPECT and Advanced Care Plan is visible across all systems; IT systems across Leeds are not interoperable there is no consistent way of tracking and updating changes.

Learning from SBU Mortality Review meetings:

I. Review of tender processes in SBU to include governance and mortality process for all services. This will support services in the clarity of mortality processes.
II. Usual mortality process continues with Clinical Lead and Quality Lead reviewing deaths. Deaths will be escalated and discussed at the SBU/ABU mortality case meetings when appropriate. SBU services sitting outside the usual mortality process will revert to previous audit process, as agreed at QAIG. From Q3 a sample size of 5% deaths will undergo review every quarter for assurance; an update will be provided in next report. Rapid reviews will continue as per process with agreed services.
III. **Secure estates: Death in custody (2).** 1. Unexpected death in adult HMPS of individual following transfer from WYOI (LCH secure estate). As the death occurred within 3 months of transfer WYOI has contributed to this investigation. Non-contributory learning has been identified for WYOI. 2. Unexpected death in community following discharge from LCH secure estate, WYOI. Pending rapid review.
IV. **LMWS death:** Non-contributory learning identified regarding admin process at point of referral into service. KPI met within timescale for this incident, but there were issues with how the referral was processed which could have led to a delay in appointment; highlighted as a potential risk for future incidents. A review of related Policies took place and updates were made, reflecting the need for accurate recording of dates, ensuring timescales are always met.

Learning from LD / autism deaths

Themes:

1. Deaths In ABU / SBU remain within SPC parameters. (Pulling data earlier this month means that Dec data appears low; it is expected to rise by end of quarter and will be monitored in the next report.)
2. Deaths in ABU are the lowest they have been for one year.
3. Over the last 3m there is a gradual increase in the number of people who died in a care home.
4. The number of people who died in hospital in last 3m appears to be consistent with prior quarter.
5. Visibility of the most recent version of the RESPECT and Advanced Care Plan difficult as IT systems across Leeds are not interoperable.
6. Mortality Pilot started in Q2 continues. Data analysis will complete at end Q4.

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*

I. The fast-track process for those with LD takes a different route. Meeting arranged with PCQL to highlight this process for all. II. There have been no deaths of people with autism recorded on SystmOne in recent years. **Deaths reported to inquest:** Six deaths were referred to inquest in ABU / SBU. Three in October (two from SBU: S Yorks custody suites and LMWS; one city wide services). Three were referred in November (two from SBU: one S Yorks custody suite, one from LMWS and one ABU from Wetherby NT.	
Overall: 1. Mortality pilot commenced 1 July 2023; continues through Q3 with final analysis in Q4. 2. A city-wide discussion is underway to review how patients with a Learning Disability are cared for at the end of their life. 3. ICB Commissioned End of Life Doula Pilot: Aims to support patients, families and Carers.	**Risks:** See risk 1 below 1. See risk 1 below

Opportunities/Successes (Making Stuff Better/Celebrations)

[info relevant to subject area] PLEASE INDICATE WHICH BAF RISK IS MITIGATED

Opportunity/Success

Business units and QPD have been working together to develop an improved mortality review process and are now piloting and developing as one integrated team. Within ABU the palliative clinical quality leads are providing a significant contribution to the ABU mortality reviews which includes more sharing of thematic learning. Work continues.

***BAF RISK 1**	**BAF 2**	**BAF 3**	**BAF 4**

Opportunity/Success

During the review of the mortality questionnaires to inform a pilot, it was noted that the wording for 'Serious mental illness' was only linked to cause of death. This has been updated to a serious mental illness at time of death as opposed to being a causative factor. This should ensure data is accurate in future.

Inclusion of the LD Lead within the mortality quarterly review process continues to develop. LD hub in MY LCH now active for staff support and learning from LD deaths. Now reviewing LD deaths in more detail from a qualitative perspective.

BAF 1	**BAF 2**	**BAF 3**	**BAF 4**

Risks/issues

PLEASE INDICATE WHICH BAF RISK THIS LOCAL RISK RELATES TO (LIST ON PAGE 3)

RISK 1

Piloting the new mortality process continues. Progress has been made in the timely review of ABU mortality Level 2 reviews and we are able to list them for Mortality Case Review within the same quarter.

Mitigation

Any urgent cases requiring review for assurance are being completed within the month. This includes virtual frailty ward (Homeward), community care beds and any escalated for review by the NHT clinical lead.

***BAF 1**	**BAF 2**	**BAF 3**	**BAF 4**

RISK 2

Difficulty in obtaining data due to submission timescales, continues to be a challenge. Data is usually pulled this on the first working day of the month after the quarter; this is usually the submission date for QAIG. This means that completing analysis of data is difficult. Consideration for this to move to 20th-19th as per BU reports to align.

Mitigation

Reporting this month has been aligned with the business unit reports. Data was pulled on 20 December for this report. For QAIG discussion and approval to repeat in future.

BAF 1	BAF 2	QUERY BAF 3	**BAF 4**

[Adult Mortality Report – QAIG], Q[3] 2023/24 (October – December 2023)

NB * BI data was captured earlier than usual on 20.12.2023 It is usually captured on 3rd of month; brought forward to ensure submission deadline can be met. Please be aware it will impact on Dec data.

RISK/Opportunity

LTHT discharge pathways 1 & 2 means there are changes in the proportion of discharges from hospital to home and therefore more poorly patients are being discharged home; community care beds are seeing more frail patients that are not for active rehabilitation.

Mitigation

To be closely monitored and update to be shared in next report.

BAF 1	BAF 2	BAF 3	BAF 4

RISK 3

Data quality regarding documentation of expected and unexpected deaths persists; there are a large number listed 'unknown'. This does not affect completion of Level 1 and 2 mortality review.

Mitigation

Business units have requested a review of data to ensure accurate and sensitive reporting.

BAF 1	BAF 2	BAF 3	BAF 4

BOARD ASSURANCE FRAMEWORK (BAF) – QUALITY COMMITTEE RISKS

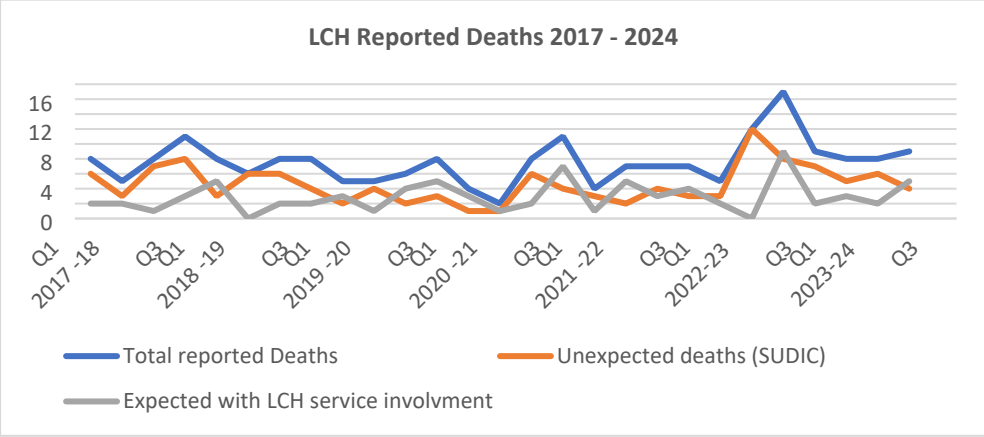
Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm. **Quality Committee (Exec Director of Nursing and AHPs)**	**Risk 2** Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage. **Quality Committee and Business Committee (Exec Director of Operations)**	**Risk 3** Failure to invest in digital solutions. If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable and the impact will be delays in caring for patients and less than optimum quality of care. **Quality, Business and Audit Committees (Exec Director of Finance and Resources, Exec Medical Director)**
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention. **Quality and Business Committees, and Trust Board. (Senior Management Team)**	**Intentionally Blank**	**Intentionally Blank.**

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*

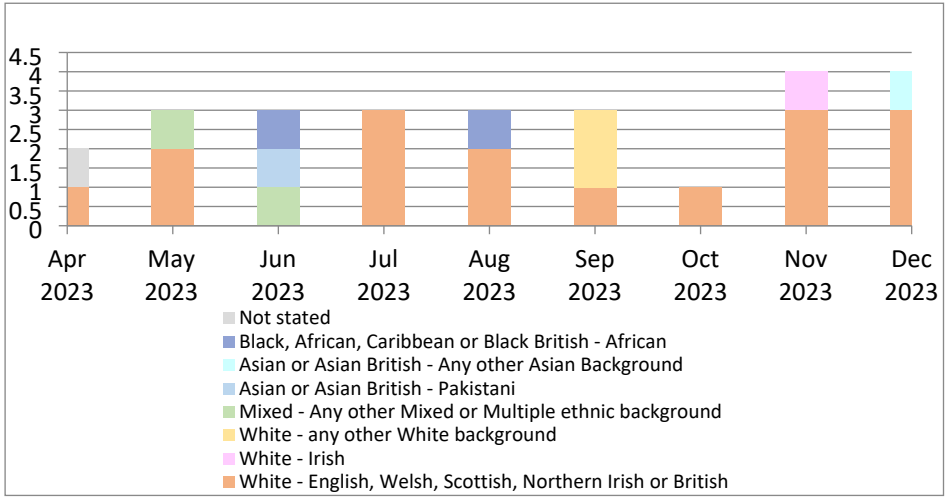
Key Opportunities Risks and Successes - Child Death, Q3 2023/2024 (Oct-Dec)

Quantitative data

All LCH reported deaths – Q1 2017 – Q3 2023



Ethnicity



Analysis/Narrative

There were 9 deaths in quarter 3, the average for the previous 24-months is 7.

Expected deaths.

Age	Cause of Death	Immediate LCH Learning
16y5m	Complex medical needs	No immediate learning
0y 5m	Meningoencephalitis, Streptococcus Pneumoniae Bacteraemia	
6y8m	1a. Acute Respiratory Distress Syndrome. 1b. Pneumonia. 2. Atrioventricular Septal Defect repaired. Trisomy 21	
16y4m	Pneumonia	No learning
11y8m	Pontocerebellar Hypoplasia	
SUDIC		
15y1m	Stabbing	No learning
15y1m	Hanging (no LCH involvement)	No learning
5m	Smothering (residing in Leeds)	SI via LYPFT
2 weeks	Cardiac arrest	

The Child Death Review Data Release: Year ending 31 March 2023

There were 3,743 child (0–17 years) deaths in England in the year ending 31 March 2023, an estimated rate of 31.8 deaths per 100,000 children. The number of deaths increased by 8% on the previous year and was the highest number of deaths in a year since NCMD started data collection in 2019. Infant (children under 1 year) deaths increased by 4% on the previous year and deaths of children aged between 1 and 17 years increased by 16%. Child death data release 2023 | National Child Mortality Database (ncmd.info).

Learning

From the Child Death Review Meetings

- Covid templated added to the ICAN Paediatric Consultations.
- 0-19 Clinical Lead linking in with LTHT Neonatal Paediatrician to improve notification and information sharing.

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Key Opportunities Risks and Successes - Child Death, Q3 2023/2024 (Oct-Dec)

Opportunities/Successes (Making Stuff Better/Celebrations)

Opportunity/Success

0-19 PHINS – Every Sleep Safe Sleep training underway. The EQIA was approved for the change, for 0-19 Practitioners to request to see where the baby sleeps.

Safer Sleep :: West Yorkshire Health & Care Partnership (wypartnership.co.uk)

*BAF RISK 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success

BAF 1 √	BAF 2	BAF 3	BAF 4

Risks/issues

RISK

There are currently 35 child deaths to review, this has increased due to availability of presenters for their cases, and cases having to return due to further information required.

Quarter and year	Number of deaths to review
Q3 22/23	35 (total number to review, not number of deaths per quarter)
Q4 22/23	39
Q1 23/24	28
Q2 23/24	24
Q3 23/24	35

Mitigation

Continue to review between 8 and 9 cases every 2 months.

*BAF 1 √	BAF 2	BAF 3	BAF 4

RISK

Risk remains of limited number of Paediatricians covering the Service, the service has Paediatricians who can cover notifications. The SUDIC Paediatrician has now provided two training sessions. This is on the risk register ID 1121.

Mitigation

The service has Paediatricians who can cover notifications.

BAF 1 √	BAF 2	BAF 3	BAF 4

Additional or supporting information (optional)

Unable to supply data regarding children with a registered Learning Disability for this report due to a system issue, the Dif 2 (investigation page) does not pull through the information from the Dif 1 (reporting page) QL to work with the Governance Systems Manager to resolve.

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Trust Board Meeting held in Public: 2 February 2024

Agenda item number: 2023-24 (110)

Title: Review of standing orders, reservation and delegation of powers and standing financial instructions

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Category of paper: for approval (to recommend to Board)
History: Approved by Audit Committee 15 December 2023

Responsible director: Executive Director of Finance & Resources
Report author: Company Secretary and Deputy Director of Finance & Resources

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Executive summary

The Trust has an established set of standing orders and standing financial instructions which also include a schedule of powers reserved to the Board and a scheme of delegation. Together, these provide a governance framework that enables the organisation to demonstrate it is well governed and meets the requirements of key corporate governance codes.

In order to ensure that the Board is discharging its role effectively it should regularly review the components of the standing orders and standing financial instructions and receive assurances that it is meeting the requirements contained within these documents.

This paper summarises a number of amendments and updates. Once approved, a fully updated version of the whole document will be made available electronically to Board members and more widely through the Trust's intranet and website.

The Audit Committee reviewed this paper at its meeting on 15 December 2023 and agreed to recommend that the Board should approve the proposed amendments.

Recommendations

The Board is recommended to:

- approve version 3.5 standing orders, reservation and delegation of powers and standing financial instructions in line with the summary of changes outlined in this paper.

1.0 Introduction

This report is to inform the Board of the review undertaken in updating the Trust's standing orders and standing financial instructions. This paper summarises recommended changes to be made in order to amend and update content and takes account of: the merger of NHS Improvement into NHS England, the publication of the Fit and Proper Person Test Framework (2023), changes in the Trust's structure and changes that the Trust's executive directors wish to introduce to better regulate good governance and management.

2.0 Background

NHS trusts are required to adopt standing orders and standing financial instructions and to establish a schedule of powers reserved to the Board and a scheme of delegation.

Under its terms of reference, the Audit Committee is required to review the adequacy of policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements.

Standing orders and standing financial instructions are essential foundations for the good governance of the Trust and set out:

- Mechanisms for how the Trust Board conducts its business
- Decision making powers delegated from the Board
- Expectations of the Trust as to the conduct of individuals entrusted with public resources
- Principles and procedures that direct financial conduct

3.0 Current position

The Trust's Board approved an amendment to the standing orders, reservation and delegation of powers and standing financial instructions on 26 May 2023 (version 3.4).

The current standing orders and standing financial instructions are fully functional but there are a number of aspects that, on review, require updating.

The Audit Committee reviewed this update at its meeting on 15 December 2023 and agreed to recommend that the Board should approve the proposed amendments

4.0 Proposed changes

The table shown at appendix 1 summarises the changes to be made in order to amend and update content. The revised version, if approved, will be numbered as version 3.5 and retained by the Company Secretary.

In addition to the changes to listed, NHS England and WY ICB have imposed additional financial control measures on all organisations in Summer 2023. This is in response to a forecast deficit for the WY ICB as a whole.

All WY organisations have been required to set up measures that ensure there is Director level involvement and sign off of all non-pay expenditure in excess of £10k that is over and above their existing run rate. All relevant expenditure will be recorded and reviewed weekly by the Trust Leadership Team. As a second control all requisitions in excess of £10k will be reviewed by the Deputy Director of Finance before actioning to ensure the Trust remains compliant with the revised arrangements.

These additional steps supplement rather than replace the authorisation limits in the SFIs during a time of increase grip and scrutiny.

5.0 Resources

There are no resource consequences resulting from this paper and its proposals.

6.0 Risks

Failure to establish, implement and assure compliance with standing orders and standing financial instructions may impact on the Trust's decision making and assurance processes, and may adversely affect its reputation and CQC rating.

7.0 Regulatory and Legal

These changes to the standing orders and standing financial instructions ensure compliance with all applicable legislation and NHS regulations and guidance.

8.0 Next steps

Once approved, an electronic version of the full amended document will be made available to Board members and managers and staff. Use will be made of the Trust's intranet and website to publish the documents.

9.0 Recommendation

The Board is recommended to:

- Approve the updating of the standing orders and standing financial instructions in line with the summary of changes outlines in the attached paper.

APPENDIX 1

Leeds Community Healthcare NHS Trust
Summary of changes to standing orders and standing financial instructions

Section	Change
Section B: Standing orders	
Paragraph 1.1 (1)	**Statutory framework** Sentence to be amended: ~~The principal place of business of the Trust is: First Floor, Stockdale House, Headingley Park, Victoria Road, Leeds, LS6 1PF~~ Replaced with: The principal place of business of the Trust is: Building 3, White Rose Park, Millshaw Lane, Leeds LS11 0DL
Paragraph 3.12 (viii)	**Voting** Sentence to be amended: ~~For the voting rules relating to joint members see Standing Order 2.5.~~ Replaced with: For the voting rules relating to joint members see Standing Order 2.6.
Paragraph 7.5.2	**Fit and proper person declaration** Remove references to "NHS Improvement" and replace with "NHS England".
Paragraph 7.5.3	**Fit and proper person declaration** Addition of the following bullet point at the end of the paragraph: • The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.
Paragraph 9.1	**Joint finance arrangements** Remove reference to "NHS Improvement".
Section C: Schedule of Reservation and Scheme of Delegation	
Decisions reserved to the Leeds Community Healthcare NHS Trust Board	**Strategy, plans and budgets** Addition of point 17 at the end of the list: The Board retains the authority for approving high risk partnership agreements with authority delegated in accordance with the levels set for investment decisions in section 6.0 of the Detailed Scheme of Delegation.

<table>
<tr>
<td>Detailed Scheme of Delegation: Delegated matter (3)</td>
<td>Payment of Orders: Authorising orders and contracts (and subsequent variations) for goods and services

Amendment of reference to “Executive Director” for authorisation above £50,000 to £100,000 to “Director” in order to include the Director of Workforce role:

<table>
<tr><td>Up to £30,000 within a delegated Revenue Budget</td><td>Budget Holder</td></tr>
<tr><td>Above £30,000 to £50,000</td><td>General Manager/ Deputy Director of Finance & Resources</td></tr>
<tr><td>Above £50,000 to £100,000</td><td>Director</td></tr>
<tr><td>Above £100,000 to £500,000</td><td>Chief Executive/ Executive Director of Finance & Resources</td></tr>
<tr><td>Above £500,000 to £1,000,000</td><td>A Group comprising the Chair or Vice Chair, Chief Executive and the Executive Director of Finance & Resources</td></tr>
<tr><td>Over £1,000,000</td><td>Trust Board</td></tr>
</table>
</td>
</tr>
<tr>
<td>Detailed Scheme of Delegation: Delegated matters (6.1, 6.2, 6.3, 6.4 and 6.5)</td>
<td>Remove references to “Senior Management Team” and replace with “Trust Leadership Team”.</td>
</tr>
</table>

Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (111)

Title: LCH Patient Safety Incident Response Plan (PSIRP)

Category of paper: Approval

History: Quality Committee & Board included within engagement

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Responsible Director: Executive Director of Nursing and Allied Health professionals

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Report author: Deputy Director of Nursing and Quality

Executive Summary (Purpose and main points)

This paper provides the Board with the final draft of the LCH PSIRP for 2 Jan 2024 – 31 March 2025. This is a national requirement as part of the implementation of the Patient Safety Incident Response Framework (PSIRF) which is replacing the historical Serious Incident Framework from 2015.

A period of engagement took place in November 2023 to inform this final version. In addition to requesting general feedback, this specifically asked:

- Do the safety priorities feel appropriate (local and national priorities)?
- Do you agree with these priorities?
- What else would you add?

In addition to circulating the document to numerous stakeholders, feedback was obtained from LCH staff through existing forums as well as specific engagement events. Feedback was sought from patients / service users / public and partners through an engagement event, attendance at a third sector event and feedback from Healthwatch Leeds Board Directors and with engagement and support from our Patient Safety Partners. The engagement list is attached at the end of the PSIRP.

The feedback received resulted in changes to the flow, readability and accessibility of the document, in addition to a specific review of local priority 4 and the process for reviewing and escalation of self-harm incidents in the secure estate.

Recommendations

- The Board is asked to approve the Patient Safety Incident Response Plan (PSIRP)

Patient safety incident response plan

Effective date: 1 January 2024

Estimated refresh date: 1 April 2025

	NAME	TITLE	SIGNATURE	DATE
Author	Claire Gray-Sharpe	Head of Clinical Governance		
Reviewer	Sheila Sorby	Deputy Director of Nursing and Quality		
Authoriser	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals		

Contents

Introduction

The NHS Patient Safety Strategy available here was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework (2015).

The PSIRF challenges us to think and respond differently when a patient safety incident occurs. PSIRF is best considered as a learning and improvement framework with emphasis placed on the system and culture that support continuous improvement. One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better with a focus on improving quality and safety.

PSIRF recognises the need to ensure we have support structures for patients and staff involved in patient safety incidents. A key part of this is fostering a psychologically safe culture, a ‘Just culture’ where our staff and patients feel confident to speak up when things don’t go as planned.

This document is the Patient Safety Incident Response Plan (PSIRP) for Leeds Community Healthcare Trust (LCH). This version of the PSIRP provides the blueprint of how we intend to respond to patient safety incidents over a period of 15 months (2 Jan 2024 to 31 March 2025). The plan will then be reviewed at least annually and refreshed in line with future fiscal years. This plan details our approach to reviewing incidents in line with nationally defined patient safety priorities and our locally defined safety priorities. The plan will remain a live document and will remain flexible to consider new and emerging patient safety issues.

There is no remit within this PSIRP, or indeed within PSIRF, to apportion blame or determine liability, preventability or cause of death. The responses we will conduct to patient safety incidents are for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resource matters, legal claims and inquests.

Our services

Leeds Community Healthcare NHS Trust is proud to provide great care to our communities. The Trust provides and/or sub-contracts NHS services that include services from pre-conception to the end of life across many different specialities and professional disciplines. This includes services to promote and maintain health, and to provide care and treatment to manage existing conditions or ill health.
The Trust primarily serves the population of Leeds, in addition to some regional services. Services are delivered within the patient's home or from a range of sites including health centres, GP practices, hospital sites, schools, police custody suites and HM Prison and secure estate sites.

LCH is commissioned and registered with the Care Quality Commission to provide the following Services:

Table One –Clinical Business Units

Adult Business Unit	Childrens Business Unit	Specialist Business Unit
• Neighbourhood Teams (Community Nursing and Rehabilitation, HomeWard, Integrated Clinics and Self Management) • Community Discharge and Assessment Team • Continence, urology and colorectal service • End of Life Team • Falls Team • Health Case Management • Neighbourhood Night Service • Recovery Hubs • Tissue Viability • Transfer of Care • Bed Bureau • Wharfdale Recovery Hub	• Integrated Children's Additional Needs Service (ICAN) • Audiology • MindMate Single Point of Access • MindMate Support Teams • Childrens Community Nursing Service • Children's Speech and Language Therapy • 0-19 Public Health Integrated Nursing Service • Infant Mental Health • Children's Community Eye Service • School Aged Immunisations Service • Children and Young People's Mental Health Service	• Dental • Musculoskeletal • Adult Speech & Swallowing • Podiatry • Wetherby Young Offenders Institute • Adel Beck Secure Childrens Home • Leeds Sexual Health Service • Homeless & Health Inclusion Team • Long COVID Rehab • Gynaecology • Police Custody Suites • Leeds Mental Wellbeing Service • Tuberculosis • Community Stroke Rehabilitation • Community Neurological Rehabilitation • Community Intravenous Antibiotic Service • Diabetes • Liaison and Diversion • Respiratory • Dietetics • Tier 3 Weight Management • Cardiac • Leeds Community Pain Service

Defining the LCH patient safety incident profile

It is recommended that this document be read alongside the Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed: PSIRF

To identify our Trust local priorities a review was conducted of the data outlined below within the data section. As part of this we identified incident categories, and then reviewed other data sources against this list. Once all the data had been reviewed, the information was then cross referenced to inform the priorities, identified in Appendix 1.

In accordance with NHS England guidance on developing a PSIRP, we also identified and compared the on-going quality improvement work and quality improvement priorities currently in place for the Trust to inform our decision making on the Trust's local patient safety priorities.

Patient Safety Priorities Profile
To inform the Trust priorities (Appendix 1) we have assessed a breadth of data from the LCH Incident Management system (RLDatix ®) and other Trust information systems, which included incidents, complaints, inquests, claims and mortality data (see Table Two and Data review summary table). We also considered our learning from incidents, causal and contributory factors from incident reviews, post infection reviews and safeguarding reviews. The soft intelligence gained through our engagement phase has also been used to inform our priorities.

A period of four years (1 April 2019- 31 March 2022) was used to inform our priorities to include one-year pre COVID-19 pandemic in this first Patient Safety Incident Response Plan. The diagram below depicts the data reviewed.

Infographic one: Overview of data reviewed

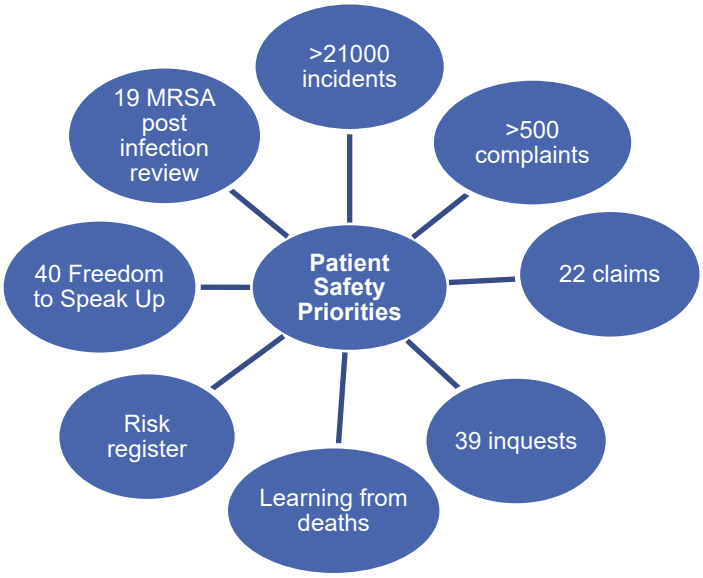

Table two: Data review summary:

Incidents: There were 21,353 incidents recorded during the four-year period. This is broken down by annual incidence within the table below. As expected, the data shows an increase in incidents for the 2020/21 period which coincides with the onset and first lockdown of the COVID-19 pandemic.

Year	No. of incidents
2019/20	4779
2020/21	6139
2021/22	5065
2022/23	5370

The highest reported category of incidents, annually and in total, in order, was:

- Skin damage
- Patient falls
- Medication
- Access/ admission/ appointment/ transfer/ discharge
- Self-harm
- Implementation of care.

On further analysis, although medication was the third most frequently reported incident, quarterly analysis by the medicines management team shows these generally occurred because of a preceding incident, for example, a missed visit. These incidents were predominantly no or low harm incidents (99.5%) with the remaining 0.5% of medication incidents resulting in moderate or major harm. During the period analysed only one incident (0.02%) was identified to meet the Serious Incident Framework (2015) criteria. As these incidents are already subject to a quarterly specialist review, they will not be included as a specific priority.

A detailed review was completed of the access/ admission/ appointment/ transfer/ discharge category. Given the breadth of this reporting category the sub-categories were reviewed and

individually these were small numbers of incidents with low / no harm. The category will therefore not be included within specific priorities. Self-harm was the fourth highest category during the total period. Most of these incidents were related to a Tier Three Inpatient CAMHS provision and incidence reduced when that service was transferred to another care provider in April 2021. However, the Trust continues to support children and young people within our Secure Estate provisions of Adel Beck Secure Children's Home and HMP Wetherby Youth Offending Institute. Whilst most self-harm incidents are low harm, there can be a cumulative psychological effect on these children that results in moderate or major harm. Therefore, self-harm will be captured as a local Trust priority. Although most of these self-harm incidents occur within the Secure Estate, the Trust also provide other services i.e. Community CAMHS and Leeds Mental Wellbeing Service, where self-harm is a heightened risk. We will therefore consider self-harm within these other services over the initial term of the plan and consider this within future iterations of the PSIRP. There is no data to indicate this is required within this initial plan. To ensure learning continues to be captured from incidents resulting in moderate or major harm a local priority will be captured to review all moderate or major incidents for consideration of a Patient Safety Investigation and against the legal Duty or Candour regulation.
Serious Incidents: There were 261 serious incidents reported for the four-year period, and when cross referenced with the above data 112 (42.9%) related to pressure ulcers, 54 (20.6%) to falls, and 20 (7.6%) for self-harm.
Complaints: There were 542 complaints during the period that have been reviewed
Claims: On review of the claims profile over the period, 36% (8/22) of claims related to wound care including pressure damage and 9% (2/22) related to self-harm, the remaining 55% varied.
Inquests: There were 39 inquests registered with the Trust during the period reviewed. The review of this data has supported the local priority around pressure ulcers and informed the priority for deteriorating patients.
Learning from Deaths: From the Trust learning from death reports, the key themes from mortality review are early identification of the end of life phase for palliative patients, obtaining end of life anticipatory medication, and ensuring people's wishes are know for their end of life through advanced care planning.
Risk Register: A review was completed of the Trust wide clinical and operational risks. There were 117 risks that were reviewed to understand our wider risk profile. Our patient safety priorities will be added as risks to the register.
Freedom To Speak Up: The Freedom to Speak Up Guardian annual report was reviewed. The Freedom to Speak Up Guardian reviewed concerns from the previous four years. Of 374 concerns, 40 were patient safety related. Information held within the overview provided was assessed to be considered within the identified priorities.
Infection Prevention and Control (IPC) Post Infection Reviews: <u>MRSA Bacteraemia:</u> Three years of Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia data was reviewed. Of the 19 reviews for the 2020-2023 period the identified learning was cross system. Although there were no major specific themes for the Trust, there was some learning around deteriorating patient. The Post Infection Reviews (PIR) will now fall under the PSIRP and are captured within the local priorities below.

MSSA Bacteraemia:
As an emerging trend Meticillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia will be reviewed in LCH in line with discussions across Leeds during the term of this initial PSIRP. Individual learning will be identified, managed and this intelligence will then inform the 2025 PSIRP.

Escherichia coli (E. coli)*
All E.coli bacteraemia infections are currently reviewed and a PIR is completed if they occur in an LCH inpatient, where the bacteraemia is cited in Part One of a death certificate or where the Infection Prevention Control (IPC) team identify a specific trend in review findings. This approach will continue and the approach is captured within the local priorities below.

Clostridium Difficile
Reviews for Clostridium Difficile (C. Diff)* over the three year time period has found both an increasing trend (consistent with national trends) and similar learning to the national learning and therefore they will not inform a PSIRP priority at this stage. Reviews will continue within the IPC team as part of the Trust's contractual requirements.

*Due to changing processes during the time period reviewed, the dataset cannot be reliably quantified and therefore qualitative data has been used to inform this version of the PSIRP.

Health Equity

Health equity is a priority for the Trust and we currently consider patient safety incidents against the equity domains for those incidents. At present we have reporting that includes falls, pressure ulcer, medication and access incidents and mortality reviews and these are considered in relation to deprivation, ethnicity, age, learning difficulty, Autism Spectrum Disorder and communication requirements. This is being prioritised also for incidents of deteriorating patient / sepsis. Whilst implementing reporting changes in response to PSIRF we will aim to deliver the ability to assess equity across all patient safety incidents to allow us to identify groups at risk of poor access, poor experiences or poor outcomes to deliver targeted improvements to reduce health inequalities.

Acknowledging patient safety incidents are experienced unequally with increasing evidence of disparities in healthcare outcomes we are also committed to identifying whether and how current patient safety culture and mechanisms contribute to such health inequalities. Each of the Trust wide improvement plans referred to in Appendix 3 will include dedicated actions to ensure we view health inequalities through the lens of patient safety to generate tangible actions for improvement.

Stakeholder Engagement

The identification and agreement of our patient safety profile / priorities was a collaborative process that involved the people described in Appendix 2.

The proposed priorities were shared with our stakeholders for their feedback. Our patient safety specialists sought feedback from their respective areas in teams and with individuals including clinical and non-clinical staff. Colleagues were asked whether the safety priorities felt appropriate and were specifically asked, “do you agree with these priorities and what else would you add?”.

Patient safety incident response plan: national requirements

The national requirements and how we will respond to these are detailed in Appendix 3.

Patient safety incident response plan: local focus

This part of the plan outlines our local priorities for the period 1 January 2023 to 31 March 2025. These priorities are detailed within Appendix 1 and are based on the review of local data as described above.

In relation to the local safety priorities, the Trust will apply one of three principles in the way we will respond to incidents:

1. Where safety issues are well understood and/or improvement plans are well developed, we will ensure the details of the patient safety incident is added to the improvement project and consider no further investigation, with time and people resource focussing on the improvement activity.
2. Where contributory factors are not well understood and/or where local improvement work is still being developed, we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.
3. Where it is not clear if there is further learning in relation to an improvement plan OR where the incident highlights an area for future learning / improvement we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.

For incidents that are not related to local safety priorities but warrant further review we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning, on a case-by-case basis.

For each local safety priority underpinned by a Trust wide improvement plan, we will assess the quality of the improvement plan ensuring it is systems based e.g. ensuring that all known contributory factors have been addressed, and using appropriate data to measure progress. The plans will be signed off by the relevant committees and executive lead.

Ongoing progress against the plans and tracking of subsequent incident trends will be monitored by the relevant improvement group and overseen by the relevant Trust committee.

The table below defines the criteria the Trust will use to decide which incidents require a Patient Safety Incident Investigation (PSII) to be undertaken.

Table Three – PSII criteria

Criteria for PSII response	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding • Likelihood of influencing healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII • Value: extent of overlap with other improvement work; adequacy of past actions
Systemic risk	• Complexity of interactions between different parts of the healthcare system

Appendix 1: Local patient safety priorities

Priority	Patient safety incident type or issue	Planned response / Sampling technique	Improvement route
1.	Pressure damage with lapses in care causing moderate, major harm or death	Any incident with themes corresponding to the Trust Pressure Ulcer Improvement Plan will be managed via the associated improvement group. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, After Action Review (AAR), SWARM huddle, Multidisciplinary Team (MDT) review.	Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes PSII actions will be added and monitored through Datix. A quarterly PSIRF newsletter will be distributed to include learning from each improvement group.
2.	Patient falls with lapses in care and resulting in moderate, major harm or death	Any incident with themes corresponding to the Trust Falls Improvement Plan will be managed via the associated improvement group. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, AAR, SWARM, MDT.	Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes PSII actions will be added and monitored through Datix.

			A quarterly PSIRF newsletter will be distributed to include learning from each improvement group ABU audit CBU / SBU investigators share with safety team to cross reference with improvement plans
3.	Implementing care / deteriorating patient resulting in delayed admission to hospital or death	Thematic review of failure to recognise the deteriorating patient (review of incidents from 12 Dec 2023-12 Feb 2024) to inform a new Trust Improvement Plan which will be managed via the associated Deteriorating Patient Improvement Group. The Once established, new incidents will follow the approach of Priority 1 and 2.	Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes PSII actions will be added and monitored through Datix. A quarterly PSIRF newsletter will be distributed to include learning from each improvement group
4.	Successive minimal harm, self-harm incidents in children and young people within the Trusts secure estate	After ten consecutive low harm incidents (or less if clinical review suggests repeated incidents equate to moderate harm sooner or continued concerns despite weekly review within secure estate) related to the same young person in a secure estate, a moderate harm incident will be reported for the same young person to assess the longer-term impact on their psychological harm.	All self-harm incidents discussed at the weekly secure estate patient safety panel for initial review. This includes HMP staff and LCH Quality Lead. Where assessed as cumulative moderate harm, case will be escalated to LCH Rapid Review. Appropriate learning response will be determined at rapid review meeting

5.	MRSA bacteraemia with LCH involvement.	A PSII will be completed where a PIR would have been completed	Learning and improvement to be determined by PSII and added to Datix to track actions. These will also be aligned with a Trust Improvement Plan if relevant Learning will also continue to be shared at IPC Committee with a resultant flash report to QAIG
Additional incident management processes:			
6.	Moderate and major harm incident relating to the clinical triage process in Neighbourhood Teams.	Service led improvement plan. This is expected to be a short-term (<6 months) local plan. If recurrent themes and trends continue this will be considered for future iterations of the PSIRP.	
7.	Moderate and major harm incidents (outside of priority 1, 2 and 3) will be reviewed for Patient Safety Incident Investigation consideration.	Initial service level review / learning to be cross referenced against the Trust Improvement Plans and managed in line with principles described in the PSIRP. A review of the legal requirement for Duty of Candour will be completed for all.	
8.	Moderate and major harm incidents relating to meatal tears	Any incident with themes corresponding to the specialist service (CUCS) Improvement Plan will be managed via the ongoing improvement work. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, AAR, SWARM, MDT.	
9.	Review of all E.coli bacteraemia, where circumstance is any of the following:	Initial IPC review against the relevant Trust Improvement Plan	

	• LCH inpatient, • E. coli is specified on Part One of a death certificate • Identified trend by the IPC Team.	Where new learning is identified, further review will be through a Rapid Review. A review of legal Duty of Candour will be completed for all.	
10.	Near miss or no / low harm incidents identified to be high risk by the team or via the Business Unit Quality Lead monthly report	Reviewed for learning through a Rapid Review	
11.	Near miss, no and low harm incidents	Service level review and response.	

Appendix 2: Stakeholders

Stakeholder	Involvement
Trust board	The proposed patient safety incident profile (within the PSIRP) was presented to the Trust board for comment and ratification
Quality Committee	The proposed patient safety incident profile (within the PSIRP) was presented to the Quality Committee for comment and approval
Patient Safety Strategy Implementation Group (PSSIG)	The proposed patient safety incident profile (within the PSIRP) was presented to the PSSIG for feedback and discussion
Clinical Business Unit Senior Leadership Teams	The proposed patient safety incident profile (within the PSIRP) was shared with local clinical leads for comment
Front line staff	The patient safety specialists shared the patient safety incident profile with front line staff for comment. Staff feedback was also obtained through conversations at third sector event Q&A drop in sessions were set up as all user invites
Patient safety partners	Patient safety partners were involved via their membership of The Patient Safety Strategy Implementation Group. They were also specifically asked to comment on the safety incident profile and the draft Patient Safety Incident Response Policy and plan.
Third Sector Partners	Our proposed local and national safety priorities were shared for comment through our Third Sector Partner Groups and through the LCH engagement champions forum.
Healthwatch Leeds / Forum Central	The proposed patient safety incident profile was shared for comment
Patients	Our proposed local safety priorities were discussed with patients at engagement activities at both health centres and third sector event
Leeds office of the West Yorkshire Integrated Care Board (ICB)	The proposed patient safety incident profiles (within the PSIRP) were presented to the ICB for comment and final approval.
Partner Trusts	The proposed patient safety incident profile (within the PSIRP) was shared with local clinical leads for comment

Appendix 3: National patient safety requirements

Patient safety incident type	Response	Improvement approach
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Local organisational actions and feed these into the quality improvement activity
Death thought more likely than not to be due to problems in care. This can be identified through an incident and / or the learning from deaths process.	PSII	Local organisational actions and feed these into the quality improvement activity
Deaths of person who has lived with a learning disability or autism	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death LeDeR programme.	Respond to recommendations from LeDeR programme
Child death	Refer to Child Death Review process. If incident meets the learning from deaths criteria undertake a PSII.	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Deaths in custody (e.g. police custody, prison) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO – carry out independent investigations in to deaths and complaints in police custody) or the Independent Office for Police Conduct (IOPC – police complaints watchdog who investigate the most serious complaints and conduct matters) to carry out the relevant investigations.	Respond to recommendations from PPO or IOPC.
Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence 2) adults (over 18 years old) are in receipt of care and support	Refer to local authority safeguarding lead via LCH designated professionals for child and adult safeguarding. LCH will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.

needs from their local authority 3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	
Domestic Homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII, with consideration of any local learning response	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Incidents that meet the statutory Duty of Candour threshold (Regulation 20)	Will be reviewed on individual incident basis to determine most appropriate response to undertake to meet regulation 20	

Summary of stakeholder feedback

Stakeholder	Response
Peoples Voice partnership & Healthwatch Volunteer Group	1/12/2023 – response from Healthwatch Leeds Board Directors I particularly support the inclusion of self-harm as a local priority and the development of the equity domains to enable effective analysis of patient safety incidents occurring within the identified vulnerable groups. The approach is data led and has resulted in the prioritisation of the most frequent incident types. This is logical. Subsequently, each priority type is to be dealt with by the appropriate working specialist group, and results fed back/distributed for the purpose of learning. Again, logical. However, in my experience with patient safety, this data driven approach alone tends not to lead to the organisational change needed to promote a more mature safety culture - looking at lagging indicators (reactive scrutiny when something has gone wrong) is not as fruitful in the long run as focussing on leading indicators (looking proactively at measures designed to prevent things going wrong). I have gone through this framework and it looks good to me and complies with the NHS Framework and requirements. Requested copy of Trust Improvement Plans – sent topic areas for PU, whilst improvement plans being worked up
Third sector event	21/11/23 LCH staff member • Staff member stated that narrative regarding PSIRF/priorities needs to be visible for staff on wards especially services linked to priorities. • A service has pressure ulcer champions and feels that this is an important role to share information/updates regarding PSIRF through. • Staff member discussed around good and bad practice; staff member stated if staff have bad practice in regards to priority areas this is then new staff members may pick this up. • Staff member discussed how many new staff will complete the care certificate and feels this may be a tick box exercise and further training with eg pressure ulcer categorising is required. 12 other staff spoken to from LCH – all need further awareness and understanding of PSIRF/PSIRP – weekly Q&A drop in sessions established in Dec and remain ongoing
Forum Central	7/11/23 Suggested engagement events which he would promote through networks – undertaken by Patient engagement manager and Patient Safety Partner.
ICB	27/11/23 Overall, we are pleased with the level of detail and dedication evident in identifying your priorities. We fully align with these priorities. However, upon reviewing the attached document, you'll note that our comments predominantly focus on

	certain aspects of the PSIRP, such as support mechanisms for those affected and staff, as well as the approach to incident closure. In summary, • PSIRP designed according to national requirements. • May benefit from some signposting (and hyperlinks) to guidance and other relevant documents. • Would be helpful to see reference to how patients will be engaged in the processes and at strategic level (e.g plans for PSP's) • Would be helpful to highlight the different types of review that might be used to investigate patient safety events
Health & Justice Leeds / NHSE commissioner	No response
Coroners (Wakefield)	No response
(Bradford)	No response
CQC	No response
SWYFT	6/11/23 I've had a read of your plan and I feel it is reflective from a SWYPFT perspective. I was hoping to see self-harm in secure estate, which you have in there, and like the approach of sticking with the rapid review process for these. I haven't any other comments, apart from it is really well written and easy to understand.
LTHT	27/11/23 The local patient safety priorities you have identified are consistent with those identified in other PSIRPs, and these are linked to existing improvement plans, or used to inform the development of improvement plans, which is consistent with the PSIRF.
Patient Safety partners	29/11/23 Why will we only review self-harm in children after the 10th occasion – shared that the child concerned would have wrapover clinical and medical support at the time of the incident and an ongoing careplan but after 10 consecutive incidents we would complete a central review to ensure the care package was appropriate and meeting their needs and whether the lower harm incidents were equating to a higher harm psychological impact. No further questions.
Engagement event	**Patient -** • Priority was appropriate for him re falls, felt this priority was important. • Positive experience of care, felt staff communicated well, received all the information he needed. • Was asked if he felt someone wanted to come out, felt listened to and included in processes. • Noted that having a name to a face is important. • During his care, patient felt safe in the environment and felt if needed he could raise concerns around his safety.

	Key Theme – Communication throughout his care, knowing who he could speak to and how he could raise concerns around safety, felt being involved in his care was important. This will be considered within the Trust response to Part A of the Involving Patients in Patient Safety Framework. **Patient** – • Felt if he felt concerned around patient safety, he would raise this through GP as a point of contact. • Hospital setting would be different would want to raise this through a third party, feels this option is important. • Felt that removing blame culture is key, patient felt that when removing this staff will not be as defensive. • Patient felt that in certain circumstances if he complained around patient safety his care he would then be treated differently, or care would be removed. Key Theme – Patients having a key point of contact in regard to raising concerns about safety, importance around removing blame culture and enabling patients to voice concerns without feeling care would be different. This will be considered within the Trust response to Part A of the Involving Patients in Patient Safety Framework.
Engagement champion network	Covered in above sections
Board	12/11/23 It seems to be an extremely good and comprehensive piece of work, but much of the relevance and the risk issues will fall into the detail of LCH work and delivery – noting the multivarious types of activity carried out across the Trust. So, on the face of it – fine, but would equally welcome the views and knowledge of others in order for you to make the necessary adjustments and improvements that you are seeking. It will be very important to capture the views of first line managers and patients.
Quality Committee	23/11/23 Generally agree with the priorities within the Plan but feel that use of data to drive the prioritisation process and further actions is lacking. I know you talk about getting a full data set on page 7 but you don't say what this will look like, what the data will be used for and when this data set will be completed. I think you should say more about this in the equity paragraph and also in the appendix 3, local patient priorities, there should be a 6th priority about use of data to highlight/respond to evidence of disproportionality in patient outcomes or experience. ACTION: Updated wording in health equity section. Not requiring a specific priority as Trust approach within Health Equity Strategy and this will be a golden thread through each improvement plan so operationalised
	14/11/23

	Personal preference that the priorities should be within the main document given it is these that you will be reporting on. I like the national and local elements. Provided clarification in response to question about medication incidents will be reported (would be within priority 7 if moderate or major harm, low / no harm continue to be reviewed in quarterly medicines management report). Priority 4 - where did the number 10 come from in relation to self harm incidents for an individual? (Priority reviewed given volume of feedback on this)
Equity lead	No response
ABU Clinical Quality Managers (CQMs)	Collective response 20/12/23 Clarification over meaning of swarm huddle, no other comments
BU Clinical leads	22/12/23 Correction of ABU service list Addition of equity data in mortality reviews
Quality Leads	1/12/23 Clarity regarding CBU service list
	14/12/2023 Clarity on ABU service list provided Question regarding “10 self harm” incidents
	23/11/23 Clear and Appendix 3 was consistent with the narrative explained within the plan so no further comment
	10/11/23 Re-wording suggestions to various parts of the document to improve flow and understanding Query regarding the cases to be involved in thematic review for priority 3
	13/11/23 CUCS name corrected ICB name corrected Clarity added regarding the difference between PPO and IOPC (page 9) Corrected wording re Domestic Homicide (page 11) Linkage to local priorities corrected – from priority 1 and 2 to priority 7 Priority 7 made clear this is incidents outside of priority 1,2 and 3 Added in priority 8
Other internal	7/11/23 LCH Safeguarding Team Feels like the national priorities have safeguarding in its wider remit, covered. Based on LCH data analysis of the highest categories of incidents and from my specialist reviewing of Datix, self-harm does feel appropriate to have as an LCH priority.

	Agree with the priorities. Understandably most of the priorities appear to be adult focused I wonder if specifically looking at what kind of children's Datix, complaints etc. come through might be useful to identify other child focused learning With regards the 10 consecutive self-harm incidents - allocating a number of incidents can work alongside clinical decision making and great that we are looking to ensure the corrosiveness of repeated self-harm is explored. Would like to see clearer narrative that not a matter of waiting for 10 incidents, if repeated incidents before that equate to moderate harm. ACTION: Specific narrative related to CYP incidents for next iteration. ACTION: Change narrative around number of self-harm incidents to reflect above Library services 24/11/23 Numerous comments to improve readability – all applied. Question about how is the learning from the improvement groups going to be captured and shared, addressed within policy Library team directly linked with improvement group chairs to see if there is more support that we can give to support these Trust priority areas – completed.

Trust Board Meeting held in public: 2 February 2024

Agenda item number: 2023-24 (112)

Title: Frontline Digitisation Update

Category of paper: Approval

History:

This proposal has been approved by the Business Committee on 24/01/24

Responsible director: Executive Director of Finance
Report author: Associate Director of Digital Transformation

Executive summary (Purpose and main points)
The purpose of this document is to request approval to proceed with the plans to utilise the National Frontline Digitisation funding for 2023/24.

Recommendations
It is recommended that the Board notes the plans and approves the allocation of funding against these plans.

Frontline Digitisation Update

1 Introduction

Levels of digitisation across health and social care is variable. In order to maximise the benefits of digital transformation for patients and clinicians, and to harness the power of data, the NHS is investing £1.9bn to ensure there are the right digital foundations in place. This is a three year programme of funding running from 2022/23 to 2024/25.

The investment will support the roll-out and maturity of electronic patient records (EPRs) to drive care quality and efficiency which in turn will release efficiencies back into the NHS.

This will ensure that health and social care staff have the technology they need to do their jobs, and that these systems can talk to each other to share vital information to support the delivery of care without adding additional burden. It will also help ensure people have an improved, safer experience of care, more convenient access to care and support of new tools that allow them to manage their own health and wellbeing needs.

The Trust were initially awarded three year funding allocations but made the decision not to drawdown funding in 2022/23 due to the limited work that could progress in the timeframes. There was also an opportunity in 2023/24 to apply for additional funding due to underspend funding. The following funding profile has now been confirmed:-

Year	Capital Allocation ('000)	Revenue Allocation ('000)	Capital Underspend ('000)	Revenue Underspend ('000)	TOTAL ('000)
2023/24	£1,194	£351	£554	£92	£2,191
2024/25	£1,306	£371			£1,677

2 Background

This proposal has been approved by the Business Committee on 24/01/24 and the members were supportive of the approach. Prior to this, the Chief Executive Officer had reviewed and signed the NHS England Investment Agreement to confirm support for the funding award.

3 Current position/main body of the report

The Trust's business case for utilising funds for 2023/4 reflects the strategic priorities identified in the newly refreshed LCH Digital Strategy 2023/4 to 2025/6 and is also aligned to NHS Digital 'What Good Looks Like [WGLL] standards, and finally to areas in need of further development as identified by the recently published (April 2023) Digital Maturity Index for LCH.

Our Digital Strategy identifies a number of digital projects to be undertaken over the next three years which include several to commence in 2023/4. Frontline Digitisation (FD) funding will be utilised to support a number of those projects. This Investment

Agreement therefore outlines the overall aims of these projects collectively in delivering our Digital Strategy.

The proposals will support the path to digital transformation enabling staff and patients to take advantage of new digital products and service to deliver care in more productive, effective and safer ways. The Digital Strategy and plans within it actively supports the Trust to deliver outstanding care and be responsive to the needs of our populations as we deliver safe and effective care on our journey to outstanding care, by enhancing the care we can deliver through digital solutions. It also ensures our workforce community is able to deliver the best possible care in all of the communities that we work with, by enabling our staff and services to utilise digital technology to enhance patient care and to maximise the scope, reach and impact of our services. The strategic investments also support our goal to use our resources wisely and efficiently and supports and enables the Trust to improve how we work in partnership to deliver integrated care, care closer to home and reduce health inequalities; the focus of enabling staff and service to use digital technology is to provide increasingly safer, and more effective, responsive care for our patients.

The key priorities of our Quality Strategy include transition to the national Patient Safety Strategy, embedding and maximising the impact of Learning, embedding Equity in our approaches to quality and patient safety, and to Develop Collaborative Governance Structures at Leeds Place.

Achievement of the Digital Strategy priorities will support achievement of the Quality Strategy priorities as staff, services, patients are supported to utilise technology to support patient care and outcomes. Utilising digital approaches will support our approach to learning, adoption of the Patient Safety Strategy, support innovative ways of considering equity within quality and will support methods of integrated and partnership approaches to governance.

With a mature EPR solution in place, the Digital Strategy builds on this foundation, utilising new functionality or bringing in digital tools and services which work alongside the core EPR.

A plan of the funding portfolio is detailed at Annex1.

4 Next steps

The next steps of the approach are to conclude the current procurements that are open, to award contracts for additional technologies to be implemented. Liaise with finance colleagues around implications of utilising funding for additional resources. Drawdown the National funding. Determine the plan for utilisation of the funding award for 2024/25 and follow NHS England approvals process.

5 Recommendations

The Board is recommended to note the plans and approve the allocation of funding against these plans for the 2023.

Annex 1: 2023/24 Funding proposals

Project		2023/24 Funding		Status
Name	**Description**	**Capital**	**Revenue**	
Patient Information Hub / Electronic letters	Web system to provide patients with centralised access to information, training, leaflets, guidance, etc. EPR integrated system to provide patients with digital access to letters.	£220,000	Funds for 1wte PM and 1wte BA	• Resources funded and recruited. • Electronic letters procurement underway, currently evaluating responses, BC and decision by early March. • Patient Hub requirements gathering underway. Cross-checking with Sexual Health web-site requirements – Jan-24.
EPR Optimisation	Development of EPR in use across all LCH Services to make best use of new digital capabilities available, including patient communication and self-management tools.	£0	Funding for 2 WTE CAs	• Resources have been recruited (Jan and Feb starts) • Project scoping underway – PID / Plans by Feb.
IT Hardware (laptops / phones)	Provision and replacements of mobile digital devices (laptops, phones, tablets) to enable staff to make full use of digital tools available to support delivery of care.	£854,000		• Phone and IT requirements checked and planned for.
Business Continuity solutions	Implementation of advanced business continuity processes and solutions across all LCH Services, to ensure that Services can continue functioning in the event of a major loss of EPR / digital systems.	£30,000		• Still exploring options, including external NHS provision or internal web-development. Decision by Feb

Project		2023/24 Funding		Status
Name	**Description**	**Capital**	**Revenue**	
HEARTT Algorithm	HEARTT patient prioritisation tool based on health equity to enable active waiting list management.	£235,000		• Database / informatics expertise to be recruited into the Business Intelligence team asap.
Wound Care app	Service specific app to support wound care management	£100,000	£5,000	• Out to procurement – evaluation to start end January. • BC and decision by early March 2024.
MYMUP 3rd sector Integration	MYMUP Digital is a simple, but powerful, recording, reporting and self help tool, designed in collaboration with service users and health care professionals.	£51,000	£22,000	• Further demo's and use-case exploration due to take place Jan/Feb 2024.
LMWS & Community EPR Integration / Robotic Process Automation [RPA]	To enable more integrated working across the system the different EPRs need to be integrated and enable information sharing across all involved in the Community transformation programme. Direct integration preferable, but RPA offers alternative solution and wider time/cost saving benefits for LCH.	£168,000		• Have explored local NHS and Contractor options to evaluate integration, currently contractor option circa £30k. • RPA – Exploring joint funding proposal with LCC / ICB to utilise LTHT solution and alternative options. Final proposal by Feb 2024.
Video Observed Treatment (VOT) for TB	VOT will enable patients on TB treatment regimes to be actively supported in adhering to the treatment protocol for the duration of their treatment. This will	£15,000		• Service to complete DPIA and Clinical Safety assessments required for wider use of system. • Service to engage with supplier to secure contract extension by March 2024.

Project		2023/24 Funding		Status
Name	**Description**	**Capital**	**Revenue**	
	increase compliance and outcomes for patient with TB.			
Patient allocation automation tool	The manual process of allocating work within the neighbourhood teams represents a significant amount of time for both clinical and admin staff. The introduction of a digital tool to automate this process would enable more patient focused time.		£50,000	• Nov Business Committee extended pause and project is pursuing set up and testing of integration asap. Dependent upon LCC/ICB infrastructure support.

Trust Board meeting held in public: 2 February 2024

Agenda item number: 2023-24 (115)

Title: Information Governance and Data Protection Officer update

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Category of paper: For assurance
History: Audit Committee 15 December 2023

Responsible director: Executive Director of Finance and Resources
Report author: Head of IG & DPO

Executive summary (Purpose and main points)

The report briefs the Board on the IG agenda progression, the activities of the IG team, and the responsibilities of the Office of DPO.

This report covers the DSPT (and associated workstreams), Statutory requests, Data Breaches and the other functions of the IG Team and Office of DPO.

Issues for consideration

The Data Protection and Cyber Security Panel has been found to be a sub optimal way in which to manage risk and provide/receive assurance and following a review of its effectiveness, is being moved to an "operational group" (to discuss IG related workstreams) and an "approval group" (to approve the recommendation of the operational group, receive assurance, and provide assurance to the Audit Committee).

The ToR for these groups, and the rationale for changes, are included within this update as appendices- the committee is asked to review and approve these changes.

Due to SIRO absence there has not been a quorum for the Data Protection and Cyber Security Panel since August. At SIRO request an update was provided for Audit Committee re specific activity carried out by the IG Team, however I am unsure if this was presented- it has been added as an appendix to this update

Data Security & Protection Toolkit (DSPT)

Compliance with the DSPT[1] is mandatory for all NHS Trusts & organisations which have access to NHS patient data and systems.

It is a self-assessment based around the ten security standards developed by the National Data Guardian and consists of thirty four assertion areas and 108 required evidence items.

A successful DSPT submission means we are regarded as a "safe pair of hands" for handling NHS data.

An unsuccessful DSPT submission may jeopardise our ability to access key NHS technical infrastructure and data flows, which could impact our ability to deliver care and services to our patients.

DSPT compliance is a requirement for, inter alia:

- Access to HSCN connection
- Access to NHS Datasets
- Contracts with EPR providers
- Contracts to provide medical and health services.

[1] DSPT scope and information < Data Security and Protection Toolkit assessment guides - NHS Digital >

Of note- DSPT compliance does not equate with compliance with GDPR or any other compliance standard.

The DSPT has been successfully completed for the assessment year 2022-2023

- Baseline assessment submitted – 28 February 2023
- Final Assessment submitted – 26 June 2023

The 2023/2024 DSPT was released in August, a baseline submission will be required in February and a final submission in June.

There may be significant changes to the DSPT next year- over the years the successive iterations of the DSPT and its predecessor have become increasingly focused on IT (two thirds of the current assertions require a response form the Trust's IT team) and cyber security rather than Information Governance and Data Protection.

It is expected that this trend will continue and that the forthcoming DSPT will be likely to align with the National Cyber Security Centre's (NCSC) Cyber Assurance Framework[2] (CAF).

A working group has been formed to ensure that the DSPT will be completed satisfactorily, and a workplan has been provided to IT which covers their required assertions (76 of the 108 required) .

At the time of submission there are 44 of the 108 items completed, awaiting confirmation from IT re their progress.

As a requirement of the DSPT submission we were subject to an independent DSPT Audit conducted by Audit Yorkshire, to the specification stipulated by NHSE/D[3]. This audit has identified a number of actions and areas for improvement.

There are several areas that have been identified internally from the DSPT workstreams where the Trust could improve performance, including:

- Cyber/information Security controls
- The management of Information Asset Register (IAR)
- Risk visibility and management of information risks
- Training Compliance

Action Plans have been put in place to remedy these shortcomings:

- Cyber/Information Security controls

[2] NSCS CAF Guidance < https://www.ncsc.gov.uk/collection/caf#:~:text=The%20National%20Cyber%20Security%20Centre,guidance%20linked%20from%20this%20collection >
[3] NHS Digital DSPT Audit Framework < https://www.dsptoolkit.nhs.uk/Help/Attachment/707

The Trust has successfully completed Cyber Essentials accreditation[4], and is working towards Cyber Essentials Plus[5], subject to an external audit.

We plan to achieve compliance with IASME[6] within the next year.

- The management of Information Asset Register

A review of the Information Assets held by the Trust is being conducted, as many service's Information Assets have not been reviewed for some years due to pandemic pressures, and some services have not been reviewed at all.

It is envisaged that the IAR will be a rolling process, rather than a once yearly exercise, and will reinforce GDPR compliance[7] and add value[8] to the Trust by ensuring we know what information we hold and who is responsible for it.[9]

The Records Management Policy will be reviewed in conjunction with the IAR review, and the IG Team intends that Asset Register, and Records Management across the Trust as a whole, will comply with ISO14589[10]. There is a planned Records Management Audit that will inform this process.

- Risk visibility and management of information risks

A subgroup made up of Head of Informatics teams is being set up to improve visibility of information risks, and to address and mitigate those risks- these will be discussed as part of the IG Operational Group Standing Agenda

- Training Compliance

Training compliance with Mandatory Data Security Awareness training has increased from 86% to 96% this has been achieved using weekly reminders and by maintaining a "lockout list" whereby all those staff whose training is more than two weeks out of date have had access to S1 suspended until evidence of completed training is supplied.

The 2023/2014 DSPT training requirement has changed from the traditional 95% target, and now offers a greater degree of flexibility in regard to training that is relevant to the staff members role. The IG training matrix has been updated to include this, and discussions are ongoing regarding new content to add to the ESR training package.

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[4] Government pages re Cyber Essentials < https://www.gov.uk/government/publications/cyber-essentials-scheme-overview >
[5] Cyber Essentials Plus National Cyber Security Centre < https://www.ncsc.gov.uk/cyberessentials/overview
[6] IASME cyber security assurance < https://iasme.co.uk/iasme-cyber-assurance/ >
[7] GDPR Article 30 "Records of processing activities" < https://www.legislation.gov.uk/eur/2016/679/article/30 >
[8] *"The world's five most valuable companies are worth £3.5 trillion together but their balance sheets report just £172 billion of tangible assets. 95% of their value is in the form of intangible assets, including intellectual property, data and other knowledge assets."* <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/752003/Getting_smart_about_intellectual_property_and_other_intangibles_in_the_public_sector_-_Budget_2018.pdf >
[9] National Archives guidance regarding Information Asset Registers < https://cdn.nationalarchives.gov.uk/documents/information-management/info-asset-register-factsheet.pdf >
[10] ISO 15489-1:2016 Records management < https://www.iso.org/standard/62542.html >

Statutory requests and Data Breaches

Please see attached screenshots within the appendix showing levels of:

- Subject Access Requests
- Freedom of Information Requests
- Data Breaches

Data Requests

The volume of requests for data continues to be high.

The graphs within the appendix show quarterly figures for requests and data breaches, and show the trends over the last year.

Data Breaches

Please see attached screenshots within the appendix showing numbers of data breaches, sourced from Datix.

All data breaches are evaluated by the IG team and graded by the IG Team against our NHS Digital aligned policy[11] , and if they meet the appropriate threshold they are reported via DSPT to the ICO and/or DHSC as appropriate.

Reportable Data Breaches

Since the update to the Audit Committee in July 2023 there have been three data breaches that the Trust has evaluated as reaching the threshold to report via the DSPT[12], of these:

- One did not meet the threshold to be reported to either the ICO or DHSC.
- Two were reportable to the ICO.
- None were reportable to the DHSC.

The ICO has been satisfied with our responses to all these breaches.

Other IG functions:

The committee is asked to also consider the other work done by the IG Team and Office of DPO to support the Trust. This includes, but is not limited to:

- Data Privacy Impact Assessments
- Records management and retention
- Confidentiality and Caldicott support
- IG policies/procedures
- Information Risk Management
- Information Security

[11] IG-005 Data Breach Management < IG-005: Data Breach Management (lch.oak.com) >
[12] DSPT data Breach Reporting Tool < https://www.dsptoolkit.nhs.uk/Incidents >

- IG Related Queries, Advice and Guidance
- Information Sharing Agreements / Data Processing Agreements/ MoU
- Development of interagency data sharing models
- Contract Clause Development and Review
- Review of Service Tender submissions
- Induction / Bespoke Training for staff
- Personal Data Handling Audits
- Communications / Website/ Publication scheme

Recommendations

- The Board is asked to note the work undertaken during this period and that the Audit Committee approved the Terms of Reference for the changes to the IG groups.

Appendices

Appendix 1

Statutory requests and Data Breaches since last update (July 2023)

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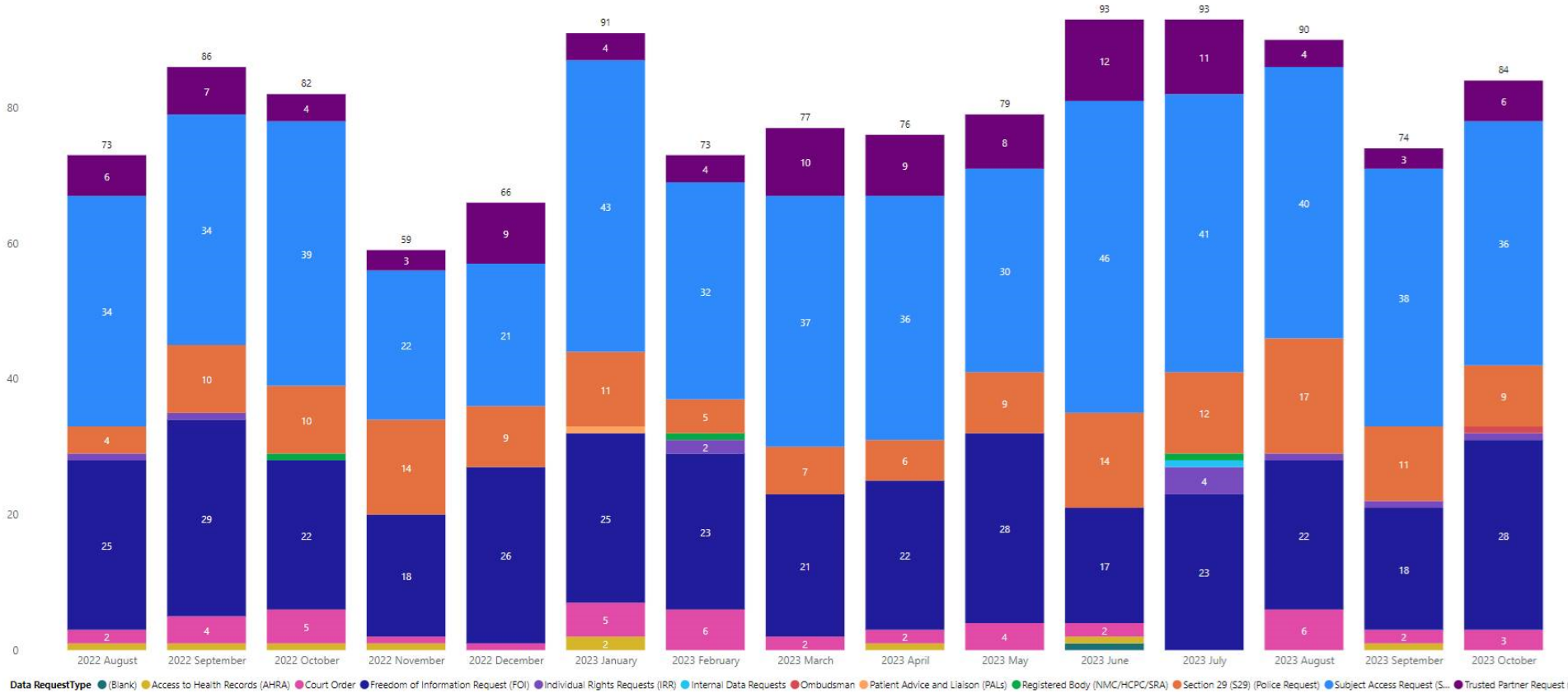
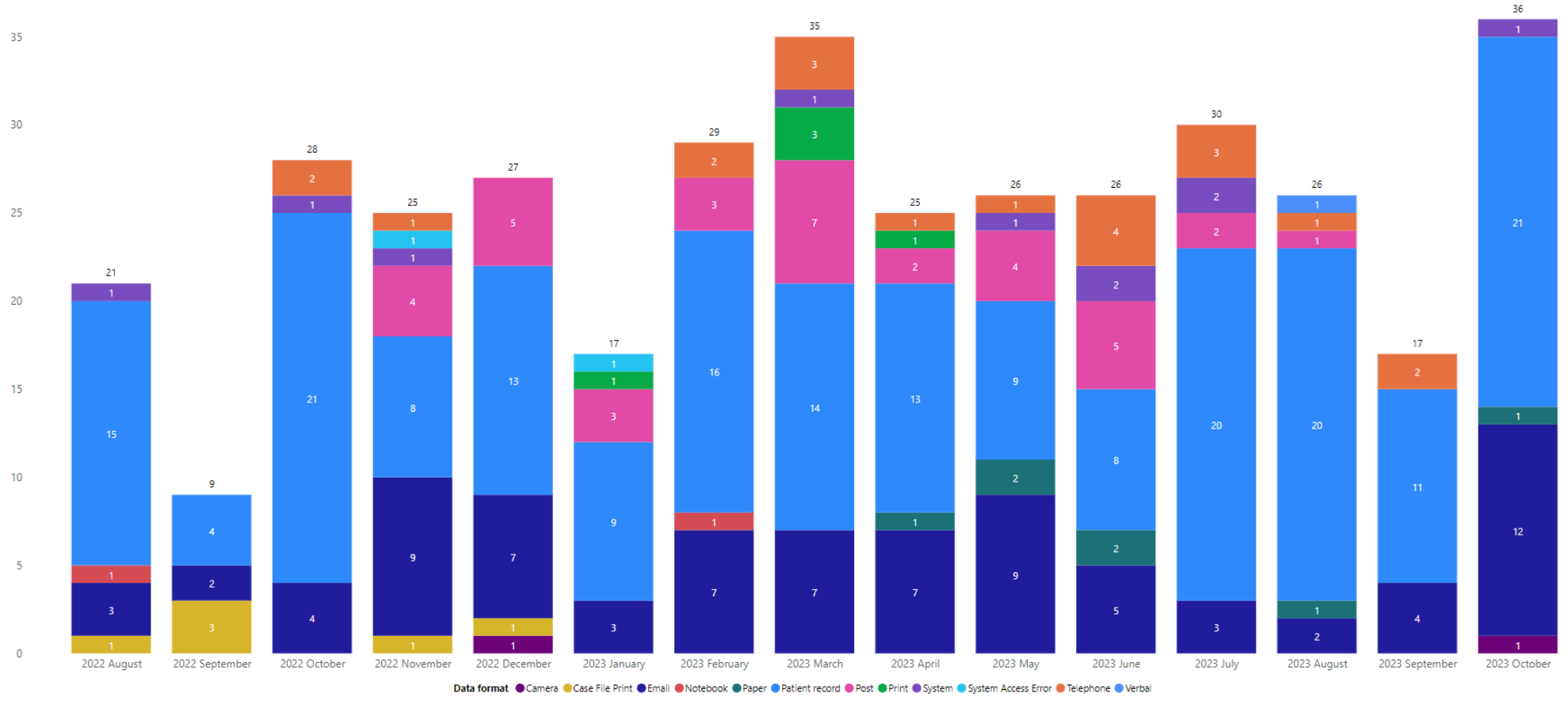
Data Requests



Data.

Data Breaches



Appendix 2

DATA PROTECTION & CYBER SECURITY PANEL
Update October 2023 in lieu of Panel

DATA PROTECTION & CYBER SECURITY PANEL
Update October 2023 in lieu of Panel

The Activities of the IG Team have included:

Data Protection Impact Assessments (DPIAs) in progress • Transfer of Care- Approved • Allocate- sent for approval • Clinical Partners/CAMHS- ongoing • Niche/WYICB CMHT evaluation- ongoing (discussion regarding release of data) • People Safe- sent for approval • My Diabetes- ongoing • Abbott Diabetes- ongoing • Dentally- ongoing • Dr Julian- ongoing • Loop- ongoing • ATS- ongoing • TB VOT- ongoing • Staff Wellbeing- ongoing • Joy- sent for approval • CHWS- ongoing • Inhealthcare- on hold • Moodle- ongoing
Information Sharing Agreements / Memorandum of Understanding / Data Processing Agreements • CMHT evaluation- ongoing discussion regarding release of data • YHCR- Approved • CPIP- for approval • CME- under review
Data Requests • CMHT evaluation- ongoing discussion regarding release of data
DSPT • New DSPT specification released, work ongoing to complete. • Separate workplan created for IT and distributed to IT for action

• Working Group set up • Baseline Audit submission required for end February • Full submission required end June
DSPT Audit • DSPT Audit spec released, significantly different to last year (which was a repeat of 2021/2022) • Audit brief expected from Audit Yorkshire late this year
N365 • DPIA completed • Policy re N365 usage submitted for ratification • Requirement identified for data labelling/classification scheme
Cyber Security Strategy • The need for a stand alone cyber strategy has been identified, separate to the Trust's Digital strategy • Strategy in initial stages of development, informed by CE+ • Proposed IASME cyber accreditation for 2024/25 (aligned to ISO27001) • Significant Trust investment to support our Cyber resilience, including upgrade firewall capability, vulnerability scanning and patch management tools
Cyber Essentials+ progress update • CE+ schedule for 30th November
Information Asset Register • Development of Trust Wide IAR
Privacy and Transparency notices • Extensive rewrite of Trust Privacy Notice • Creation of new Staff Privacy Notice
SIRO training • SIRO Training completed by Yasmin Ahmad, Richard Slough and Steve Creighton
Expansion of Caldicott Function • Deputy CG now in place • CG training completed by Geraint Jones and Steve Creighton • Creation of new Caldicot function mailbox for general Trust usage • Development of internal and external Trust comms re the Caldicott Function
Staff Data • Recognition that the same level of confidentiality should apply to staff data • Development of training resource to cover this

Leaders Network Web Chat & My LCH awareness raising • S170 convictions • IAR • Staff information and confidentiality • Cyber Security • Staff working outside the UK • Caldicott Function Mailbox
Ad hoc projects • Staff working abroad • CMHT Transformation • Wharfedale Recovery Ward • eAllocate • Policy document re amending records in development
Other Audit work (with Audit Yorkshire) • CE+ Audit- complete, with high assurance • Cyber Audit- brief in development • Medical Records Audit- brief in development
BAU functions • IG inbox • DPO inbox • Statutory requests (FOI, SAR, data rights, other requests • Ad Hoc queries re Data Protection, confidentiality, privacy and cyber security

Appendix 3

Changes to “Data Protection and Cyber Security Panel”

Appendix 3.1 Panel changes proposal put forward June 2023

Panel changes proposal

Background

- Structure of IG meetings was amended last autumn to streamline processes and replace the:
    - Information Governance Group
    - Information Security & Review Working Group

- Standing agenda structure defined in ToR
    - New projects
    - IG Dashboard
    - DPIAs
    - DSA/DPA
    - DSPT
    - Cyber essentials
    - IT/Cyber incidents
    - Risk?

Issues

- Unsure as to whether this is an approval or discussion group?
- There doesn’t seem to be the time to discuss **and** approve the various items (and some are specifically for approval, other to be discussed, others for info/assurance)
- Many items not relevant to non IG members
- Doesn’t “add value”?
- Frequently require ad hoc approvals outside the meeting.
- Rigid agenda offers little flexibility

Considerations

- Overall effectiveness?

- Is this effective to the Audit committee/board? (e.g. one IG report submitted over 18 months)
- Currently supplemented by other groups e.g. DPIA review to feed into this, but this is IG only- there does feel to be requirements for a cross informatics group/risk group, DSPT group etc

Timescales

Revised Timescales for meetings:

- "Operational"
    - Monthly Working group meeting (informatics based quorum)
        - Assoc director BI, CCIO
    - Weekly DPIA reviews (IG)
        - CSO
    - Monthly DSPT working group (IG, IT)
    - Cyber
    - Risk
    - HoS

- "Strategic"
    - Monthly approval meeting (SIRO, CG, DPO, Assoc director BI?)

DPIA/DSA/DPA/Process/other approval changes

- Production of executive summary of artefact listing:
    - Purpose
    - Agreements/contracts/relationships in place
    - mechanism
    - Data and Data flow
    - Risks
- Format to be fully agreed
- To be reviewed at "approval" meeting
- To be provided to Audit Committee (if required)

Other assurance requirements of Approval/Strategic group?

- DSPT
- Cyber
- Stat requests
- “projects”
- Horizon scanning
- Clinical safety
- BI/DQ

Other considerations

Role of CG function

Reports to QA

Appendix 3.2

ToR for Operation and Approval groups

Appendix 3.2 (a) Operational Group ToR

Leeds Community Healthcare NHS Trust

Information Governance Working Group – Principles

Aim: To promote and monitor information security within the Trust as an aid to the delivery of effective healthcare.

Membership: The Information Governance Working Group (IGWG) will be made up of:-

- Assistant Director of Business Intelligence(Chair)
- Head of IT
- Head of IG & DPO
- Head of Clinical Systems
- Clinical Safety Officer
- Chief Clinical Information Officer
- SIRO (open invitation)
- Caldicott Guardian (open invitation)

Other members may be incorporated as appropriate for the organisation.
In order to ensure a holistic approach to information security is maintained a variety of other officers will be invited to attend at appropriate meetings. Such officers may include.

- Risk Manager
- Incident & Risk Assurance Manager

Frequency: The Information Governance Working Group will meet on a monthly basis. .

Responsibilities: The Information Governance Working Group will be responsible for:-

Risk Management and identifying any emerging threats through:

- Incident reviews
- (High Severity) CAREcert reviews

- Information Governance / Security Risk reviews

Co-ordinated check, challenge and review

- Data Protection Impact Assessments
- Information security risk assessments
- Clinical safety risk assessments

Information Asset Management

Receiving and reviewing information security related reports (e.g. internal audit)

Reviewing and commenting upon the security impact of information system development.

Reporting: The Information Governance Working Group will report to the Information Governance Approval Group on progression and outcome.

The Information Governance Working Group will escalate any issues / concerns as appropriate to the Information Governance Approval Group.

Appendix 3.2 (b) Approval Group ToR

LEEDS COMMUNITY HEALTHCARE NHS TRUST

Information Governance Approval Group Terms of Reference

Document History:

Version:	1 Draft
Date:	September 2023
Version received by:	Information Governance Approval Group
Date received:	
Ratified by:	Audit Committee
Date ratified:	
Name of author:	Head of Information Governance & Data Protection Officer
Name of responsible committee:	Audit Committee
Date issued:	
Review date:	Nov 2024
Target audience:	Audit Committee Information Governance Approval Group

Contents

Leeds Community Healthcare NHS Trust

Information Governance Approval Group
Terms of reference

1 Introduction

1.1 The Information Governance Approval Group has been established by, and is a sub group of, the Audit Committee. In that capacity it provides assurance to the Audit Committee and in turn to the Trust Board. It is responsible for ensuring that the Trust has effective and robust management arrangements covering all aspects of information governance in line with the Trust's Information Governance aims, i.e.

- Openness, transparency & fairness
- Legal & regulatory compliance
- Information Security Assurance
- Information Risk Management

2 Constitution

2.1 *The Information Governance Approval Group is authorised by the Audit Committee to conduct its activities in accordance with these terms of reference*.

3 Purpose

3.1 The Information Governance Approval Group is the primary approval group for all information governance artefacts, including DPIAs, DSAs, DPA, Policies, processes etc and is chaired by the Trust's Senior Information Risk Owner (SIRO). The Information Governance Approval Group will receive reports and executive summaries from, and monitor the activities of, working groups as required.

3.2 Organisational and managerial structures that support appropriate consideration of IG issues are essential to a properly managed IG work programme to sustain continual improvement, and a summary of activities and issues along with the minutes will be sent to the Audit Committee

3.3 The Caldicott Guardian's role is to ensure that any initiatives presented for approval are congruent with the requirement that confidential information about health and social care service users is used ethically, legally, and appropriately, and in accordance with the Caldicott Principles:

- Principle 1: justify the purpose(s) for using confidential information.
- Principle 2: use confidential information only when it is necessary.
- Principle 3: use the minimum necessary confidential information.

- Principle 4: access to confidential information should be on a strict need-to-know basis.
- Principle 5: everyone with access to confidential information should be aware of their responsibilities.
- Principle 6: comply with the law.
- Principle 7: the duty to share information for individual care is as important as the duty to protect patient confidentiality.
- Principle 8: inform patients and services users about how their confidential information is used and what choice they have. There should be no surprises.

4 Membership and attendees

4.1 The Information Governance Approval Group will meet every two months as a minimum. The membership of the group will comprise the following roles

- Executive Director of Finance and Resources / Senior Information Risk Owner (SIRO) (Chair)
- Executive Medical Director / Caldicott Guardian (Deputy Chair)
- Assoc Director of BI
- Head of Information Governance & Data Protection Officer
- Non-Executive Director of the Audit Committee (open invitation)

5 Meetings and Quorum

5.1 The Chair will preside at all meetings. In extraordinary circumstances where the Chair cannot attend, the Deputy Chair shall preside.

5.2 A quorum shall be the Chair or Deputy Chair of the Group and one other group member. If the group is not quorate, the meeting may be postponed at the discretion of the Chair. If the meeting does take place without the SIRO or Caldicott Guardian no decision shall be made at that meeting and such matters must be deferred until a quorate meeting.

5.3 Other Officers will be invited to attend and present as dictated by the agenda. Members will be required to attend at least 60% of all scheduled meetings within each year and where they cannot attend send an authorised deputy to represent them.

6 Authority

6.1 The Information Governance Approval Group is authorised to instigate any actions arising from its meetings and through the reporting bodies. It is authorised to seek clarification and further investigation of any information

governance matters. It is authorised to endorse information governance policies and approve procedures within its remit.

7 Duties

7.1 The Information Approval Group will fulfil the following core duties:

- To provide leadership and direction on strategic information governance matters in relating to the use of information specifically: information security, information quality, confidentiality, data protection and the management of records.
- To develop and co-ordinate the information governance policy and framework, including associated policies, integrating appropriate information governance standards and activities into the standard working practices of the Trust.
- Monitor the Information Governance Workplan
- Monitor the Data Security & Protection Toolkit (DSPT) assessment by exception reporting
- *Oversee and review significant risks on IG / Information / Cyber Security, ensure risk management strategies are in place, and instruct the IG Working Group (or relevant sub group) to investigate and report upon any risk or irregularities.*
- *Approve Data Protection Impact Assessments that are identified, where there is high risk or unmitigated risk to the processing of personal data, as a result of new / reviewed processes, services and information systems. Receive and note all other Data Protection Impact Assessments approved by the Data Protection Officer.*
- *Approve other information governance artefacts, including DSAs, DPA, Policies, processes etc*
- *Monitor compliance with Data Protection legislation and national guidance.*
- *Ensure linkages are made to other assurance processes for example Care Quality Commission standards and KLOEs.*
- *Receive reports of significant personal data breaches or information/cyber security incidents and monitor remedial actions.*
- *To approve the use of any new Apps the Trust will implement*
- *Receive assurance on the management of the Trust's Information Assets, in particular those containing patient information*
- *To receive an annual Registration Authority Activity Report to provide assurance that the Trusts Registration Authority function is compliant with national guidance.*
- *To provide assurance to the Audit Committee regarding the Trusts information Governance and Data Protection activities and compliance,*

and produce highlight /exception reports as required for the Audit Committee or Trust Leadership Team.

8 Sub-Groups

8.1 The Information Governance Approval Group is supported by relevant groups to deliver its duties effectively. These groups provide periodic reports to the IG Group

- Information Governance Working Group, supported by sub groups such as
  - DSPT Working Group
  - Cyber Security Working Group
  - Information Risk Group
  - Other task and finish groups as required

9 Administrative Arrangements

9.1 The Chair will provide administrative support to act as secretary and ensure appropriate support is afforded to the Information Governance Approval Group.

10 Review of Terms of Reference

10.1 This document will be reviewed annually or sooner if agreed by the Audit Committee or Trust Board.

10.2 Any amended terms of reference will be agreed by the Audit Committee.

Trust Board meeting held in public: 2 February 2024

Agenda item number: 2023-24 (116)

Title: Research and Development Strategy Update Report

Category of paper: for assurance

History: *Quality Committee*

Responsible director: Executive Medical Director

Report author: *Clinical Lead for Research*

Executive summary

This report provides an update to the Board on the implementation of the Research and Development Strategy 2020-2025.

Notable achievements since the last update in January 2023 include:

- With the clinical lead in post, a new team started in June 2023, all with clinical experience of LCH services to scope and optimise research opportunities for LCH.
- Physical rehabilitation is a strong theme of the research agenda and this something we want to build on, as a community trust (e.g. key services COVID, MSK & ICAN).
- We are scoping our research potential, by benchmarking clinical services for research capacity and capability using a national tool. We are using staff surveys coupled with interviews with senior leaders at all levels in the trust (50% complete). We plan to use this intelligence to inform the new clinically led research strategy to be launched in 2025 and publish the results.

Recommendations

The Board is recommended to:

- **receive** this report and note the work undertaken to date

1 Background

The Research and Development (R&D) Strategy 2020-25 was approved by the Trust Board in February 2020. This is the first year since the pandemic we have been able to work with clinical services who are delivering business as usual. It has been important in this year to explore innovation and opportunities where services feel under pressure from backlogs, and where staff retention and wellbeing are at the forefront of the trust's culture going forward.

2 Strategy Implementation

The R&D Strategy lists 4 workstreams: Workforce Culture; Patients and Communities; Partnerships and Sustainability. Appendix 1 outlines the updated key milestones and a summary of progress in each of these areas is shown below.

2.1 Workforce Culture

The 0.5wte clinical lead in research (band 8a) started in January 2023. The research team has transitioned into a clinically focused team, which aims to remove barriers to participation and innovation.
This team has delivered on most of the milestones from the 'way forward' meeting in May 2022 (see appendix 1 and 2).

- Flexible working options for retirees and staff wanting to work extra hours on bank via CLASS.
- Band 8a senior clinical research fellow 0.2wte leading on the research and advanced practice (linking with ABU clinical fellow project) and research mentoring package.
- Scoping how research can be included in appraisal and job planning by providing a pipeline for staff and an educational offer. This has been drafted and goes to a staff focus group Feb 2024.
- Secondment for 3 clinical advisor posts in place till March 2024 (each aligned SBU, ABU and CBU, with research team sitting in CBU)

The Research Governance Manager post (0.8wte 12 months) was only in place 1 of the 12 months. We have since appointed a 0.6wte research coordinator to provide governance and resilience to the team.

In progress – 12 month Band 8a 0.5 wte Research Project Manager post has been appointed. This post will be hosted by LTHT and will work across the two organisations to support 'left shift' of research from hospital to community/primary care-based settings.

2.2 Patients and Communities

This is a key aspiration for the research team:

- We are using the national patient research surveys in research as a platform for research involvement. Research advisors will be leading patient involvement work in the next 3 to 6 months.
- We are strategic collaborators on 2 community research grants with University of Leeds, the key one will create a 'living research lab' where communities can formulate research ideas. This project (if funded via NIHR) will be the first research grant to be hosted by LCH and supports the LCH third sector strategy.

2.3 Partnerships

From 2020 to May 2023, we completed 2 NIHR Clinical Research Network (CRN) projects to undertake a scoping project to determine the feasibility of an integrated research offer outside of traditional hospital settings.

This framework mainly supported COVID research and then later onboarding GPs to studies involving up to 12 practices in research in 2022. We completed the last study in this portfolio; ALABAMA[1] study in May 2023.
Since 2022, CRN have used this project outcome to promote and deliver more primary care research.

- Scoping existing primary care structure
  The joint post (partnership with LTHT research and innovation centre) will prioritise the left shift work and recruitment opportunities across the whole of Leeds.
- Appointment of additional clinical academic posts.
  We have a number of staff starting PhDs and pre-PhD research projects with LCH and will look at supporting more via the staff pipeline including being partners in the NIHR regionally funded Master's in research programme.
  We have appointed a senior clinical academic fellow (Visiting Assoc Prof at 0.2 wte) to support research applications and talent management.
- Collaborative links
  Working with similar trusts across Y&H to look at models of success and building the research team. Building national partnerships with similar trusts.

2.4 Sustainability

Increasing the number of services who are research active is a key building block to supporting the development of advanced practice roles, creating academic career pathways and retention of new and experienced staff:

[1] ALlergy AntiBiotics And Microbial resistAnce (ALABAMA): a study to find out if people with a penicillin-allergy label in their GP health records really do have an allergy

We have 12 studies in progress across, children's, adults services with the majority siting in the specialist service.
Services that reject the most studies are neurology and CAMHS. We have a clinical advisor in place to improve the participation in neurology. We have ambitions to support future research in CAMHS and the neighbourhood team.

3 Key milestones in the next six months

Work over the next six months will focus on:

- Shaping the next research strategy through patient engagement and clinical themes that align with the trust's future ambitions.
- Invest in priority areas of research that are under-researched like mental health and frailty, while also building upon strengths in rehabilitation.
- Create a clear research roles and career pipeline for staff and services to engage in research.
- Implementing the joint LCH/LTHT leadership post to promote left shift in research.
- Working with the Leeds wide research collaboration led by ICB to scope and develop a Leeds wide research strategy
- Working with the Clinical Research Network the next steps for delivery of research in primary care once research delivery networks are set-up in 2024.

4 Health Equity

- The joint post with LTHT explore research opportunities in the community
- Adhering to Y&H research policy to collect data on ethnicity so that we can explore research uptake and benchmark regionally.
- Support studies to provide sites of research in areas of deprivation
- We have supported 3 studies that specifically explore health deprivation.
- We have supported a staff research study looking at retention of international nurses from black, minority and ethnic backgrounds.

5 Strategy Review and Oversight

The R&D strategy is reflected in the R&D corporate team workplan and as such is discussed at the monthly Research Operational Group. Discussions provide assurance of progress, with escalations being made via the quarterly reporting to the Quality Improvement and Assurance Group.

6 Recommendations

The Board is recommended to:

- **Receive** this report and note the work undertaken to date.

Leeds Community Healthcare NHS Trust

Appendix 1 Brief Update - 2024

Research Development Strategy (2020 to 2025) January 2024 update

Short (April 2021 to March 2022)	Medium (April 2022 to March 2024)	Long (April 2024 to March 2025)
Workforce culture		
☒ Development of structural research offer for retirees and part time staff through CLASS.	☐ Launch of resarch offer as part of retirement planning package and CLASS offer *In progress* ** 1 x physio interested in retire and return* ** Research posts with CLASS in progress to provide staff with flexible research opportunities.*	Review and launch next research strategy in 2025 using data and intelligence from service and staff interviews to co-produce a clinically driven corporate strategy.
☒ Implementation of clinical research advisor posts.	☑ Implementation of clinical research advisor posts. Evaluation planned March 2024 ** 3 x posts (2 physio, 1 OT in SBU and ABU)*	Use intelligence gathered to promote research career opportunities as positive reason for joining LCH
	☑ Scoping how research can be included in appriasal and job planning. ** Research and leadership staff survey launched to understand the capability,challenges & opportunities* ** Staff educational package in progress. Focus group with staff planned in Feb 24. Outcome to use in appraisal* ** Advanced practice roles - we have developed a research framework and are liaising with clinical fellow. Planned validation with national community research group (CHART).* ☑ Development of research mentoring programe ** Implemented clinical lead and clinical research fellow roles - started developing a staff pipeline to support development and champion research in clinical services. This has included mapping clinically interested staff per service to explore opportunities.*	Implementation of clinical research roles in clinical services Supporting staff development and utilising research champion, research advisor and research associate roles. Embedding of research into appraisal and job planning for research interested, research active staff, research champions, advanced practitioners and research associates

Short (April 2021 to March 2022)	Medium (April 2022 to March 2024)	Long (April 2024 March 2025)
Patients and communities		
☒ Refinement of the patient experience survey	☑ User experience of research will be measured by increased participation in patient research survey from all research active services ** This is on track for March 2024* ☑ Patients can get actively involved in developing research **LCH research have partnered with the University of Leeds to submit 2 grants in 2023 To create a Living Lab and Active living partnership. These grants, if awarded, will creating opportunities for communities and partners to co-produce research*	Explore novel ways for patient engagement including *Friends and family test to incorporate question about research and patient research survey* Ensure new strategy includes patient involvement that is representative of our community, including linking with third sector to support community driven research ** As part of the Leeds collaborative research group (ICB led) we exploring city wide patient involvement groups to optimise participation and co-production opportunities.*

Short (April 2021 to March 2022)	Medium (April 2022 to March 2024)	Long (April 2024 to March 2025)
Partnerships		
☑Scoping of additional clinical academic posts.	☑Scoping of existing primary care research infrastructure and opportunities for development **A joint post with LTHT and LCH is in progress and due to start Feb 2024. They will resume this work* ☑Appointment of additional clinical academic posts **1 PhD CAMHS (Leeds), 2 PhD in TVN (Huddersfield), 2 pre-PhD posts (Leeds). 2 in funding stages.* *- increasing LCH exposure to universities that have an interest in community centred reserch e.g. neurology and dementia.* ☑ Funding collaborations with universities and joint staff posts **4 staff have national collaborations* ** 3 joint posts in process* ☑ Collaborative links made with community trusts Hull, SWYFT, YAS and LYPFT and Birmingham and Medway.	Scope clinical academic roles in LCH and feed this into the next 2025 strategy. Active participation in the ICB led Leeds NHS research collaboration group to develop and deliver on a Leeds place research model that promotes a left shift in research focusing on people, place and processes. Create opportunities with university partners that allign with the community values. Scope the Data opportunities for research across Leeds, to improve equtable access to research participation

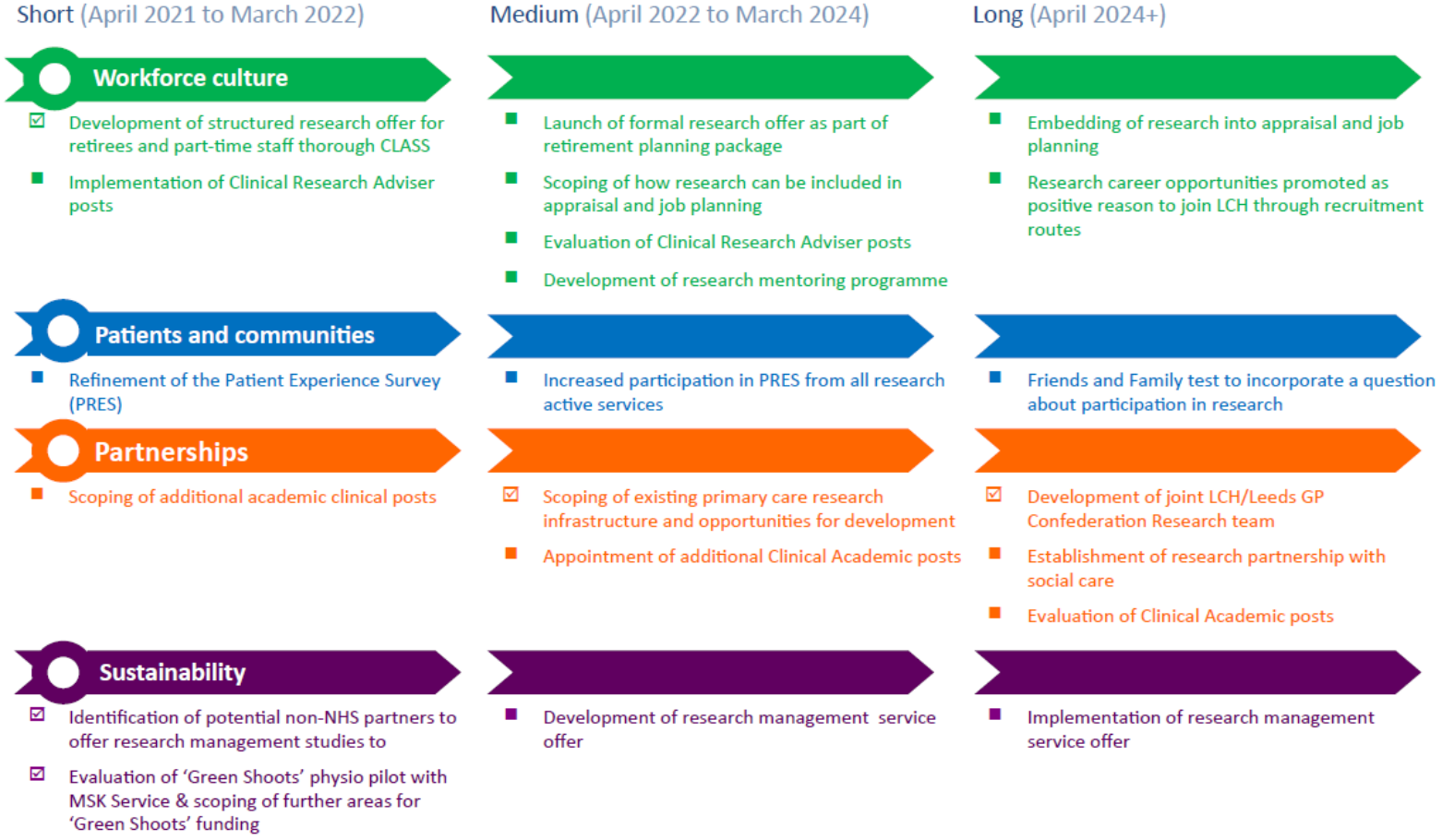
Short (April 2021 to March 2022)	Medium (April 2022 to March 2024)	Long (April 2024 to March 2025)
Sustainability		
☒ Identification of potential non-NHS partners to offer research management of studies *Not taken forward	☑ Development of research management service offer ** we have operationalised our processes to ensure we can offer clinical and governance support for research.* ** We have partnered with primary care Agile team to support 2 studies in frailty and MSK*	Grow key areas of clinical and research strength – Rehabilitation, mental health and frailty Highlight research topics and fields that allign with LCH that support health equity
☑ Evaluation of green shoots physio pilot with MSK service & scoping of further areas for green shoots funding. ** Output -2 staff went onto submit pre-doctoral applications and 1 is submitting a PhD grant application*	☑ Worked with information governance and to recognise the research team as part of the wider clinical team ** Enabled research admin to offer direct study support and improve research uptake*	

Appendix 2 – update 2023

Appendix 1

Research & Development Strategy

January 2023 update

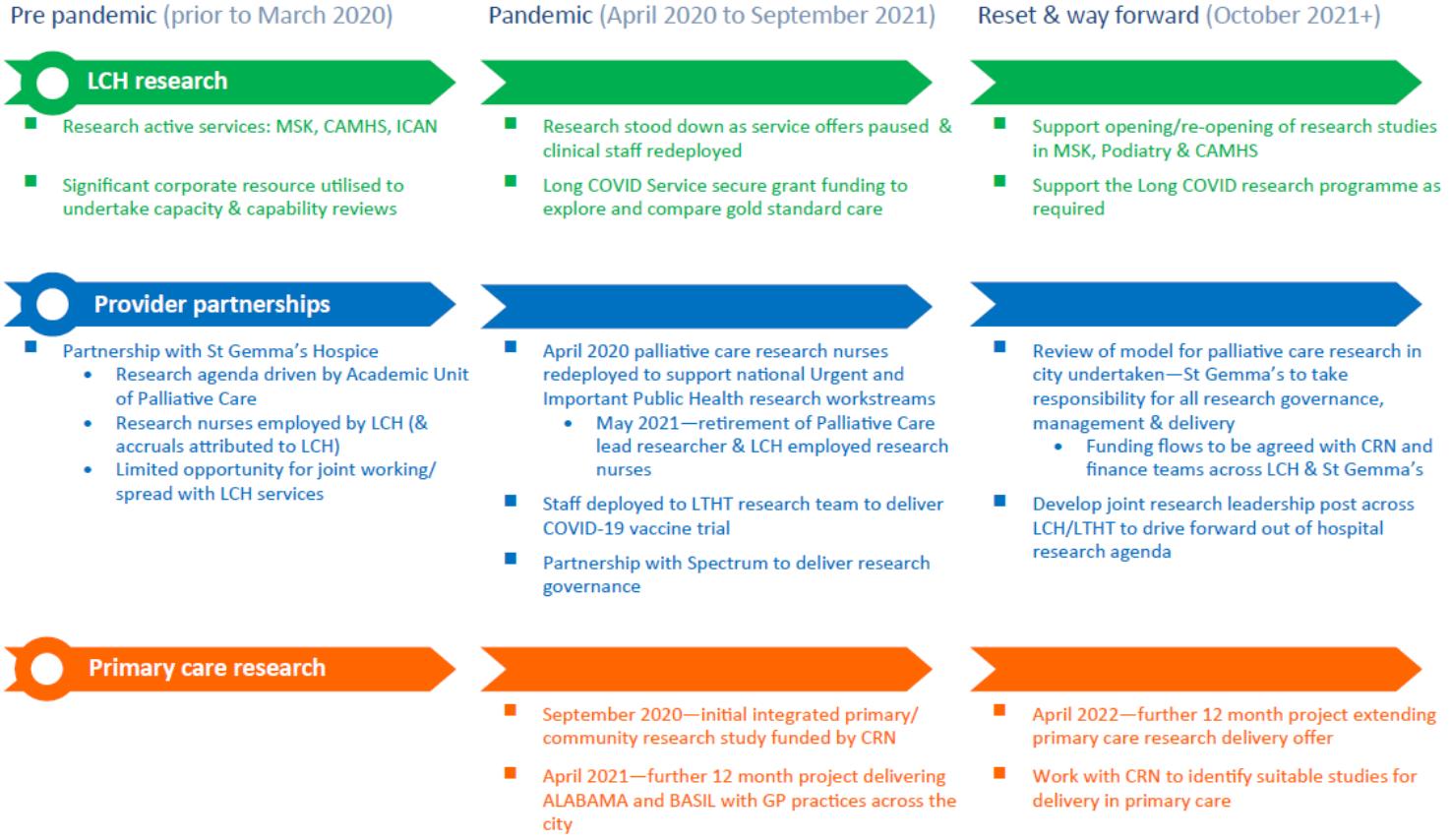


Appendix 2

NHS
Leeds Community Healthcare
NHS Trust

Research Team Development Session

May 2022



Leeds Community Healthcare NHS Trust

Agenda item 2023-24 (117)

Public Board workplan 2023
Version 5: 25 01 24

Topic	Frequency	Lead officer	4 August 2023	6 October 2023	8 December 2023	2 February 2024	28 March 2024	7 June 2024	19 June 2024-Annual Report and Accounts only	2 August 2024	4 October 2024	6 December 2024
Preliminary business												
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X		X	X	X
Action log	every meeting	CS	X	X	X	X	X	X		X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X		X	X	X
Patient story	every meeting	EDN&AHPS	X	X	X	X	X	X		X	X	X
Quality and delivery												
Chief Executive's report	every meeting	CE	X	X	X	X	X	X		X	X	X
Performance Brief	every meeting	EDFR	X	X	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	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 main agenda from Dec 23	X		X		X		X
Staff survey	annual	DW					X					
Safe staffing report	2 x year Feb and August	EDN&AHPS	X			X				X		
Seasonal resilience and system flow	Every meeting	EDO	X	X	X	X	X	X	X	X	X	X
Business Continuity Management Policy	As required	EDO										
Serious incidents report and patient safety report combined report from March 2023	2 x year (Mar and October)	EDN&AHPS		X -Blue box			X -Blue box				X -Blue box	
Patient experience: complaints and concerns report	2 x year (Feb and August Annual report)	EDN&AHPS	X Blue box Annual report			X				X Blue box Annual report		
Freedom to speak up report	2 x year (Feb and Aug)	CE	X plus Annual report			X				X Annual report		
Guardian of safe working hours report	4 x year	EMD	X		X		X	X Plus Annual report		X		X
Board members service visits	Quarterly - June/August/October/ March	EMD						x		X	x	
Patient Safety Incident Response Framework (Plan)	As required	EDN&AHPS				X						
Strategy and planning												
Organisational (Trust) priorities (for the coming year) for approval	Annual	EDFR				Taken at a Board workshop January	x Final					
Trust priorities update quarterly report	3x year February/June/Oct	EDFR/EDN&AHPS		X		X		X			X	
Third Sector Strategy	2x year (February and August)	EDO	X			X				X		
Estate Strategy	2xyear (August and December)	EDFR	X Blue box item -deferred to October 2023	X Blue box item deferred to December 2023	X -Blue box					X Blue box item		X Blue box item
Digital Strategy	2x year (Mar and Oct)	EDFR		X Blue box item deferred to December 2023	X Blue box item deferred to February 2024	X Blue box item deferred to March 2024	X -blue box				X -blue box	
Business Development Strategy	2x year(March and October)	EDO		X -Blue box taken in private			X -Blue box - taken in private				X -Blue box	
Business Intelligence Strategy	2x year First presented Feb 2022 and August	EDFR	Deferred									
Learning and Developement Strategy	2x year (March and October)	EDN&AHPS		X Blue box item deferred to December 2023	X Blue box item deferred to February 2024	X Blue box item deferred to March 24	X -Blue box				X -Blue box	
Engagement Strategy	2xyear (March and October)	EDN&AHPS		X			X -Blue box				X -Blue box	X -Blue box
Patient Safety Strategy	2xMarch/October	EDN&AHPS		X			X				X	
Health Equity Strategy	3 x year(March, August and December)	EMD	X		X		X			X		X
Children, Young People and Families Strategy	2xyear - Feb and August	EDO	X -Deferred to October Blue Box	X -Blue box		X Deferred to March 2024	X Deferred from March 2024			X -Deferred to October Blue Box	X -Blue box	
Quality Strategy	2xyear May and December	EDN&AHPS			X - Blue box item			X - Blue box item				X - Blue box item
Workforce Report and Strategy update	3x year Aug,Dec and June (from 2024)	DW	X - Blue box item		X - Main agenda item Dec 23			X - Blue box item		X - Blue box item		X - Blue box item
Research and Development Strategy	annual	EMD				X Blue box						
Governance												
Medical Director's annual report	annual	EMD	X							X		
Nurse and AHP revalidation	annual	EDN&AHPS	X							X		
Well-led framework	as required	CS										
Annual report	annual	EDFR							X			
Annual accounts	annual	EDFR							X			
Letter of representation (ISA 260)	annual	EDFR							X			
Audit opinion	annual	EDFR							X			
Audit Committee annual report (part of corporate governance report)	annual	CS						X				
Standing orders/standing financial instructions review October	annual October	CS		X - deferred to December 2023	X - deferred to February 2024	X					X	
Annual governance statement (Presented with Annual Report and Accounts)	annual	CS							X			
Going concern statement (part of corporate governance report March)	annual	EDFR					X					
NHS provider licence compliance - requirements changing in 2024	annual	CS						X				
Committee terms of reference review	annual	CS						X				
Register of sealings	4 xper year	CS	X		X		X			X		X
Risk appetite statement (part of corporate governance report March)	annual	CS					X					
Declarations of interest/fit and proper persons test (part of corporate governance report March)	annual	CS					X					
Board Assurance Framework -process update (July Audit Committee)	annual	CS	X - Blue box item							X - Blue box item		
Information Governance Annual Report	annual -(March)	EDFR				X - Blue box item						
Corporate governance report	annual	CS					X		X			
Reports												
WDES and WRES -annual report and action plan	annual	DW		X							X	
Equality and diversity - annual report combined with WDES and WRES from 2023	annual (Dec)	DW										
Sustainability report (Annual Green Plan)	Annual (April)	EDO		X Deferred to December 2023	X			x			X	
Safeguarding -annual report	annual	EDN&AHPS	X							X		
Health and Safety Annual Plan	Annual	EDFR	X - Blue box item							X - Blue box item		
Infection prevention control assurance framework	2x year(October and March)			X -Blue box			X -Blue box				X -Blue box	
Infection prevention control annual report	annual	EDN&AHPS	X deferred from March 2023				X					

Key

CE	Chief Executive
EDFR	Executive Director of Finance and Resources
EDN	Executive Director of Nursing
EDO	Executive Director of Operations
EMD	Executive Medical Director
DW	Director of Workforce
CELs	Committees' Executive Leads
CS	Company Secretary

= received
= deferred to another meeting
= not required