Leeds Community Healthcare NHS Trust
Board Meeting (held in public)
Friday 4 October 2019, 9.00am – 12.00noon
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

NHS Leeds Community Healthcare NHS Trust

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2019-20 (53)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2019-20 (54)	Declarations of interest	Neil Franklin	N
9.10	2019-20 (55)	Questions from members of the public	Neil Franklin	N
9.15	2019-20 (56)	Minutes of previous meeting and matters arising: a. Minutes of the meetings held on 2 August 2019 b. Actions' log	Neil Franklin	 Y Y
9.30	2019-20 (57)	Patient's story: Tuberculosis	Steph Lawrence	N
		Quality and delivery		
9.45	2019-20 (58)	Chief Executive's report	Thea Stein	Y
9.55	2019-20 (59)	Committees' assurance reports: a. Charitable Funds Committee : 20 September 2019 b. Nominations and Remuneration Committee: 20 September 2019 c. Quality Committee: 23 September 2019 d. Business Committee: 25 September 2019	 Brodie Clark Neil Franklin Ian Lewis Brodie Clark	 Y Y Y Y
10.05	2019-20 (60)	Performance brief and domain reports: August 2019	Bryan Machin	Y
10.25	2019-20 (61)	Risk management a. Significant risks and Board assurance framework (BAF) Summary Report b. BAF 2019/20 proposed changes	 Thea Stein Thea Stein	 Y Y
		Strategy and planning		
10.35	2019-20 (62)	Organisational priorities position report	Bryan Machin	Y
10.45	2019-20 (63)	Engagement strategy	Steph Lawrence	Y
11.05	2019-20 (64)	Workforce strategy: Health and wellbeing	Laura Smith/Jenny Allen	Y
11.15	2019-20 (65)	Implications of the Amin Abdullah review	Laura Smith/Jenny Allen	Y
11.25	2019-20 (66)	Draft estate strategy	Bryan Machin	Y
		Annual reports		
11.35	2019-20 (67)	Safeguarding annual report 2018/19	Steph Lawrence	Y
11.45	2019-20 (68)	Infection prevention and control annual report 2018/19	Steph Lawrence	Y
11.50	2019-20 (69)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2019-20 (70)	Approved minutes for noting: a. Quality Committee: 22 July 2019 b. Business Committee: 24 July 2019 c. Audit Committee: 22 May 2019	Neil Franklin	 Y Y Y
12.00	2019-20 (71)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 6 December 2019 9.00am-12noon

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust
Trust Board Meeting (held in public)

AGENDA ITEM 2019-20 (56a)

Boardroom, Stockdale House, Victoria Road, Leeds LS6 1PF

Friday 2 August 2019, 9.00am – 12.10pm

Present:	Neil Franklin	Trust Chair,
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Helen Thomson	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Professor Ian Lewis	Non-Executive Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:	Diane Allison	Company Secretary
	Margaret Duke	Aspirant Non-Executive Director Programme Participant
	Louise Popple	Infection Prevention and Control Nurse (for Item 31)
	John Walsh	Freedom to Speak Up Guardian (for Item 39)
	Dr Turlough Mills	Guardian for Safe Working Hours (for Item 40)
Minutes:	Liz Thornton	Board Administrator
Observers:	Nikki Stubbs	Deputy Director of Nursing, Interim Professional Lead for Nursing
Members of the public:	One member of the public was in attendance.	

Item	Discussion points	Action
2019-20 (27)	**Welcome and introductions** The Trust Chair welcomed Board members, a member of the public and a member of staff attending the meeting. **Apologies** Apologies were noted from Professor Ian Lewis, Non-Executive Director (IL) and Laura Smith Director of Workforce, Organisational Development and System Development (LS).	

2019-20 (28)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda.	
2019-20 (29)	**Questions from members of the public** There were no questions from the member of public in attendance.	
2019-20 **(30a)** **(30b)**	**Minutes of the previous meeting held on 24 May 2019 and matters arising** **Minutes of the previous meeting held on 24 May 2019** The minutes were reviewed for accuracy and agreed to be a correct record. **Items from the actions' log** The Trust Chair noted the actions from previous meetings were completed and closed.	
2019-20 (31)	**A patient's story** The Executive Director of Nursing and Allied Health Professionals introduced the patient's story item and welcomed Louise Popple, Infection Prevention and Control Nurse who was attending the meeting to speak to the Board about the Trust's work to raise awareness of the risks of developing E.coli due to dehydration. Louise began by outlining the background and context of the Trust's work in this area. In May 2017 the NHS Improvement and Public Health England publication: 'Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource', outlined a new ambition from the Secretary of State for Health to reduce healthcare associated gram negative blood stream infections by 50% by 2021 (broken down into 10% reductions each year) she added that since then the new 5 year strategy changed ambitions to 50% by 2024 with a starting focus on E. coli. The work undertaken by the Trust's Infection Control Team included attending 15 lunch clubs/ coffee mornings across the city, collecting data on whether people thought they drank enough, whether (following discussion) they actually did drink enough, reasons for not drinking, strategies to encourage individuals to drink more and re-visits in 3 months' time to assess changes in habits. The Executive Director of Nursing and Allied Health Professionals advised the Board that the target was difficult to achieve as improvement was based on proactive prevention and self-care. Louise explained that although the Trust did not achieve the target 10% reduction this year, further funding had been made available for another year and the Trust planned to continue to run public health campaigns, focus on health care interventions, would be making a presentation at the IPS conference 2019 "I Spy E. coli –the Leeds approach" and making better links with GP practices and prescribing behaviours. The Trust Chair thanked Louise for taking time to talk about the innovative work the Infection Control Team were undertaking in this area and wished them luck in their aspiration to meet the reduction target this year.	
2019-20 (32)	**Chief Executive's report** The Chief Executive presented her report, the items highlighted included: • Leeds Mental Wellbeing Service (IAPT contract) • Chronic Pain Management (Spinefit+) service tender award • Long Term Plan (LTP) implementation framework	

	• Sir David Behan visit • Mental Health Support Teams in Trailblazer sites • Media report for June 2019 The Board was particularly pleased to see that Sir David Behan, Chair of Health Education England had visited the Trust. He had spent time visiting the wound care clinic at Rutland Lodge and met the outreach nurse for the gypsy traveller community. In response to a question from a Non-Executive Director (JM), the Chief Executive advised that the Trust was still awaiting the draft report from the CQC's well led inspection in June 2019. Non-Executive Director (BC) noted the development of a talent pool as part of the Trust's talent management strategy and said he looked forward to hearing more about the opportunities it would offer staff in future. The Chief Executive also advised the Board that the Health and Safety Executive would be visiting the Trust between the 19 and 30 August 2019 and 9 and 13 September 2019 to look at how the Trust managed the risks of violence and aggression. No further questions were raised on any other items in the Chief Executive's report. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	
2019-20 (33)	**Assurance reports from sub-committees** **Item 33(i)- Charitable Funds Committee 21 June 2019** The report was presented by the Committee Chair and Non-Executive Director (BC) who highlighted the key issues discussed, namely: • **Charity agenda**- a meeting had taken place with the Chief Executive of Leeds Cares on 18 June 2019. The Committee felt that there was value in progressing towards the partnership with Leeds Cares subject to some further work being undertaken including due diligence. • **Draft annual report and accounts 2018/19** – these were accepted by the Committee. **Item 33(ii)- Nominations and Remuneration Committee 21 June 2019** The report was presented by the Committee Chair and Trust Chair (NF) who highlighted the key issues discussed, namely: • **CEO and Director appraisals and pay-** in line with national guidance all directors as well as the CEO had been appraised in terms of performance during the 2018/19 financial year and all the appropriate information returned to NHS Improvement. • **Clinical Excellence Awards (CEA) –** the CEA award panel for the 2018/19 round would meet on 27 August 2019. **Item 33(iii) – Quality Committee** The reports were provided by the Committee Deputy Chair and Trust Chair (NF) who highlighted the key issues discussed, namely: **24 June 2019 (workshop)** • **Focussed workshop session covering two areas –** Population Health Management and Patient Engagement Strategy.	

22 July 2019

Service spotlight review - the Committee discussed the value of service spotlight presentations and whether there was an element of duplication between what was presented to the Committee and what was dealt with by performance panels. It was agreed that in order to provide assurance, the process for choosing the topics should be systematic. Non-Executive Director (HT) and the Executive Director of Nursing and Allied Health Professionals would be reviewing the current arrangements with the aim of increasing the rigour of scrutiny and devising a proposed programme for the next six months.

- **Pressure ulcer investigation update -** the Committee had been presented with the findings of a review into the category 3 pressure ulcers reported in quarter one of 2019/20. The Committee had discussed the factors identified as having contributed to the development of pressure ulcers. It was recognised that it was not due to staffs' lack of knowledge about the prevention of pressure ulcers, but more about how the knowledge was being applied – there was a lack of risk assessments and care planning, as well as not using EPR appropriately and some poor communication. An overarching issue was a lack of capacity within neighbourhood teams and it was recognised that teams needed to work differently. The Committee heard that a significant amount of learning had taken place and that the Trust was now in a better position, in terms of numbers of 'avoidable' pressure ulcers, than in some previous years.

  The Trust Chair invited the Executive Director of Nursing and Allied Health Professionals to provide members with further information about the data on pressure ulcers reported in Quarter 1.

  The Executive Director of Nursing and Allied Health Professionals advised that the method of identifying and reporting avoidable pressure ulcers had changed to allow more timely StEIS reporting when avoidability was determined. She reported that five of the avoidable pressure ulcers which had been reported in the performance briefs for the 2019/20 reporting period had now been moved to the 2018/19 reporting period. This was to ensure accurate data was reported within the appropriate timeframe.

  Referring to the Serious Incident report presented for Item 38 on the Agenda, the Board discussed the themes and trends identified for all reported pressure ulcers which were included at Appendix 2 of the report.

  The Chief Executive said that scrutiny of pressure ulcers had been delegated to one group the Patient Safety, Experience and Governance Group within the organisation, as currently monitoring took place in three separate groups. An action plan for the reduction in pressure ulcers would be presented to the Quality Committee in September 2019 and subsequently reported to the Board.

  The Trust Chair summarised the need to maximise clinical capacity, improve EPR to be more innovative whilst recognising that the position was improving and not to lose sight of other issues related to patient safety.

Item 33(iv) – Business Committee

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

26 June 2019

- **Patient Administration Project** – the Committee had received an update on the project, including key milestones achieved since the last update: overarching workforce principles agreed and a single professional structure with three leadership roles approved.

	• **Workforce presentation** – the Committee received a presentation on the delivery of the Trust's Leadership and Learning and Development offer and agreed that the programme was progressing at a significant pace. **24 July 2019** • **Performance brief -** overall performance remained good in June 2019. Under the Well-led domain the Committee noted that well led measures were positive in a number of areas, whilst appraisals remained an area requiring ongoing focus and support. • **Business development strategy –** the Committee was advised about two recent successful bids: Leeds Mental Wellbeing Service (IAPT) and the Community Chronic Pain Service and had agreed that the current position for the Trust was very positive. • **CAMHS waiting times update –** the Committee received a presentation about the service's performance and progress against waiting time targets and was advised that due to increased demand the current turnaround rate for mindmate spa referrals was four weeks against a contracted target of two weeks. The Committee recognised the challenges faced by the service and asked for further updates to be provided at future meetings – the timetable would be agreed with the Executive Director of Operations. **Item 33(v) – Audit Committee 1 August 2019** A verbal report was presented by the Committee Chair and Non-Executive Director (JM) who highlighted the key issues discussed, namely: • ***Internal audit*** **–** an internal audit of Risk Management processes had recommended that the Board and sub-committees (and other groups) should consider whether issues raised in meetings were already on the risk register and if not, they would need to be risk assessed. • **Leeds Community Healthcare Charitable Funds and Related Charities draft annual report and accounts 2018/19 –** the Committee was provided with the Trust's Charitable Trust and Related Charities draft annual report and accounts for 2018/19 together with the findings of the independent examination. The Committee recommended the adoption of the accounts by the Charitable Funds Committee at its meeting on 20 September 2019. • **Security Management annual report –** the Committee received the annual report from the Trust's Local Security Management Specialist and recognised the valuable support he provided to staff in the Trust. • **Board Assurance Framework –** the Committee reviewed the sources of assurance to consider whether they were sufficient to provide assurance to the Board, via the receiving committee. • **Risk Management update report –** the risk appetite statement was reviewed and approved with no changes made. The Committee agreed that a more robust mechanism of monitoring risk assessments should be adopted by the Trust and asked for a proposal to be developed. **Outcome:** The Board noted the update reports from the committee chairs and the matters highlighted.	
2019-20 (34)	**Performance brief and domain reports June 2019** The Executive Director of Finance and Resources presented the report, which provided a high level performance summary within the Trust during June 2019. The Executive Director of Finance and Resources said that the report highlighted any current concerns relating to contracts held by the Trust, a focus on key performance areas that were of current concern to the Trust and a summary of performance against targets and indicators in these areas. Overall performance remained good in June 2019.	

The Executive Director of Finance and Resources highlighted two items relating to Trust finances which had been considered by the Business Committee in July 2019 but also required Board agreement:

Allocation of additional funding
The Executive Director of Finance and Resources reminded Board members that in the financial plan for 2019/20 there were two outstanding financial issues for which an in year solution was assumed; the £500k balance of the 'roadmap' issue and a £300k corporate CIP. It was proposed to apply the "public health" pay award funding of circa £700k and IAPT contract contribution of circa £400k to offset the total £800k issue. In year the balance would mitigate net overspending in other budgets; utilisation recurrently being subject to next year's financial planning process.

Board approval of this allocation of additional funding was sought.

Outcome: The Board approved the proposal for the allocation of addition funding as set out above.

National shortage of capital funding
The Executive Director of Finance and Resources reported that in response to a 20% national shortage of capital funding, the West Yorkshire and Harrogate ICS was asked to deliver a formula based 21% reduction in its capital plans. All Trusts, working together have agreed a set of individual organisational reductions that deliver that target. Given the short timescale, the Executive Director of Finance and Resources and the Chief Executive agreed that LCH could defer £302k of the Trust's 2019/20 capital plan. Retrospective Board approval to the revised capital plan was sought.

In response to a question from Non-Executive Director (JM), the Executive Director of Finance and Resources confirmed that Leeds and York Partnership NHS Foundation Trust's savings would not have an impact on the CAMHS build.

Outcome: The Board retrospectively approved the decision made by the Executive Director of Finance and Resources and the Chief Executive to defer £302k of the Trust's 2019/20 capital plan.

Safe
There had been one category 3 pressure ulcer and one Category 4 unavoidable pressure ulcer reported by the Children's Business Unit in June 2019.

Responsive
Performance in the responsive domain remained good with the majority of targets being met.

The Board noted that the IAPT targets remained a challenge and the Trust continued to work with commissioners on waiting list initiatives.

In response to a question from the Trust Chair, the Executive Director of Operations confirmed that there was a separate funding stream to address the IAPT legacy waiting list.

Effective
The Board noted that there was no narrative included in the brief to accompany data on the effective domain. This would be included in the next report to the Trust Board.

	Well-led The Board noted that in July turnover remained low at 13.1%, supporting a high stability index of 87.6%. Both were better than target. Sickness absence remained below target and well within tolerance levels. Appraisal compliance rates had improved and currently stood at 84.6% The Board heard that the Statutory and Mandatory Training Compliance Project was focussing on improving the configuration and structure of ESR to make its information more reliable and the training matrix was being redesigned to provide better information for staff about the specific training required by different roles within the Trust. In summary the Trust Chair said that there were some satisfactory outcomes in the well-led domains in terms of a number of issues particularly the position of sickness absence, retention and statutory and mandatory training but concerns remained in recruitment and appraisal rates. The Committee noted that actions to remedy this were underway to get those targets on track. ***Financial position*** The Executive Director of Finance & Resources said that the headline for this month was that the Trust was slightly overspending. The Trust would need to take action to reduce spending by £0.05m to meet the control total by the end of the financial year. The Trust's cash position remained positive. The Executive Director of Finance & Resources advised that very careful monitoring of the budget performance would be required with options being developed to reduce spending levels if necessary. He added that any over spending above current forecasts in the business units was also discussed at the operations performance panel meetings resulting in actions being taken to bring budgets back into balance. **Outcome:** The Board noted the Trust's performance for June 2019	
2019-20 (35)	**Significant risks and Board Assurance Framework Summary Report** The summary report provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures. It also provided a description of any movement of risks scoring 12 (high risks since the last report received in May 2019. The Board noted changes to the register as follows: • No risks currently scoring 15 or above (extreme) • No new risks scoring 15 or above • No risks deescalated, which previously scored 15 or above • Two new risks scoring 12 • One risk escalated to a score of 12 The Board reviewed risks 975 and 976 which both related to CAMHS Tier 4 development and noted the controls and planned actions for each risk. The BAF summary report provided the Board with an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by SMT, committees and the Board. **Outcome:** The Board;	

	• Noted revisions to the risk register • Noted the current assurance levels provided in the revised BAF summary	
2019-20 (36)	**Working with primary care networks** The Chief Executive presented the paper which set out the Trust's progress on developing relationships with the 19 newly formed Primary Care Networks (PCNs) in Leeds. The Board discussed the four options considered in respect of PCNs employing staff and described in more detail the proposed offer that the Trust had made to PCNs. **Outcome:** The Board: • Noted the detail provided in the paper and approved, in principle, the proposal that LCH offer to employ the community pharmacy mandated roles on behalf of PCNs. • Agreed in principle to use the same model to employ and deploy other PCN staff as they become commissioned. • Agreed that the model be kept under review and to assess against the risks outlined.	
2019-20 (37)	**Safe staffing report** The Executive Director of Nursing and Allied Health Professionals presented the report which set out progress in relation to maintaining safe staffing in the Trust over the last six months. The statutory requirements and data contained in an appendix with the main body of the paper provided assurance to the Board in relation to the effect of staffing pressures on services and how these were being mitigated. The Board noted that safe staffing has been maintained across all inpatient units for the time period, however, this had meant that on a small number of occasions stays in Hannah House had had to be cancelled to maintain and ensure patient safety. There continued to be pressures in a number of the neighbourhood teams. The paper sets out the mitigation in place and also triangulates elements of patient safety data to the staffing numbers where this was possible. A Non-Executive Director (HT), asked that future reports contain data relating to the use of agency staff. The Executive Director of Operations reminded Board members that agency staff were not used to fill posts for registered staff. **Outcome:** The Board noted that: • The Trust continued to meet the national monthly collection and publication of staffing data as recommended in "Hard Truths" • Kept staffing levels under constant review • the progress being made and support six monthly reviews in a public Board meeting	
2019-20 (38)	**Serious incidents report** The Executive Director of Nursing and Allied Health Professionals presented the report which provided the Board with an update and assurance in relation to the management of Serious Incidents (SI's). It summarised the outcomes, themes, actions and learning from SI investigations closed within the organisation during the period 1 April 2019 to 30 June 2019.	

	Outcome: The Board: • received this report and note the current position with regards action plans and learning • received assurance regarding the management of Serious Incidents and handling of inquests.	
2019-20 (39)	**Freedom to Speak Up Guardian- annual report** The Freedom to Speak Up Guardian (FTSUG) presented the report which provided an overview of his work, basic activity data and the future direction of the stream of work. The Guardian said that the role was working well and he had received strong support from the Chief Executive, directors and the wider Trust in establishing the role. A clear approach had been established which aligned to the Care Quality Commission's well led domain's aspect of the Trust's work. The Board noted that during 2018/19 40 staff members had met directly with the Guardian and raised concerns and he gave a broad overview of some of the issues raised. The Board were pleased to note the peer review of the LCH FTSUG service by the FTSUG at Locala had been undertaken and offered areas for celebration and development. The Board discussed the activity data and the themes which had emerged from the work to date. The Guardian agreed that cultural changes across the Trust were contributing to staff feeling more able to raise their concerns including members of the BAME communities. He added that more work would be done to analyse trends for inclusion in future reports. The Chair thanked the Guardian for presenting his report and commended his work in the Trust and his positive interaction with staff. **Outcome:** The report and activity to date was noted. The Board indicated its continuing support to embedding the work of the Freedom to Speak Up Guardian across the Trust.	
2019-20 (40)	**Guardian for Safe Working Hours – update report** The Guardian for Safe Working Hours (GfSWH) presented the report which included information on the issues affecting trainee doctors and dentists in the Trust, including morale, training and working hours. The Guardian provided a brief overview of the background and context to the report and drew Board members attention to the quarterly data summary. A Non-Executive Director (RG) referred to the payment of £60,000 the Trust had received from Health Education England to improve working conditions for junior doctors and asked how this would be spent. The Executive Director of Workforce, Organisational Development and System Development (JA) said that information would be shared with the Board when a plan had been developed to utilise the funds. The Chair, on behalf of the Board, expressed support for this work across the Trust and thanked the Guardian for attending to present his report.	

	Outcome: The Board: • Receive assurance that trainee doctors and dentists within LCH NHS Trust were working safely and in a manner compliant with the 2016 Junior Doctors contract TCS (2016) • Recognised the work underway to engage trainee doctors and dentists within LCH NHS Trust and to promote the role of the GfSWH • Received the update from the BMA regarding the implications of the most recent changes to the Junior Doctors' Contract.	
2019-20 (41i) **2019-20 (41ii)**	**Workforce** *Workforce strategy: resourcing* The Executive Director of Workforce, Organisational Development and System Development (JA) presented the report which provided the Board with an update on the delivery on the Resourcing priority within the Workforce Strategy. The key headlines from the last six months were that retention rates had consistently improved and remained better than target, the recruitment team had been nominated for a Nursing Times Award for Best Recruitment Experience and the e-rostering project successfully completed its pilot phase and had entered into the implementation phase. The Board noted that challenges remained around operational recruitment, due to high staff turnover and absence levels in the recruitment team. The overall rating for the resourcing priority had been rated as amber at quarter one. There was a commitment that the situation would be stable by the end of quarter two and revert back to green. **Outcome:** The Board: • Noted the progress made with resourcing in the last six months • Noted the amber rating of the Resourcing priority, linked to operational recruitment challenges which were currently subject to a recovery plan *Interim NHS People Plan for LCH* The Executive Director of Workforce, Organisational Development and System Development (JA) presented the report which highlighted the key themes of the Interim NHS People Plan, published in June 2019. She explained that the Plan had been developed with involvement from NHS Employers and a wide range of other stakeholders to set out an initial approach to tackling a range of workforce challenges. **Outcome:** The Board: • Noted the content of the paper and the Interim NHS People Plan • Noted that a whole-NHS engagement exercise is expected to take place "over the summer" • Noted that conversations about the Interim Plan have taken place within LCH at SMT, JNC and JNCF; and are additionally expected to take place at the LCH / GP Confederation CIC • Noted that a substantive version of the Interim Plan is expected to be published before the end of the 2019 calendar year.	
2019-20 (42)	**Research and development strategy: update** The Executive Medical Director provided a verbal update on the the progress of the Research and Development strategy. She explained that a formal report would be presented to the Board at its meeting in October 2019.	

	A Non-Executive Director (JM) observed that the external funding allocations from the NIHR CRN had fallen in recent years and she agreed to feedback the Trust's perspective about strengthening links with them and other research organisations and she offered to meet with the Executive Medical Director to discuss this further **Outcome:** The Board received and noted the verbal update report.	
2019-20 (43)	**Quality improvement strategy** The Executive Director of Operations presented the report which set out the context, ambitions approach and actions for the Quality Improvement (QI) work across the organisation. She drew the Board's attention to the priorities within the Strategy for 2019/20 and the specific actions and measures identified under each category to achieve impact during 2019/20. A Non-Executive Director (BC) observed that patients, service users and their carers remained integral to the ongoing improvement work in the Trust and asked what plans were in place to involve them in future development of the strategy. The Executive Director of Operations confirmed that there had been involvement and the QI strategy would be a focus at the admin conference in November 2019 and plans were in place to ensure that it was supported by an effective communication plan. **Outcome:** The Board : • Approved the Quality Improvement Strategy.	
2019-20 (44)	**Workplace Disability and Equality Standard (WDES): action plan** The Executive Director of Workforce, Organisational Development and System Development (JA) presented the report and action plan. She reminded the Board that it had been reviewed in detail at a Board Development workshop on 2 July 2019. The Board was now being asked to review and agree governance arrangements for the performance management of the WDES action plan. The Executive Director of Workforce, Organisational Development and System Development (JA) explained that she was seeking the Board's approval as to whether it was sensible for WDES action plan to mirror closely to WRES action plan. She said that nationally WDES and WRES mirror each other and the expectations were very similar. She added that the governance for WRES was being monitored through the Business Committee as part of the workforce quarterly report and the Business Committee had agreed that this could equally apply to the WDES. A Non-Executive Director (BC) and Chair of the Business Committee said that briefing paper and WDES action plan had been reviewed by the Business Committee on 24 July 2019 and he had expressed concern that the WDES approach was almost identical to the WRES program. He thought that there should be more reflection and consideration of the work involved and there was agreement to do this. **Outcome:** The Board: • Approved the Trust's WDES action plan.	
2019-20 (45)	**Medical Director annual report on doctors' revalidation** The Executive Medical Director introduced the report which was a requirement for revalidation of doctors and provided assurance to the Board on the appraisal process. The report covered the period 1 April 2018 to 31 March 2019. The report	

	followed the guidance: *Framework of Quality Assurance for Responsible Officers and Revalidation, June 2015.* The Board was asked to approve the statement of compliance which had been considered by the Quality Committee on 22 July 2019 and recommended for approval by the Board. **Outcome:** The Board approved the 2018-19 Executive Medical Director's report, noted the requirements by NHS England for inclusion in the statement of compliance and approved the sign off of the statement of compliance.	
2019-20 (46)	**Nurse and Allied Health Professionals revalidation** The Executive Director of Nursing and Allied Health Professionals introduced the report which provided an overview of the last year in relation to nursing and Allied Health Professional (AHP) revalidation. The information covered the year from 1 July 2018 to 30 June 2019. As of June 2019 there were 1043 nurses employed by the trust and 508 AHPs. One nurse who should hold registration does not do so. The Directors of Nursing and Allied Health Professionals and Workforce were aware of this and are actively engaged with the Nursing and Midwifery Council in supporting this person. All AHPs who should be registered were. **Outcome:** The report was welcomed and noted.	
2019-20 (47)	**Health and safety policy –ratification** The Company Secretary presented the Health and Safety Policy and summarised the revisions made and agreed by the Corporate and Clinical Policies Group and the Senior Management Team (SMT). The Company Secretary explained that the revised policy had been widely consulted on including input from a specially convened health and safety working group. The Board were asked to ratify the revised policy as presented. **Outcome:** The Board: • Ratified the revised Health and Safety Policy	
2019-20 (48)	**Procedure for emergency powers and urgent decisions** The Company Secretary presented the procedure which had been reviewed and amended and now required Board approval. The Company Secretary drew the Board's attention to the amendments and the rationale listed in the version history contained within the document. **Outcome:** The Board: • Approved the amendments made to the procedural document.	
2019-20 (49)	**Urgent decisions taken** The Executive Director of Finance and Resources drew the Board's attention to two urgent decisions which required formal ratification by the Board: • <u>Mobile phone contract new arrangements</u> O2 had offered the Trust a new 28 month contract, which can be extended until December 2021. This contract offers better value for money than the existing contract. The contract required sign off by 30 June 2019 for the Trust to secure the pricing. A paper detailing the contract offer was	

	received at Business Committee on 26 June 2019 and the Committee recommended that the Board should approve this. An urgent decision was signed by the Trust Chair and Chief Executive on 27 June 2019. The Board is requested to formally ratify that decision. **Outcome:** The Board: • Formally ratified the urgent decision made by the Trust Chair and Chief Executive made on 27 June 2019 in relation to the mobile phone contract arrangements. • <u>CAMHS Tier4 development stage 3 contract procurement</u> On 25 May 2018 Approval was obtained from the Trust Board to commit an estimated £1.5m of fees and associated development costs to take the CAMHS Tier 4 development to Full Business Case**.** Following a selection process Interserve Construction Ltd was selected as the P22 Partner and the expenditure of fees has largely been managed through that Partner. At Trust Board on the 3 May 2019, approval was given to the expenditure of fees to agree the GMP, along with approval in principle to enter into a Contract with ICL. On 26 June 2019 Business Committee agreed to recommend that the Board should formally sign the P22 contract for stage 3. An urgent decision was signed by the Trust Chair and Chief Executive on 27 June 2019. **Outcome:** The Board: • formally ratified the urgent decision made by the Trust Chair and Chief Executive made on 27 June 2019 in relation to the CAMHS Tier4 development stage 3 contract procurement.	
2019-20 (50)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information. She said that the work plan would be revised, as and when required, in line with outcomes from the Board meetings. **Outcome**: The Board noted the work plan.	
2018-19 (51)	**Approved minutes for noting:** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Quality Committee: 20 May and 24 June 2019 b. Business Committee: 22 May and 26 June 2019 c. West Yorkshire Mental Health Services Collaborative Committee in Common Chair's report 28 June 2019	
2019-20 (52)	**Close of the public section of the Board** The Chair thanked everyone for attending and concluded the public section of the Board meeting.	

Date and time of next meeting
Friday 4 October 2019, 9.00am – 12 noon.
Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF

Signed by the Trust Chair:
Date: 4 October 2019

AGENDA ITEM 2019-20 (56b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 4 October 2019

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting 2 August 2019				
	None			

Actions on log completed since last Board meeting	
Actions not due for completion before 4 October 2019; progressing to timescale	
Actions not due for completion before 4 October 2019; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 2 August 2019; not having met agreed timescales and/or requirements	

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NHS
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AGENDA ITEM
2019-20
(58)

Meeting: Trust Board 4 October 2019	**Category of paper**	
Report title: Chief Executive's report	**For approval**	
Responsible director: Chief Executive **Report author:** Chief Executive	**For assurance**	✓
Previously considered by Not applicable	**For information**	

Purpose of the report

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 CEO 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.

Main issues for consideration

This month's report focusses on:

- Annual General Meeting
- Working with Primary Care Networks (PCNs)
- Leeds Virtual Frailty Ward
- New assistant directors
- Flu vaccine campaign
- Staff survey 2019
- NHSE/I oversight framework 2019/20
- Communications report for August (appendix one)

A further verbal update will be provided at the Board meeting.

Recommendation

The Board is recommended to:

- Note the contents of this report and the work undertaken to drive forward our strategic goals and particularly our collaborative work

Chief Executive's report

1. Annual General Meeting

The Trust held its Annual General Meeting on 17 September 2019. It was hosted by the Trust's Chair, Neil Franklin. We were very fortunate to have Chris Pointon as guest speaker. Chris Pointon is the husband of the late Dr Kate Granger MBE and co-founder of the 'hello my name is …' campaign, for which he remains the campaign ambassador.

Around 70 attendees (comprising Board members, staff and members of the public) heard presentations from myself and Bryan Machin, Executive Director of Finance and Resources, which reflected on the previous year's challenges and successes, with opportunities for attendees to ask questions of the Board. Members of the public who asked questions were keen to learn about our patient engagement strategy, as well as procurement and commissioning decisions. The Executive Director of Nursing and AHPs then presented a long service award to one of our health visitors who had achieved over 40 years working in the NHS.

2. Working with Primary Care Networks (PCNs)

The first five PCNs have signed up to the PCN scheme for 'employ deploy' that has been developed at the Trust. These are hugely significant developments on our journey with the primary care community and the executive team has worked hard to make the scheme work.

3. The Leeds Virtual Frailty Ward

A new service, the Leeds Virtual Frailty Ward (VFW) is due to start Phase One implementation in late October 2019. The ambition of the VFW, which is a collaborative service between Leeds Teaching Hospitals NHS Trust (LTHT), Leeds Community Healthcare NHS Trust and partner organisations, is to provide coordinated rapid care 7 days per week, 24/7 to people who:

- are living with moderate or severe frailty, and
- can be safely supported in their home, and
- have become unwell and would previously have required hospital based input.

The primary focus of the Virtual Frailty Ward (VFW) will be:

- Phase One (Attendance and admission avoidance from October 2019 is to keep people who are assessed as living with frailty and experience an acute medical episode, at home (usual place of residence i.e. care home or community bed) if their needs can be safely met within the community without requiring a hospital admission. In Phase One, admission avoidance relates to the source of the referral outside of LTHT (e.g. GP, Neighbourhood team, YAS)

- Phase Two (Attendance avoidance, admission avoidance and Early Discharge city wide) will extend support to facilitate an earlier discharge from LTHT if ongoing care needs can be met on the virtual ward and the admission/exclusion criteria is met. In Phase Two, admission avoidance relates to the source of the referral inside of LTHT (e.g. hospital ward, Emergency department or assessment areas

Funding is being provided from an NHS Leeds CCG transformation fund. The high level Business Case that has been prepared for the Frailty Board, chaired by myself, was presented to the Business Committee on 25th October 2019. Implementation and evaluation will be overseen by the Frailty Board which will make recommendations as to future funding in due course.

4. New assistant directors

We welcome Sheila Sorby as Assistant Director of Nursing & Clinical Governance Sheila trained as a Registered General Nurse in Airedale & Bradford and has worked across primary, secondary and community care. Throughout her 27 years in the NHS, Sheila has developed her clinical specialism within Cardiology, trained and practised as an Advanced Practitioner & independent prescriber in Leeds and worked in a Clinical Governance role in community services in Kirklees.

We also welcome Stuart Murdoch who has been appointed Deputy Medical Director. Stuart is a consultant anaesthetist specialising in Liver Transplant Anaesthesia and Critical Care. He was appointed as a consultant in 2002 and has been the Clinical Director (CD) of a number of Clinical Service Units at the Leeds Teaching Hospitals Trust, until stepping down in September 2018. Between June 2017 and July 2019 Stuart was the National Clinical Lead in NHS Improvement focussing on medical workforce issues - initially focussing on medical locum spend but more latterly was involved in the interim workforce plan and the Associate Specialist & Speciality Doctors (SAS) strategy.

5. Forum Central Big Conversation

As part of development of a new third sector strategy, LCH collaborated with Forum Central (the collective voice for health and social care third sector in Leeds) in September to host a big conversation with the sector to find out about how partnership working could be improved and what some of the further opportunities for working together might be. Existing partners Touchstone and Community Links gave testimonials to demonstrate LCH's experience and track record of working with and supporting the sector. Over 60 health and social care charities attended, big and small. Conversations touched on volunteering, business development, utilising the specialist expertise of the sector to navigate the health system and working together to make the best of Leeds' resources. Led by the Head of Business Development and Business Planning Manager the next steps will be to use all of the intelligence gathered to further develop our work with the third sector and to bring it all together in to a strategy for November 2019.

6. Carers Lead

The Executive Director of Nursing and AHPS is now the Board level Carers Lead. This will ensure we consider carers of all ages in our services and that we support our carer workforce.

7. Prof Tim Briggs visit

Prof Tim Briggs, the Chair of the 'Getting It Right First Time' (GIRFT) programme and National Director of Clinical Improvement for the NHS, visited the Trust on the 4 September 2019. The GIRFT programme is a quality improvement programme based on the premise of using data to drive improvements and consistency in clinical practice and was developed initially in the acute sector. Prof Briggs is visiting community provider organisations to explore how the GIRFT methodology can be utilised in community care. During his visit to the Trust, Prof Briggs was particularly interested in seeing the Wound Care Service, Intermediate Care, MSK, Continence Service and Community Dentistry and made a number of useful contacts throughout the day to support the future development of the community implementation programme.

8. Flu vaccine campaign

The launch date for the start of the seasonal staff influenza program is 1 October 2019. This year the CQUIN target is for 100% of staff to be offered the vaccine and with 80% of frontline staff to be vaccinated. A robust plan has been followed by the flu lead, who has engaged with staff across the organisation. Staff will be offered the vaccine at drop in clinics across the city, team meetings, study days and inductions. A communication plan is in place and the flu lead has been identifying different ways to engage with staff to increase uptake. A range of posters have been developed in collaboration with Leeds City Council outlining 'sickening stories' about flu, which we hope staff will engage with and be encouraged to have their vaccine in order to protect themselves and the patients they care for. The Infection Prevention and Control Team (IPC) are trialling e-rostering for Class staff during this campaign, and as a result we have a number of staff identified to deliver the program over the up and coming months. Once the campaign has started, the Board will receive regular communication regarding up take, themes and trends.

This year IPC are delighted to be using 'Have a jab – give a jab' to encourage staff to have their vaccines. For every vaccine administered, a tetanus vaccine will be delivered via Unicef to a child in an underdeveloped country.

9. Staff Survey 2019 Launch

We are preparing for NHS Staff Survey 2019, which goes live on 7 October and will runs until the end of November 2019. We are aiming to exceed our target response rate from last year (52%) and have begun engagement discussions across the organisation about how to achieve this, involving 50 voices, Leaders Network and discussions with Business Unit senior teams. We will be focussing our communications on the actions and achievements which have been directly influenced by feedback from the Staff Survey, including our development work this

year around inclusion with the BAME community and people with disabilities, and our Making Stuff Better campaign around improvement.

We have agreed a covering letter to go with the Staff survey which I am pleased to say is, this year, signed not only by myself but collectively with staff side chair, JNC chair and the Chair of the BME network telling staff about its importance, ensuring them of its confidentiality, and most significantly that the board and senior leaders always listen and learn from the results.

10. Shadow Board

This month we have launched the Shadow Board Leadership Development programme. This is an additional and complementary part of our overall leadership development offer which is targeted at senior leaders in the organisation. The objectives of the programme are as follows:

- To develop directors of the future and help to bridge the gap between being a functional specialist and a corporate director.
- To increase participants' knowledge, experience and sphere of influence of senior and strategic decision making.
- Add value and challenge within the topics of conversation at board level and to enhance cognitive diversity and decision making
- To support talent management and succession planning within the organisation and across the system
- To create a network of experienced individuals to be stretched and support organisational and systems leadership.

The programme consists of three full day learning modules, together with three Shadow Board meetings, held the day before the Trust Board meetings, and chaired by the Executive Director of Finance and Resources. It will consider a subset of the same agenda items and decisions will be shared with Trust Board to support overall decision making. Eleven senior leaders are participating in the programme which will run from September 2019 to February 2020.

11. BAME Talent Management discussion group

BAME (Black, Asian, Minority ethnic) colleagues were invited to a discussion group on Tuesday 1 October 2019 about Talent Management for BAME people in LCH. This was in response to the annual staff survey findings that BAME staff felt that they experienced less fairness with regard to career progression and promotion. The action planning session was well attended and will ensure that the BAME voice is part of the talent management agenda in the Trust.

12. Infant Mental Health Service annual report for 2018-2019

The Infant Mental Health Service has produced its 2018-19 annual report. The service supports healthy social and emotional development for babies from conception to their second birthday – a critical time for development. Highlights from the annual report include: the service accepted 95% of referrals, suggesting referrals are appropriate; it delivered three times more consultations compared to last year; in

July the service organised a city-wide conference for perinatal practitioners on how dads can be better engaged in services. The service was proud to have had 6 publications in the year, which is a record number. 353 practitioners received training on 'Babies, Brains and Bonding'. Formal evaluation of the Early Attachment Observation (EAO) found that both aspects of the tool are being well used across health visiting teams in the city. If you would like a copy of the full report, please contact the Trust's Company Secretary.

13. Infection Prevention and Control Team win national awards

We are very proud of our Infection Prevention and Control (IPC) Team who won the IPC team of the year award at the Infection Prevention Society National Conference which took place in Liverpool on 22–24 September 2019, for their work over the last year particularly on E.coli, sepsis and flu.

Joanne Reynard, who is the Trust's Senior Infection Prevention Nurse and IPC Lead for the Leeds GP Confederation, was deservedly awarded practitioner of the Year, for her continuous hard work and dedication to IPC, not only in her day job but her role as Yorkshire Infection Prevention Society (IPS) Coordinator.

14. Leeds Community Equipment and Telecare Services – national accreditation

Leeds Community Equipment and Telecare Services have become the first integrated equipment service in the country to achieve national accreditation. The accreditation process, led by Leeds City Council, was intense and challenging, requiring lots of hard work from those involved. Well done to everybody in the service who participated in the assessment process.

15. NHSE/I oversight framework

In August NHS England/ NHS Improvement (NHSE-I) published the NHS Oversight Framework for 2019/20. This establishes a single framework for NHSE-I's assessment of both provider and CCG performance, support needs and segmentation across STPs / ICSs. The approach remains largely the same: NHSE-I assesses performance throughout the year from triangulating reporting against Oversight Framework metrics, regular review meetings with Exec Director teams and other intelligence local intelligence. There is a stronger focus on leadership and culture and more associated metrics to report on. We will incorporate these in Workforce reporting / the Performance Brief once metrics have been fully defined. There are no changes in the Quality or financial metrics relevant to LCH. There is no change in the segmentation scale and descriptors: the ratings are from 1 to 4: 1 indicates no support needs and maximum autonomy, 4 reflects providers / CCGs in special measures. LCH's rating remains: 2

The most significant change is that from 2019/20, (emerging) ICSs will be increasingly involved in the oversight process and support of organisations in their system. This is, however, dependent on NHSE-I's assessment of STPs / ICS maturity. NHS England and NHS Improvement are developing a maturity matrix for systems that will determine the relative responsibilities and freedoms and support available.

16. Communications report (August)
(See appendix one)

17. Recommendation

The Board is recommended to:

- Note the contents of this report and the work undertaken to drive forward our strategic goals and particularly our collaborative work

Appendix one

LCH Trust Communications report -August 2019

This report has been put together by the Trust's Communications Team. All figures provided are true figures (not percentages) taken at the date of collection. Further information is available on request.

Social and Online Media

Twitter

		Last month
7,927	**Followers**	7,882
23	**Tweets** (excluding retweets)	46
386	**Mentions** (Number of times someone has tweeted @LCHNHSTrust)	550
53,100	**Impressions** (number of times a tweet from LCH is delivered to someone's twitter feed)	84,700

Facebook

		Last month
3,412	**Page likes**	3,334
25	**Posts**	33
1,932	**Engagement** (likes, comments, shares, clicks etc.)	2,936
45,828	**Total reach** (total number of people LCH posts have reached over the month)	43,674

Website

		Last month
54,301	**Page views** (total times any website page has been accessed)	69,091
22,561	**Sessions** (where a user is actively engaged i.e. clicking links, accessing multiple pages)	27,207
12,418	**New visitor sessions**	14,997
01:46	**Average length of visit**	01:50

Twitter

1. **East #Leeds Health Centre has now become the latest donation station and collection point for @freedom_4_girls to help fight against #periodpoverty - find out more here: (link) @nhsleeds @LeedsNews – 3,880 reached, 12 retweets, 24 likes**
2. **Massive thanks to @EdSheeran and @StuartCamp's team for recognising our wonderful nurses by personally sending them 10 guest list tickets for the concert at Roundhay Park – our 'A Team' loved every minute! Read more here: (link) @nhsleeds @NHSuk – 3,792 reached, 9 retweets, 39 likes**
3. **In celebration of World Breastfeeding Week we want to share that our Health Visiting Service has been re-awarded gold status by @UNICEF_uk Baby Friendly Initiative for care provided to pregnant women and families in Leeds! (link) @Child_Leeds @nhsleeds #WBW2019 – 3,585 reached, 6 retweets, 15 likes**

Facebook

1. East #Leeds Health Centre has now become the latest donation station and collection point for Freedom4Girls to help fight against #periodpoverty - find out more here: (link) – 3,847 reach, 250 reactions, 196 likes, 9 comments, 18 shares
2. Are you a dedicated, resilient, nurse who is looking for a challenge in a dynamic environment? Join our team of like-minded healthcare professionals and make a difference to the lives of vulnerable young people in this exciting role in our prison healthcare team. As part of the new developmental post you will progress through a structured competency based training programme to develop your skills. Find out more and apply now – 2,605 reach, 31 reactions, 10 likes, 4 comments, 16 shares
3. Massive thanks to Ed Sheeran and his management team for recognising our wonderful nurses by personally sending them 10 guest list tickets for the concert at Roundhay Park – our 'A Team' loved every minute! Read more here: (link) – 2,385 reach, 228 reactions, 137 likes, 39 comments, 17 shares

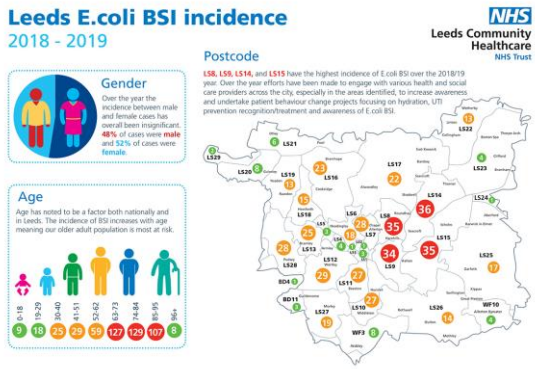
Website

1. IAPT Home – 7,508 page views
2. Homepage – 4,680 page views
3. Our services A – Z – 2,554 page views
4. Speech and Language Therapy Toolkit – 2,185 page views
5. Neighbourhood Teams – 1,546 page views

Most mentioned on Twitter

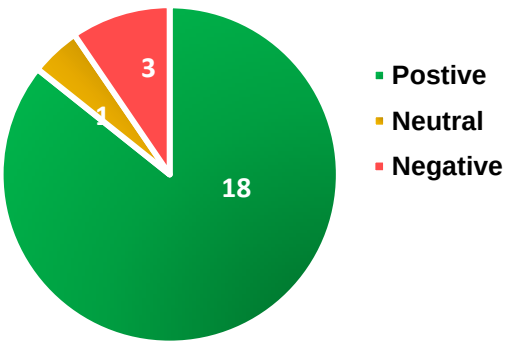
*Based on Trust tweets between 1 August 2019 and 31 August 2019

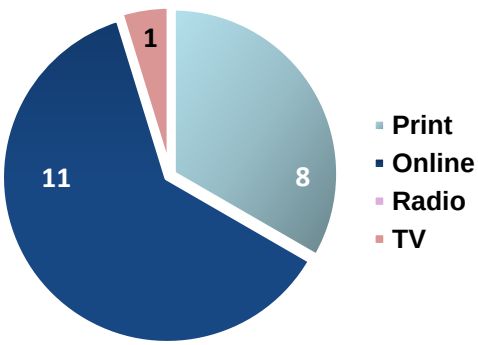
Graphic Design Examples



Print and Broadcast Media

Coverage by tone and type (total year from 1 April 2019)





Summary of coverage

1. **Patients miss 63,080 appointments with Leeds NHS Trust**
   Yorkshire Evening Post, 16 August 2019
   Article about missed appointments at LCH. The way the reporter totals figures released by NHS Digital creates an inaccurate picture. We were not asked for comment.
   https://www.yorkshireeveningpost.co.uk/health/patients-miss-63-080-appointments-with-leeds-nhs-trust-1-9935039

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (59a)

Report to: Trust Board: 4 October 2019
Report title: Charitable Funds Committee 20 September 2019: Committee's Chair assurance report
Responsible director: Chair of Charitable Funds Committee **Report author:** Executive Director of Nursing and Allied Health professionals
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Charitable Funds Committee held on 20 September 2019 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Finance Report
This was accepted by the committee.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

The Chair of the Committee noted that there was still an outstanding and important piece of work on better defining the appropriate criteria for using charitable funds within the Trust. This had been a commitment following the previous committee meeting and The Director of Finance agreed to follow this up.

Annual Report and Accounts 2018/19
This was signed off by the Committee

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

More than a welcome - health centre waiting areas improvement plan
There has been further progress and the work is ongoing with the purchase of new chairs planned for a number of areas. The provision of drinking water was also considered for inclusion at Centres. The work is ongoing, following a consultation exercise with Centre users – staff and patients. There would be a further progress report at the next meeting. The Chair expressed the view that is was good to see some progress in this area.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (59b)

Report to: Trust Board - 4 October 2019

Report title:
Nominations and Remuneration Committee - Committee Chair's Assurance Report
20 September 2019

Responsible director:
Chair of Nominations and Remuneration Committee

Report author:
Director of Workforce

Previously considered by: Not applicable

Purpose of the report

This paper outlines the key issues for the Board arising from the Nominations and Remuneration Committee held virtually on 20 September 2019.

CEA Awards Process 18/19:

The Committee noted that the CEA Awards panel for the 18/19 round had met on 27 August 2019 and approved the panel's recommendation to award seven 18/19 Employer Based Clinical Excellence Awards to the suggested consultants.

Assurance level							
Substantial		**Reasonable**	**X**	**Limited**		**No**	

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Agenda item 2019-20 (59c)

Report to: Trust Board 4 October 2019
Report title: Quality Committee 23 September 2019: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Company Secretary
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Quality Committee meeting held on 23 September 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

The Committee has previously agreed to reformat its work plan and to hold of six 'business' meetings linked to Board and four 'focus based' workshop style meetings per year, as this would allow the Committee to focus more sharply and effectively on key items. The September 2019 Quality Committee meeting was a business meeting.

Quality Spotlight – Palliative and End of Life Care
The Committee was provided with a briefing in advance of the Quality Spotlight presentation, with the presentation focussing on two patients' stories. The Children's Business Unit presented the story of a 15 year old patient who had been known to the service for a long time, as she had her long term condition from being neonatal. The message from this story was that strong relationships and good communication was the key to providing the best care. The Adult Business Unit (ABU) described the feedback they had received from the daughter of a patient who had received palliative care. Some aspects of care had gone very well, including that the patient had died in her preferred place of choice and her rapid deterioration had been recognised and acted upon. Potential improvements were identified in relation to senior clinician oversight, particularly in the last few days of life, communication with the family could have been better and medication for symptom management could have been better optimised. The Committee heard that there were opportunities for sharing the feedback across the service and with primary care. Following a healthy discussion, the Committee asked for a further update to be brought to a future meeting regarding assurance that robust senior clinician oversight was being effectively addressed.

The Committee can provide the Board with the following assurance:

Serious Incident update report (patient AY)
The Committee received a further update on the progress with the action plan which had been developed following the investigation into the suicide of a patient who had previously accessed the CAMHS service. The Committee was advised that all the actions had been completed and that plans were in place for LCH, LYPFT and the CCG to monitor compliance through a Quality walk. The CCG had also met with AY's mum and will maintain contact with her. The Committee reviewed the action plan and requested an amended action plan, inclusive of assurance measures to be received at the January 2020 Committee. The Committee concluded that the action plan reflected the initial actions taken currently providing limited assurance. Further assurance is to be expected with an updated action plan inclusive of audit / assurance activity.

Duty of Candour
The Committee was provided with the result of an audit into compliance with the statutory Duty of Candour (DoC) process. The conclusion was that there were inconsistencies in the way DoC information

is captured and a lack of awareness of the timescales for a statutory DoC response. The recommendation was that a system should be designed to monitor compliance, and there should be a review of the policy, guidance and training. The Committee was reasonably assured by the action plan that had been produced in response to the recommendations. It was agreed that future assurance in relation to statutory DoC compliance would be provided through the performance brief.

Performance Brief and Domain Reports
The Committee agreed that reasonable assurance was provided for the Safe and Caring domains. It noted that 30% of reported patient safety incidents originated from external providers and was keen to understand the process for ensuring that such incidents were picked up by the appropriate provider, or in the case of incidents where there was joint responsibility, there was a process for learning across the health system.

Winter planning (quality implications)
The Committee was provided with an update on the additional contingency arrangements required for the winter period to maintain service continuity and quality of care. This provided the Committee with reasonable assurance. The Committee was mindful that the impact of the EU Exit may also need to be managed alongside resilience plans for winter.

Mortality Report (quarter one)
The Committee was apprised of the progress of the Mortality Surveillance Group. Data integrity continued to be a challenge to obtaining an accurate picture of all deaths reported across the Trust, however it has significantly improved. The Committee was advised that people with Learning disabilities and those with a serious mental illness appeared to be underrepresented in the Trust's mortality data. This is due in part to the fact that GP data codes currently can't be transferred into the Trust's system; this was actively being worked on to try resolve the issue. The number of deaths and level of review required a substantial amount of resource and the Committee was advised that capacity is being carefully monitored. The Committee agreed that the paper was helpful and provided reasonable assurance.

Quality Strategy implementation plan update
The Committee was advised that work to embed self-management, better conversations and personalisation was having an impact across the business units, and each business unit was working proactively with stakeholders to deliver new models of care. The implementation plan was making good progress with all areas on track to meet the objectives. The Committee received reasonable assurance from this update.

Quality Priorities month five position The Committee was advised that good progress is being made in delivering the Organisational and Quality Account Priorities. Priority 12, which relates to progressing the CAMHS Tier 4 build and service model to the agreed timescale, has been amended from Red to Amber as the timescales have been revised. No concerns were raised by the Committee in relation to the priorities.

Research and Development Strategy
The Committee received an update on the progress being made with the draft Research and Development Strategy and was asked to confirm whether it felt the comments the Committee had provided previously were now reflected in the revised draft strategy. The strategy's scope had been expanded as the Committee had previously commented that it appeared too ambitious for the timescales involved. The revised draft now incorporated patient and academic input. There were plans to capture further patient feedback. The Committee agreed the Board needed to determine its appetite for research in order to influence the level of investment. The Committee agreed to provide further comments to the strategy author with a view to receiving a further iteration of the strategy at a future meeting.

The Committee reviewed and recommended that the Board approves the following documents:

- Draft Patient Experience and Engagement Strategy (with minor amendments)
- Safeguarding Annual report
- Infection Prevention and Control Annual Report

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AGENDA ITEM 2019-20 (59d)

Report to: Trust Board 4 October 2019
Report title: Business Committee 25 September 2019: Committee Chair's assurance report
Responsible Director: Chair of Business Committee **Report author:** Company Secretary
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Business Committee held on 25 September 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Estates Strategy – Reasonable Assurance
The Committee reviewed the draft Estates Strategy, having previously seen an earlier version in June 2019. The revised draft strategy listed fewer priorities and was more ambitious in the utilisation of estate. The strategy was well received with the Committee recognising that this was an enabling strategy, which opened up possibilities for different ways of working. The Committee suggested some minor changes (to add a glossary of terms, to include potential outcome benefits) and recommended that the Board should review the draft strategy at its October 2019 meeting.

Workforce Strategy – Health and Wellbeing – Reasonable Assurance
The Committee was provided with an update on the delivery of the Workforce Strategy, focussing on the Health and Wellbeing priority. The key message was that the rate of staff sickness absence has been below 5% for three months since April 2019. This could be attributed to a number of factors including leadership and engagement. There has been media interest in the Trust's innovative approach to staff health and wellbeing. The Committee also discussed the findings of the Amin Abdullah review and agreed that the learning from this should be incorporated in the Workforce Strategy and were very keen to see a rigorous and early delivery of the promised improvements

Standards of Partnership Governance – Substantial Assurance
The Committee reviewed the draft Standards of Partnership Governance and welcomed the proposed approach for management of partnership arrangements. The Committee was assured of its effectiveness as the standards had been reviewed and tested out by business managers and the internal auditor, all of whom had provided positive feedback. The Company Secretary will amend the draft version based on feedback received and the Standards of Partnership Governance will be presented to Audit Committee in October and to the Board in December 2019.

Projects update (Change Board) – Reasonable assurance
The Committee was provided with an update on the Trust's key projects, including a flash report indicating key milestones achieved since the last update, and where there had been, or expected to be delays.

The Committee was advised that the Administration review project had identified some serious legacy issues concerning a misalignment of roles and bandings. The extent of the issue was being scoped and resolution to this was anticipated to be complicated, which would mean the project would be potentially significantly delayed. The Committee recognised the importance of ensuring these legacy issues are resolved effectively – and they are difficult issues. The financial risk associated with this will be added to the Trust's risk register.

There were no issues of concern raised with the other projects. The Committee noted that the e-rostering project was achieving its timescales in line with the project plan and there had been good progress in recruiting to the project team.

Performance Brief

The Committee reviewed the August 2019 performance data. The Committee was advised of the discussion that had taken place in Quality Committee regarding other provider incidents reported on the Trust's incident system. In the Finance section of the Performance Brief, the Committee was apprised of the risk concerning the interaction between the new care model, CAMHS Tier 4 and the Trust's budgets. The forecast overspend situation on the new care models budget was being addressed through a renewed focus on the length of stay of inpatients. The conclusion was that the Trust could still achieve its control total though there was more risk attached to this than had previously been reported. The committee expressed concerns about the current position. The Executive Director of Finance and Resources also drew the Committees attention to the concerns raised by the West Yorkshire and Harrogate Health and Care Partnership regarding revenue, for which the Trust has a share of the risk.

Triangulation – Reasonable Assurance

The Committee received the quarterly update on quality, staffing and finance, triangulated into one report. It was advised that in future the Quality Committee would also receive this report. The Committee recognised that the overall position was stable, and there had been an important improvements on the previous year. There was variation, with some teams under pressure, and resource was being used flexibly to manage these. There was a concern about losing staff within the first year; however the Committee was advised that the Trust is in a similar position to the national picture.

Productivity

The Committee expressed its disappointment that the Productivity Group had not met recently and that this matter was not progressing. It gave a clear sense of not yet getting off the starting blocks, some months after its inception.

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AGENDA ITEM 2019-20 (60i)

Meeting: Trust Board, 4 October 2019	**Category of paper** *(please tick)*	
Report title Performance Brief and Domain Reports	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 18th September 2019 Quality Committee, 23rd September 2019 Business Committee, 25th September 2019	**For information**	

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.

It highlights any current concerns relating to contracts that the Trust holds with its commissioners.

It provides a focus on key performance areas that are of current concern to the Trust.

It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

Main issues for consideration

This month's Performance Brief contains the most up to date information available for the month of August 2019.

Across the domains in this Performance Brief, the summary position is as follows:

In the **Safe and Caring** domain, 144 (30%) of all patient safety incidents this month originated from external providers; this is currently being discussed with those providers to agree on how to manage these incidents and share learning.

There is 100% compliance with Duty of Candour: A review of the process is ongoing, the new process will trigger prompts for an initial verbal and written apology.

Overall, 97.05% of Community patients and 100% of inpatients responding to the survey would recommend the service to family and friends. Updated FFT guidance has been released with a new FFT question; "Overall, how was your experience of our service?" this will be implemented in April 2020.

Effective: This domain is reported on quarterly. The Q1 summary position is included for information only on page 10.

Performance in the **Responsive** domain remains good with the majority of targets being met. The exception to this is waits for diagnostic tests. 13 patients are currently waiting more than 6 weeks. This is due to unforeseen extended staff sickness. No breaches are expected next month.

Sickness absence (in the **Well Led** domain) remains lower than in previous years, at 4.8%. At the end of month 5 of 2019/20, there have already been three months where overall sickness absence has been below 5%; compared with no months below 5% during 2018/19.

Statutory & mandatory training figures have seen a dip in performance linked to organisation-wide amendments to Infection Prevention & Control training as part of the LCH statutory and & mandatory training project. Currently standing at 87.4% against a target of 95%, the figures are set to improve considerably when the reconfiguration work is complete.

Appraisal figures continue to rise steadily, at 87.2% at the end of August 2019.

Turnover and stability rate both remain well within tolerance.

In the **Finance** domain the year to date financial position is consistent with previous months and overall the surplus is £0.1m more than planned.
Pay costs are £0.2m underspent and there are 63 WTE vacancies reported for the month this is 19 less than last month. Non-pay costs continue to report an overspending.

The Trust continues to forecast delivery of the control total at the end of March. The Trust has a forecast shortfall on 2019/20 CIP efficiency savings for the year; this will be mitigated by un-planned savings elsewhere. All other finance targets are forecast to be achieved for the year.

The Director of Finance remains confident that the required savings will be achieved or mitigated by changes to the current forecast income and/or expenditure as the year progresses; the situation is monitored closely and it should be noted that the Trust has no funds available for un-planned, ad-hoc expenditure.

Recommendations
The Board is recommended to:

- Note present levels of performance
- Determine levels of assurance on any specific points
- Comment on the intention to include reports in a “flash report” format next month

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (60i)

Meeting: Trust Board, 4 October 2019	**Category of paper** *(please tick)*	
Report title Performance Brief and Domain Reports	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 18th September 2019 Quality Committee, 23rd September 2019 Business Committee, 25th September 2019	**For information**	

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.

It highlights any current concerns relating to contracts that the Trust holds with its commissioners.

It provides a focus on key performance areas that are of current concern to the Trust.

It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

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Recommendations
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Performance Brief – August 2019

Leeds Community Healthcare NHS Trust

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It highlights any current concerns relating to contracts that the Trust holds with its commissioners.

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It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

Committee Dates
Senior Management Team – 18th September 2019
Quality Committee – 23rd September 2019
Business Committee – 25th September 2019
Trust Board – 4th October 2019

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

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Across the domains in this Performance Brief, the summary position is as follows:

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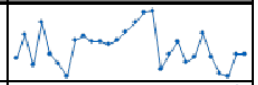
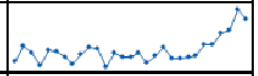
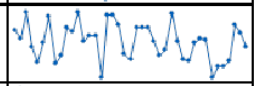
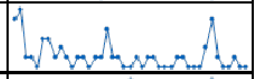
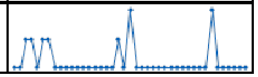
Safe – August 2019

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

Leeds Community Healthcare NHS Trust

Safe - people are protected from abuse and avoidable harm	Financial Year	Target	Frequency	Responsible Director	YTD	Q1	Jul	Aug	Forecast	Monthly Time Series
Overall Safe Staffing Fill Rate - Inpatients	2019/20	>=97%	M	SL	-	94.7%	97.5%	98.3%	●	
	2018/19				-	101.0%	104.0%	104.3%		
Patient Safety Incidents Reported in Month Reported as Harmful	2019/20	0.55 to 1.13	M	SL	1.34	1.18	1.64	1.46	●	
	2018/19				0.90	0.86	0.92	0.75		
Serious Incident Rate	2019/20	0 to 0.1	M	SL	0.04	0.04	0.06	0.04	●	
	2018/19				0.05	0.04	0.08	0.05		
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	2019/20	1	M	SL	1	1	0	0	●	
	2018/19				7	1	0	1		
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	2019/20	0	M	SL	0	0	0	0	●	
	2018/19				2	0	0	0		

Areas noted as a result of this report are as follows

- Slight overall reduction of patient safety incidents (PSI) reported this month
- Plateau effect seen within the SPC chart of PSI's per 1000 contacts
- Reduction in major harm incidents reported

Follow-up from July Data

- The reported moderate harm staff incidents have both been investigated and closed, staff given appropriate support and continue to be in work
- StEIS reportable incidents in July was 3, 1 category 3 pressure ulcer and 2 comprehensive SI's relating to a child's feeding plan not being followed resulting in weight loss and an adult with a traumatic skin injury
- There was a consistent rise in incident reporting seen from April through to July, this is due to two new categories of incidents being introduced into the Datix system. However, we have seen a plateau as expected in August. The 2 added categories (Moisture Associated Skin Damage (MASD) & Skin Tears) will be monitored and further explanation and analysis will be provided in the quarterly pressure ulcer report

- Delays in the return of 72 hour templates for falls and pressure ulcers has been noted, these are predominately within the ABU. A checksheet and a weekly escalation to the Clinical Lead & Quality Lead has now been put in place including a Datix dashboard to monitor requests for the templates and their return to the clinical governance team.

August Data Review

- 630 incidents have been reported in Datix for August with 469 (74%) reported as patient safety incidents (PSI), 327 (70%) of these are LCH patient incidents
- 142 (30%) of all PSI's this month originated from other providers, this is currently being discussed with other providers. An update on discussions with LTHT will be provided next month
- 78 staff incidents were reported– 3 reported moderate harm, 1 bending/stretching injury; a member of staff getting alcohol gel in eyes & a violent episode by a young service user kicking and biting staff member.
- 5 major harm incidents reported– 3 x falls resulting in fracture neck of femur and 2 skin damage /Category 4 pressure incidents – one found to be unavoidable at 72 hour review, whether one was avoidable is yet to be determined. This was a deterioration of a pressure ulcer under our care. The incident is still under investigation with panel review booked for early October
- There has been one incident where Duty of Candour was applicable. The initial apology letter was sent within 10 working days and is therefore compliant with the national requirement.

There has been a steady rise in patient safety incidents per 1000 contacts. This has seen the numbers above the normal variation from May. This is due to the two new categories MASD and Skin Tears which have been introduced into reporting from April. As we would expect, there has been a steady increase in reporting of the new categories until reporting is embedded in practice with a plateau effect seen this month. We will continue to monitor, but expect this plateau to continue to normal variation.

All other incident categories continue to be within normal variation.

Patient Safety Incidents (LCH only)

There were a total of 327 LCH PSIs reported in August 2019 which is a slight decrease from July's data but within normal variation. The largest categories of patient safety incidents causing harm is falls and skin damage (pressure ulcers) as expected.

Risks for Escalations and Assurance

- Standard Incident Themes have now been added to both Datix and the SI investigation templates. Data should be available from these in quarter 3, earlier themes lists will continue to be used until this point.
- Major harm incidents have reduced this month. Of the 5 reported, 1 has already been investigated and found to be unavoidable to LCH, 4 are awaiting review.
- CAS Alerts – One alert breached its closure date this month. This was due to an oversight in Clinical Governance.

Caring – August 2019

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

Leeds Community Healthcare NHS Trust

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Financial Year	Target	Frequency	Responsible Director	YTD	Q1	Jul	Aug	Forecast	Monthly Time Series
Percentage of Respondents Recommending Inpatient Care (FFT)	2019/20	>=95%	M	SL	85.7%	85.7%	-	100.0%		
	2018/19				-	91.7%	100.0%	100.0%		
Percentage of Respondents Recommending Community Care (FFT)	2019/20	>=95%	M	SL	96.7%	96.7%	97.0%	97.1%		
	2018/19				-	95.9%	96.8%	96.8%		
Total Number of Formal Complaints Received	2019/20	<175	M	SL	106	62	29	15		
	2018/19				144	43	10	17		
Number of Formal Complaints Upheld	2019/20	<175	M	SL	38	19	10	9		
	2018/19				-	-	-	-		
Number of Formal Complaints Responded to within timeframe	2019/20	<175	M	SL	59	33	14	12		
	2018/19				-	-	-	-		
Number of Compliments Received	2019/20	No Target	M	SL	596	374	116	106		
	2018/19				-	-	-	-		

Patient Experience

Friends and Family Test (FFT)

The updated FFT guidance has been released to be implemented by April 2020. The updated question will be- 'Overall, how was your experience of our service?' with updated responses of 'Very good, Good, Neither good nor poor, Poor, Very poor, Don't know'. Guidance has been released with suggested updated framing texts such as 'Thinking about your recent visit/appointment…' and 'Thinking about the service we provide…'. Providers will still be required to submit monthly numerical to FFT data to NHS digital for national publication.

Overall, 97.05% of Community patients responding to the survey would recommend the service to family and friends. Of inpatient services, 100% of respondents would recommend. A further breakdown of this is provided in the table below, by business unit.

	Number of responses received	% of which recommended	% of which would not recommend	Number of comments received	Overall response rate
ABU Services	225	92%	1%	186	5.03%
CBU Services	200	98.00%	0.50%	255	3.88%
CBU Inpatients	4	100%	0%	7	400%
SBU Services	557	98.92%	1.08%	726	5.19%
SBU Inpatients	1	100%	0%	8	0.65%

Of those who would not recommend the service the FFT comments relate to staff attitude, listening and communication and timely appointments.

There has been an increase in inpatient FFT responses in August since last month however these are still low. The Involvement lead in CBU is exploring ways to encourage response rates with staff within services across the business unit.

The is ongoing work with Business intelligence and MES (Membership Experience System) to change the FFT denominator to the number of discharges per month to help make the FFT figures more meaningful.

For CAMHS the Children's CHI-ESQ data for July is as follows:

- 74% would recommend; 21 out of 29 children said Yes, 4 Maybe, 3 don't know, and 1 not really

CAMHS Parent/Carer CHI-ESQ data for July is as follows:

- 97% Extremely likely to recommend (37/38 responses), 3% not likely to recommend (1/38 responses)

The Patient Experience Team have been working closely with Hannah House to look to develop how local volunteers could support interactions with the children at busy times; for example, mealtimes. The staff at Hannah House have been supported to put together a person specification and role description for the 'Friends of Hannah House' opportunity. This will be shared within the local community.

The Patient Experience Team have been involved in a piece of work with the Children's Nursing Services as part of a wider quality improvement piece of work. 8 interviews have been conducted with families accessing the services and the feedback from these interviews will be collated thematically using the Yorkshire Patient Experience Toolkit. This will be fed back to staff along with identified service areas for quality improvement.
In August, experience and learning from Garforth Leg Club staff and attendees has been gathered to identify areas to help increase attendance at the Otley Leg Club. Patient and carer stories have been recorded to share across the clubs to encourage attendance, this will include sharing with GPs and other potential referring agencies.

Complaints, Concerns and Claims

The table below highlights the number of complaints and concerns that have been received by the PE team.

Feedback	August 2019 Received
Complaints	15
Concerns	35
Clinical Claims	1
Non-clinical Claims	0

There were 4 complaint responses due to go out in the month of August that have had their response dates renegotiated to now go out in September. This is being closely monitored to ensure complaint timescales are only extended when absolutely necessary and the updated process will reflect this.

As prescribed by the NHS Complaints Regulations 2009, it is a statutory requirement that the Trust must acknowledge all received complaints within 3 working days. The regulations also state that all complaints must be responded to, in writing, within 180 working days – unless otherwise agreed with the complainant. We have seen an improvement with the management of complaint responses and are now meeting all our targets. There are no outstanding complaints.

The table below is a review of the number of received and closed complaints in August.

Key Performance Indicators and Developments	Status
Acknowledged within 3 days	15 (100% Compliance)
Responded to within 180 days	12 (100% Compliance)
Active PET Caseload	45
PHSO requests	0

There are 45 complaints on the caseload for August. 9 of these complaints are currently on hold. There have been 2 complaints that have been reopened within August and 2 complaints are ongoing with the PHSO.

Effective – Quarter 1 2019

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

Leeds Community Healthcare NHS Trust

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Financial Year	Target	Frequency	Responsible Director	YTD	Q1	July	Aug	Forecast
Audit: number of mandatory must do (priority 1) and should do (priority 2) audits started *(n = 73)*									
due to start in Q	2019/20	N/A				36			
started in Q	2019/20	100%				47.2%			
Clinical outcome measures: service self-reporting as achieving *(n = 56)*									
step 2 (outcome measures for service identified)	2019/20	100%				40.4%			
step 3 (outcome measures available in clinical system)	2019/20	75%				40.4%			
Medicines Management: Medicines Control Assurance Check *(n=144)*									
completed at team level within last 24 months	2019/20	100%				96.5%			
meeting all required standards	2019/20	100%				95.1%			
NICE guidance: compliance with guidance published during 2017/18 *(n = 43)*									
full compliance	2019/20	> 90%				95.2%			
action plan in place	2019/20	> 5%				4.8%			
not due yet	2019/20	-				21			
Clinical and Corporate Policies *(n = 102)*									
fit for purpose	2019/20	100%				96.0%			
overdue for review	2019/20	< 5%				4.0%			
Quality Challenge+ (QC+) Programme: services *(n = 63)*									
rated as 'good' or 'outstanding' on self assessment	2019/20	> 80%				79.3%			
who have received a QC+ Walk during 2019/20	2019/20	100%				17.2%			
who have had a change in rating following QC+ Walk	2019/20	< 10%				10.0%			
Research and Development *(n = 720)*									
patients recruited into studies	2019/20	100%				13.6%			

Audit is currently behind schedule. Analysis undertaken during Q2 has identified that 22 of the 39 (56%) must do (priority 1) and should do (priority 2) audits planned to start in Q1 progressed to timescale. A further five audits were abandoned in Q1 due to duplication on the audit programme (3), cancelled by the national sponsor (1) and no longer relevant to the service (1). An additional 11 audits were registered during Q1 as services identified further areas of improvement. The new audit training programme was launched in Q1 with three introductory sessions delivered. Further audit masterclass sessions will be delivered in Q2 to support front line staff in their audit activities. Historically, completion of audits does not follow a linear pattern within the Trust, with Q3 and Q4 traditionally being the time of the year for peak audit activity.

The corporate elements of the **Clinical Outcome Measures** programme did not progress to plan in Q1 due to a lack of suitable candidates to fulfil the projects posts. Following a further round of recruitment, and utilisation of the Trust Talent Pool, it is anticipated that all posts will be filled by the end of Q2 (September 2019). A detailed review of current position on a service-by-service basis will be undertaken as a priority piece of work during Q3.

The five services with an overdue **medicines** code assurance check have received support from the corporate team. All five will be completed within Q2.

We have full compliance with 20 pieces of **NICE guidance** published in the last two years. The one action plan relates to the Eating Disorder Service who are still implementing the 140 recommendations in NG 69 Eating Disorders (published May 2017).

The four **policies** overdue for review have now been allocated lead authors and are being updated.

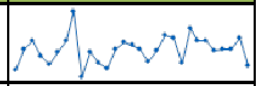
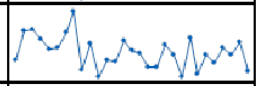
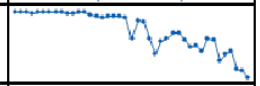
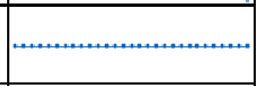
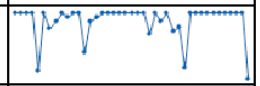
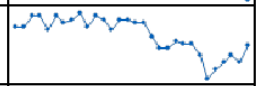
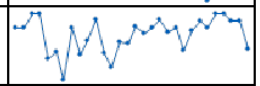
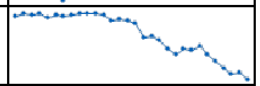
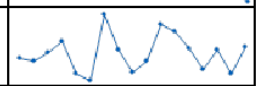
The seven outstanding Quality Challenge+ self assessments will be completed by the end of Q2. Ten **Quality Challenge+** programme visits were undertaken in Q1; the work plan includes increased activity in Q2. One service (Infant Mental Health) had their self-assessment rating reset from ‘outstanding’ to ‘good’ following a QC+ visit.

The number of patients recruited into **research** studies does not follow a linear pattern throughout the year. Ninety-eight participants were recruited in Q1. There is focussed work to recruit to the SECURE Stairs (YOI) study during Q2 which is expected to yield more than 200 recruits.

Responsive – August 2019

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

Leeds Community Healthcare NHS Trust

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Financial Year	Target	Frequency	Responsible Director	YTD	Q1	Jul	Aug	Forecast	Monthly Time Series
Patient Contacts - Variance from Profile	2019/20	0 to ± 5%	M	SP		-1.5%	2.6%	-8.7%	●	
	2018/19					-3.0%	-4.7%	-9.3%		
Patient Contacts	2019/20		M	SP		385,845	135,695	119,918	●	
	2018/19					392,694	129,534	122,169		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2019/20	>=92%	M	SP	-	94.7%	94.7%	94.0%	●	
	2018/19				-	97.0%	98.1%	98.0%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	2019/20	0	M	SP		0	0	0	●	
	2018/19					0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2019/20	>=99%	M	SP	-	100.0%	100.0%	93.5%	●	
	2018/19				-	99.7%	98.1%	98.5%		
% Patients waiting under 18 weeks (non reportable)	2019/20	>=95%	M	SP	-	97.9%	97.7%	98.2%	●	
	2018/19				-	98.9%	98.8%	98.4%		
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	2019/20	>=95%	M	SP	-	99.8%	99.8%	99.0%	●	
	2018/19				-	98.9%	99.4%	99.6%		
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	2019/20	>=75%	M	SP	-	53.4%	54.0%	48.9%	●	
	2018/19				-	98.9%	79.2%	80.0%		
IAPT - Percentage of people who complete treatment and recover	2019/20	50%	M	SP	-	51.3%	47.0%	51.7%	●	
	2018/19				51.0%	49.9%	52.8%	46.9%		
CAHMS - Percentage of children and young people with an eating disorder seen within 1 week of an urgent referral	2019/20	95%	M	SP	0 urgent referrals	-	-	-	●	
	2018/19				-	-	0.0%			

Statutory Breaches and Waiting Lists

The Trust is currently performing well against the nationally set waiting targets. There are currently hotspots in Paediatrics due to absence vacancies in the medical workforce. These gaps have been filled to date by locums but the service is now implementing a plan in place to ensure all patients are seen within 18 weeks with a reduced reliance on locums.

In August there was disappointing performance in the Audiology service with regard to the 6 week wait for diagnostic tests. As forecast last month reduced capacity due to sickness resulted in 13 patients waiting more than 6 weeks for their hearing tests. The service is looking at how resilience can be improved in this small service to avoid this happening again. If financial sanctions are imposed they would total £2,200. No breaches are expected next month.

Non-consultant-led Referrals

In addition to the national standards the Trust works to an internal target of 95% of all non-Consultant-led referrals being seen within 18 weeks (to mirror the national target). The Trust routinely meets this standard.

IAPT

IAPT performance remains a concern. In July the service focused on improving access into the service and whilst this initiative improved performance on the number accessing IAPT, it had a detrimental impact on the waiting for treatment time with only 49% of patients being seen within 6 weeks of referral (target is 75%). The service continues to meet the 95% target of patients being seen within 18 weeks of referral. As previously reported this is a shared concern with commissioners and the service is working closely with the CCG to recover performance in this area.
In line with seasonal norms, the percentage of patients completing treatment and meeting the recovery target has improved to 52% (target 50%).

CAMHS

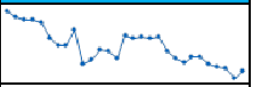
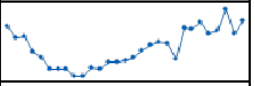
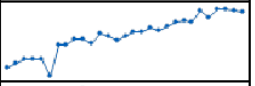
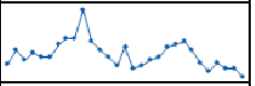
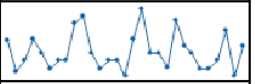
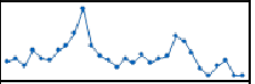
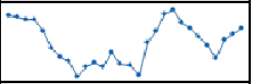
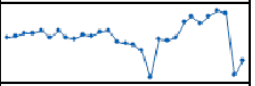
The Next Steps waiting list position has improved again with only 6 patients waiting more than 12 weeks. Of these 6, 5 have previously DNA'd or cancelled appointments.

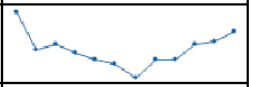
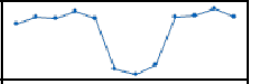
Waits for the neurodevelopmental pathway have increased in the last month. Commissioners have signalled an intention to provide transformational funding to clear the Neurodevelopmental waiting list (£100,000 for outsourcing assessments). However the greatest gains will be made through the redesign of the pathway which ensures direct access to the neurodevelopmental team rather than referral on from the Next Steps process.

Well-Led – August 2019

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

Leeds Community Healthcare NHS Trust

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Financial Year	Target	Frequency	Responsible Director	YTD	Q1	Jul	Aug	Forecast	2 Yr Monthly Time Series
Staff Turnover	2019/20	<=14.5%	M	LS/JA	-	13.1%	12.7%	13.0%	●	
	2018/19				-	14.6%	14.4%	14.5%		
Reduce the number of staff leaving the organisation within 12 months	2019/20	<=20.0%	M	LS/JA	-	20.1%	16.8%	18.4%	●	
	2018/19				-	13.2%	13.6%	14.4%		
Stability Index	2019/20	>=85%	M	LS/JA	-	87.6%	87.5%	87.4%	●	
	2018/19				-	85.6%	85.9%	85.9%		
Short term sickness absence rate (%)	2019/20	<2.2%	M	LS/JA	-	1.5%	1.5%	1.2%	●	
	2018/19				-	2.2%	1.5%	1.6%		
Long term sickness absence rate (%)	2019/20	<3.6%	M	LS/JA	-	3.9%	3.3%	3.7%	●	
	2018/19				-	3.3%	3.8%	4.1%		
Total sickness absence rate (Monthly) (%)	2019/20	<5.8%	M	LS/JA	-	5.4%	4.8%	4.8%	●	
	2018/19				-	5.5%	5.3%	5.6%		
AfC Staff Appraisal Rate (12 Month Rolling - %)	2019/20	>=95%	M	LS/JA	-	84.6%	85.4%	87.2%	●	
	2018/19				-	79.9%	78.5%	83.6%		
6 universal Statutory and Mandatory training requirements	2019/20	>=95%	M	LS/JA	-	93.8%	85.3%	87.4%	●	
	2018/19				-	89.6%	89.6%	88.7%		
Medical staff appraisal rate (%)	2019/20	100%	Q	RB	-				●	
	2018/19				-	100.0%	100.0%			

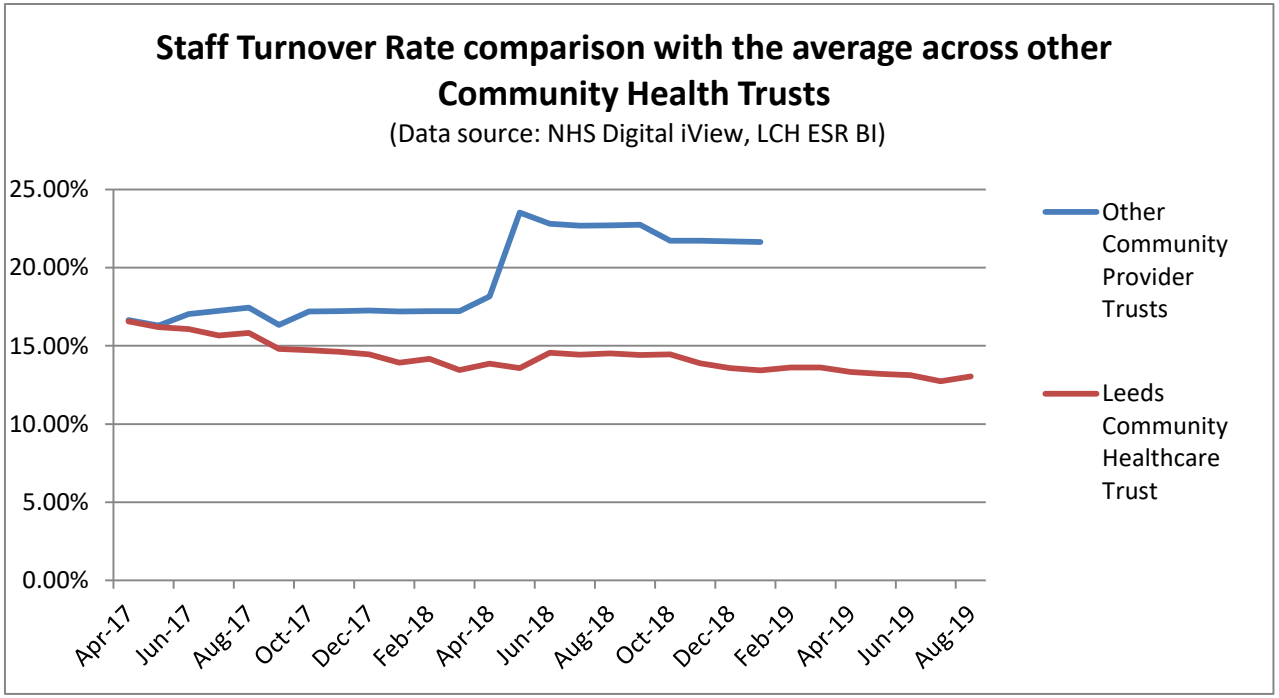
Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Financial Year	Target	Frequency	Responsible Director	YTD	Q1	Jul	Aug	Forecast	2 Yr Monthly Time Series
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2019/20	>52.0%	Q	LS/JA	-	71.1%			●	
	2018/19				-	63.0%	60.3%			
Percentage of staff who are satisfied with the support they received from their immediate line manager	2019/20	>52.0%	Q	LS/JA	-	73.3%			●	
	2018/19				-	64.0%	65.1%			
Response Rate for Staff FFT	2019/20	>22.0%	Q	LS/JA	-	19.8%			●	
	2018/19				-	24.0%	23.5%			
WRES indicator 1 - Percentage of BME staff in the overall workforce	2019/20	No Target	M	LS/JA	-	9.8%	9.9%	9.9%		
	2018/19				-			10.1%		
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	2019/20	No Target	M	LS/JA	-	3.3%	3.2%	3.2%		
	2018/19				-			3.1%		
Total agency cap	2019/20	£2,725k	M	BM	£1,965k	£1,158k	£384k	£424k	●	
	2018/19				£6,410k	£1,403k	£394k	£462k		
Percentage Spend on Temporary Staff	2019/20	No Target	M	BM	6.2%	6.2%	6.1%	6.8%	●	
	2018/19				6.8%	7.8%	5.0%	7.0%		

Retention

The overall trend continues to be positive with turnover reporting at 13.05% which is below the 2019/20 outturn target of 14.5%. The stability rate is 87.4% which is above the target of 85%. There has been a 1.5% reduction in turnover in the last 12 months.

Staff leaving within the first 12 months of employment is 18.4% (65 people) which is below target of 20%. Further analysis shows a higher rate of turnover within clerical roles which accounts for 32% (21 people) with less than 12 months service and 18.5% (12 people) were community nurses. Overall, 24.6% (16 people) left due to work life balance.
Background detail associated with retention is at Appendix 1.

The Trust continues to benchmark favourably against its Community Trust peers and is visually presented in the graph below:-



Health and Wellbeing (HWB)

Sickness absence remains lower than in previous years at 4.8%. At the end of month five of 2019/20, there have already been three months where overall sickness absence has been below 5%, compared to no months below 5% during 2018/19.

No sole intervention is attributable to this reduction, but is instead a culmination of many things that has been developed over a period of time, as the culture of the organisation grows; where open conversations/stories from staff about their HWB issues is “the norm”, leaders are equipped and upskilled to work in an inclusive and compassionate way and increasing their knowledge base around “disability”, are all contributory factors leading to improving staffs health and wellbeing, and a reduction in sickness absence rates. September Business Committee will receive a paper reporting on progress made over the last 6 months on the Health and Wellbeing Priority, as part of the Workforce Strategy.

Appraisal Rates

The overall Appraisal Rate continues to improve steadily, at 87.2%, at end of August 2019. Of note is the Children's Business Unit which is reporting a 4.2% increase this month.

AfC Staff Appraisal Rate (12 Month Rolling - %)

Imp Traj to 95%	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	June-19	July - 19	Aug - 19
833 Overall	86.3%	85.4%	84.2%	82.9%	81.1%	83.7%	84.6%	85.4%	**87.2%**
833 Adult Business unit	90.6%	89.2%	88.2%	86.1%	80.8%	86.0%	87.7%	88.7%	**88.9%**
833 Children's Business Unit	79.9%	80.4%	79.9%	78.5%	77.9%	80.3%	80.5%	85.3%	**89.5%**
833 Corporate Directorate	77.9%	85.2%	83.2%	78.3%	79.3%	82.8%	88.9%	86.1%	**85.1%**
833 Operations	88.9%	88.9%	90.6%	89.2%	86.8%	87.5%	88.7%	89.1%	**93.5%**
833 Specialist Business Unit	88.5%	85.1%	82.5%	82.5%	83.4%	83.4%	83.0%	79.6%	**80.3%**

The following measures around appraisals are in place and continuing:

- Appraisal processes are currently being reviewed in order to align with the new pay deal requirements and talent management in order to establish a mechanism to assure of high quality appraisals, which may include outcome measures for example, personal development plans recorded as complete and talent data captured.
- Self-reporting of appraisals continues to be supported, this is covered in the appraisal development sessions (above) and support is also available from the WFI team.

Statutory & Mandatory Training

This month the overall compliance level for universal Statutory & Mandatory training has fallen to 87.4% which is linked to organisation-wide amendments to Infection, Prevention & Control training as part of the Statutory & Mandatory Compliance Training Project.

Statutory & Mandatory Training Requirements

Imp Traj to 95%	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	June-19	July - 19	Aug 19
833 Overall	90.6%	92.7%	93.5%	92.5%	93.5%	94.4%	93.8%	94.0%	**87.4%**
833 Adult Business unit	91.0%	92.7%	92.6%	91.6%	92.7%	93.8%	93.5%	93.1%	**85.9%**
833 Children's Business Unit	91.3%	92.6%	94.2%	92.7%	93.5%	94.5%	94.0%	95.1%	**90.1%**
833 Corporate Directorate	92.2%	94.8%	95.4%	94.2%	95.3%	96.0%	95.0%	92.9%	**87.1%**
833 Operations	88.4%	92.4%	93.7%	92.8%	94.2%	94.9%	93.0%	94.4%	**90.5%**
833 Specialist Business Unit	90.0%	93.0%	94.0%	93.7%	93.9%	94.2%	93.7%	94.0%	**85.7%**

These changes were initiated in August and encountered some difficulties in the migration of data. Further work has been undertaken subsequently, together with a move to ensure IPC is fully compliant with the Core Skills Training Framework. The re-migration is planned for mid-September, following which we expect to see compliance rates improve once again.

Staff Engagement

We are working with Capita, our Staff Survey partner as part of preparations for this year's National Staff Survey, which will go live on October 7th. A communications and engagement plan is in place to maximise the uptake across the organisation.

National Staff Survey Pulse (Staff FFT) for Q2 is also live this month. Given the close proximity to the full Staff Survey, we are limiting this to the two nationally required questions, plus open space for comments:

- I would recommend LCH as a place for care / treatment
- I would recommend LCH as a place to work
-

Results will be reported in the October Well-Led report.

Finance – August 2019

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

Leeds Community Healthcare NHS Trust

Finance	Financial Year	Target	Frequency	Responsible Director	YTD	Q1	Jul	Aug	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	*2019/20*	-£0.2m	M	BM	**-£0.3m**	**£0.0m**	**-£0.2m**	**-£0.3m**	●
	2018/19				£4.0m	£0.3m	£0.7m	£0.8m	
Capital expenditure in comparison to plan (£k) - YTD	*2019/20*	£260k	M	BM	**£427k**	**£223k**	**£90k**	**£114k**	●
	2018/19				£1,880k	£303k	£85k	£90k	
CIP delivery (£m) - YTD	*2019/20*	963k	M	BM	**£881k**	**£529k**	**£176k**	**£176k**	●
	2018/19				£4.7m	£1.0m	£0.3m	£0.3m	

Income & Expenditure Summary

The Trust's year to date surplus continues to be £0.1m more than budgeted at the end of August. Pay costs are £0.2m less than planned, £0.1m more than last month and there are 19 WTE fewer vacancies than in July. Non-pay is running £0.2m overspent; these overspendings are being addressed by the underspending on pay. The overall position assumes the Provider Sustainability Funding allocation as the forecast is that the Trust will deliver the control total as the year progresses and will therefore be able to claim this funding from NHS Improvement. Additional income is expected in respect of the pay award funding for staff working in public health services commissioned by the Local Authority and further contributions to the Trust's fixed costs are anticipated as the year progresses.

Income

Contract income continues to be fractionally less than planned as a penalty has been incurred for police custody contract in respect of missed shifts. It is assumed that some missed shifts will continue throughout the year. The value of the penalty remains at a forecast shortfall of £53k as management's review of staffing has maximised shift coverage and reduced the previously anticipated financial impact. Non-contract income is in line with plan this month.

The Trust operates on a predominantly block contract basis so income risk is unlikely to be a significant issue in the achievement of financial targets. The position assumes all CQUIN income is achieved; at this stage in the year the biggest CQUIN risk is achievement of the flu vaccination target which has increased to 80% of staff. Based on last year's performance there is circa £13k at risk. CQUIN performance will be monitored closely and income risks will be report as they arise.

The Trust has received notification of the additional funding for the pay award for staff working in services commissioned by Leeds City Council; at this time this is a non recurrent adjustment.

Pay and Non-pay Expenditure & Vacancies

Pay expenditure is £0.2m underspent at the end of August; this is £0.1m more underspent than last month. There has been a reduction in the number of vacancies and in month costs are consistent with last month across substantive and temporary staffing.

Pay expenditure is less than planned for all directorates apart from the Children's business unit which is £267k overspent and Estates £82k over. Children's business unit overspending continues to be driven by paediatric locum medical staff £150k, CAMHS locum medical staff £85k, £40k for Speech & Language Therapy services and £44k for Hannah House. The overspending in Estates is in respect of the historic Admin Review CIP.

There are a net 63 WTE vacancies this month (82 for last month), 28 of these are in the Adult BU and 37 in the Corporate and Estates Directorates; The Specialist BU has less than 1 vacancy overall and the Children's BU has 7 WTE more than budgeted.

The Corporate Directorate continues to report an overspending in respect of historic cost savings plans relating to the roadmap contribution (£0.5m) and corporate CIPs (£0.3m) along with new savings requirements of £0.2m for procurement and £0.2m unidentified savings from the 2019/20 planning round that are reported here. The procurement savings target should be delivered as the year progresses; the others remain a significant risk.

Reserves for the year are in line with plan at the end of August. This includes a proportion of anticipated additional income for pay awards and contribution from new services. As previously reported there is no central pot to mitigate financial overspends or support additional ad-hoc expenditure this year and BUs and Directorates need to exercise strong financial management and manage to their delegated budgets if the Trust is to achieve its control total surplus.

There has been a small increase in agency staffing expenditure this month; the Trust is 28% under the cap set by NHS Improvement.

In respect of the forecast outturn position the Children's BU has £0.2m additional cost reductions to achieve a balanced position for 2019/20. The most material area to address is the general savings requirements within the Corporate Directorate where the current forecast is £0.9m overspend; this will be mitigated by the additional pay award and contribution income.

Non-pay is a net £175k overspent at the end of August. The overspending is mainly in respect of the "other" category where the savings requirements are reported.

Delivery of Cost Improvement Plans

Delivery of the identified CIPs remains strong. The £0.2m unidentified savings agreed through the planning process is not being achieved and overall savings remain 8% less than planned at the end of August.

Business Unit Budget Performance

The Business Units have a net total of 27 WTE vacancies for August (40 in July) as detailed above.
The Specialist Business Unit is marginally underspending at the end of August and forecast to be £0.25m underspent at the end of the year. This net position masks some large variances particularly in weight management, respiratory, diabetes, stroke, IAPT, Dental, Liaison & Diversion, TB and YOI services that are underspending and CIVAS, Adult SLT, Police Custody, Sexual Health and MSK services that are currently overspending.

The Children's Business Unit is £0.1m overspent at the end of month 05 and forecast to be a net £0.2m overspent at the year end; with a pay overspending of £0.6m in respect of locums being offset by £0.4m of underspending on non pay. Main areas of pay overspending for the year to date are Paediatricians, CAMHS Inpatient Unit, Hannah House, Management Team, Sickle Cell and Speech and Language Therapy; these are being partially offset by underspending on Doctors in Training, CAMHS Community services, Children's Continuing Care and Respite Services and 0-19 Services.

The Adult Business Unit has 28 WTE vacancies in August, with 22 being in the Neighbourhood Teams and 3 in the Community Care Beds Service. The Business Unit has a small non pay underspend of £149k at the end of August, and is forecasting £0.3m underspend at the end of the year. The forecast outturn is for £0.1m overspending on pay £0.2m less than last month. The reduction is in respect of an increase in maternity leave and leavers. Non-pay underspending of £0.5m is forecast; this is due to savings on continence products and the Allied Health Care contract. Continence services, Allied Health Care Contract, Neighbourhood Teams, Health Case Management, Geriatricians, Bed Bureau and the Leeds Integrated Discharge services are underspending whilst the Management Team and the Nights Nursing service are overspending.

Of the net 21 Corporate Support vacancies 2 in HR, 2 are in the performance and contracts team, 2 in the contracts team, 3 in the finance team, 2 in the infection control team and 2.5 in the Community Informatics service. Estates vacancies are 16 WTE, the biggest area being 6 for admin support to clinical teams and 4 in the domestic service.

Capital Expenditure

The Trust has an initial planned capital resource limit (CRL) of £2.0m for the year; following the Government's recent announcement of £1.8bn additional resource for the NHS in 2019/20 the anticipated £0.3m reduction in planned capital expenditure will not now take place. The Trust's original capital plan has been restored.

Capital expenditure continues to run £0.1m more than plan for August. The capital expenditure position is being closely monitored and the overspending is due to a timing issue in respect of estates projects where expenditure on refurbishing health centres has started earlier than anticipated the position will correct as the year progresses, it is not a financial risk.

Cash

The Trust's cash position remains very strong at £30.3m; this is £3.0m more than was planned and is due to the payment of PSF for last year and the balance on working capital.

Better Payment Practice Code

The Trust's cumulative Better Payment Practice Code has exceeded the 95% target for paying invoices for all measures. The Trust's performance remains strong.

Use of Resources Risk Rating

The Trust's risk rating at the end of August 1 is 1 overall, which is the lowest risk. All metrics score 1 this is consistent with last month.

Appendix 1 – August 2019

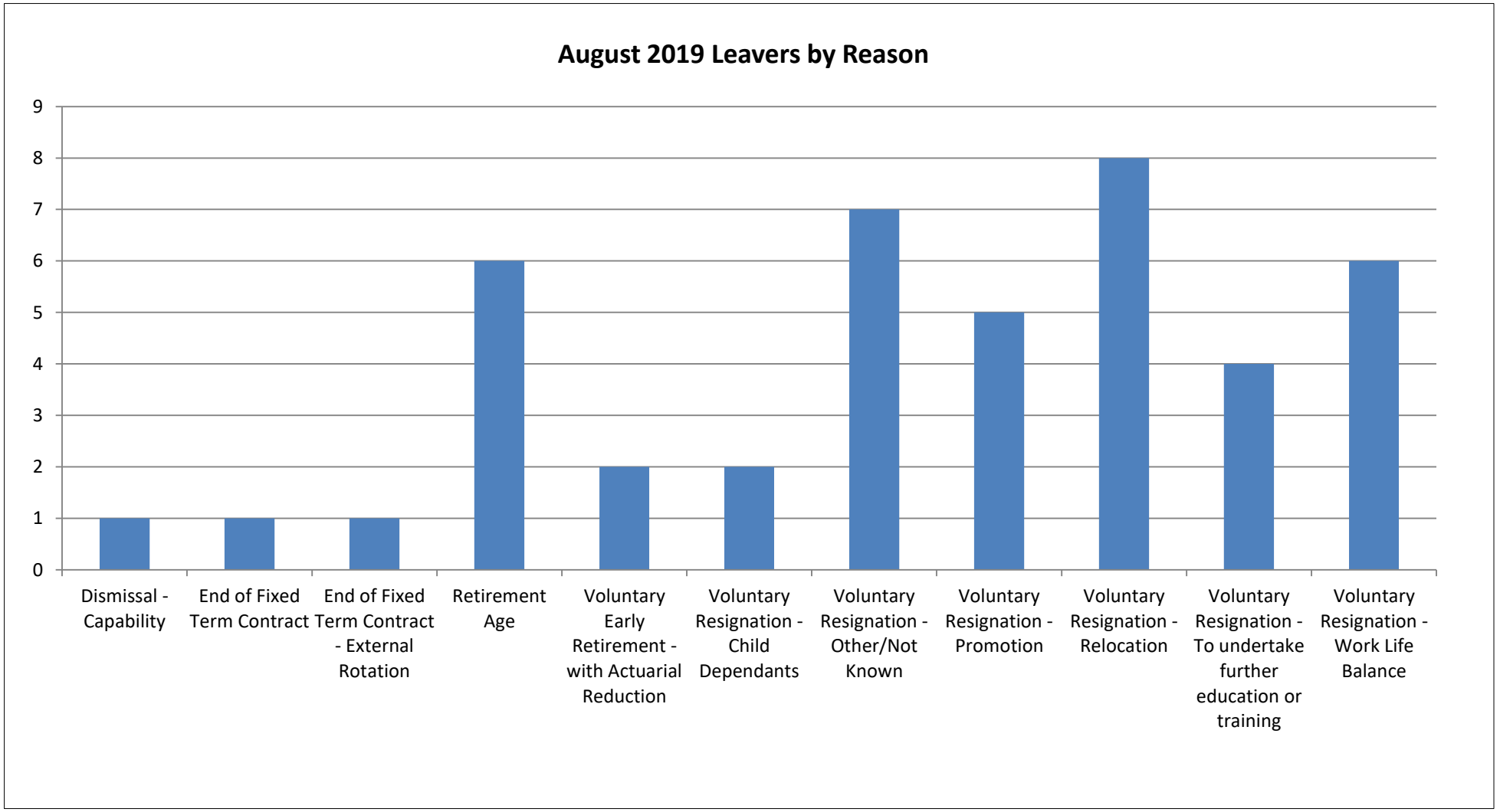
Retention Background Data

Leeds Community Healthcare NHS Trust

In August 2019 there were 43 leavers across the Trust. The distribution of leavers by Business Unit, staff group and reason for leaving is set out below:

Business Unit	August 2019 Leavers
Adult Business unit	14
Children's Business Unit	18
Corporate / Operations	1
Specialist Business Unit	9
Executive Directors	0
Operations	1
Grand Total	**43**

Staff Group	August 2019 Leavers
Clinical Services & Healthcare Scientist	7
Additional Prof Scientific & Technical	2
Administrative and Clerical	9
Allied Health Professionals	5
Nursing and Midwifery Registered	16
Medical and Dental	4
Estates	0
Grand Total	**43**


August 2019 Leavers by Reason
9
8
7
6
5
4
3
2
1
0
Dismissal - Capability
End of Fixed Term Contract
End of Fixed Term Contract - External Rotation
Retirement Age
Voluntary Early Retirement - with Actuarial Reduction
Voluntary Resignation - Child Dependants
Voluntary Resignation - Other/Not Known
Voluntary Resignation - Promotion
Voluntary Resignation - Relocation
Voluntary Resignation - To undertake further education or training
Voluntary Resignation - Work Life Balance

Appendix 2 – August 2019

Detailed Financial Data Tables

Leeds Community Healthcare NHS Trust

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus £1.7m	£0.3m	£0.1m	£1.7m	G
Remain with EFL of £0.53m			£0.5m	G
Remain within CRL of £2.0m	£0.4m	£0.2m	£2.0m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	99%	4%	95%	G
BPPC NHS Invoices Value 95%	98%	3%	95%	G
BPPC Non NHS Invoices Number 95%	97%	2%	95%	G
BPPC Non NHS Invoices Value 95%	98%	3%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £1.68m recurrent in year	£0.70m	-	£1.68m	G
CIP Savings £0.64m planned non recurrent in year	£0.18m	-31%	£0.44m	R

Table 2 Income & Expenditure Summary	August Plan WTE	August Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m	Forecast Variance Last Month £m
Income									
Contract Income			(61.3)	(61.3)	0.0	(144.9)	(144.8)	0.1	0.1
Other Income			(5.4)	(5.4)	0.0	(12.3)	(12.2)	0.1	0.1
Total Income			***(66.7)***	***(66.7)***	***0.0***	***(157.2)***	***(157.1)***	***0.2***	***0.1***
Expenditure									
Pay	2,759.4	2,695.8	47.6	47.3	(0.2)	112.2	112.7	0.4	0.7
Non pay			16.8	17.0	0.2	38.3	38.2	(0.1)	0.1
Reserves & Non Recurrent			0.9	0.9	(0.0)	2.1	1.6	(0.5)	(0.9)
Total Expenditure	***2,759.4***	***2,695.8***	***65.4***	***65.2***	***(0.1)***	***152.7***	***152.5***	***(0.2)***	***(0.1)***
EBITDA	**2,759.4**	**2,695.8**	**(1.3)**	**(1.4)**	**(0.1)**	**(4.5)**	**(4.5)**	**(0.0)**	**(0.0)**
Depreciation			0.8	0.8	(0.0)	2.0	2.0	0.0	0.0
Public Dividend Capital			0.4	0.4	0.0	0.9	0.9	0.0	0.0
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	(0.0)	0.0
Retained Net Surplus	**2,759.4**	**2,695.8**	**(0.2)**	**(0.3)**	**(0.1)**	**(1.7)**	**(1.7)**	**0.0**	**0.0**
	Variance =	**(63.5)**							

Table 3 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	YTD Actuals £k
Directly employed staff	8,932	8,571	8,546	8,542	8,558	43,149
Seconded staff costs	229	252	226	267	241	1,215
Bank staff	232	156	211	200	198	997
Agency staff	392	306	460	384	424	1,965
Total Pay Costs	**9,785**	**9,285**	**9,443**	**9,393**	**9,421**	**47,326**

Table 4 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Drugs	342	362	19	13	
Clinical Supplies & Services	4,409	4,253	(156)	(188)	
General Supplies & Services	2,128	2,109	(18)	(23)	
Establishment Expenses	2,461	2,476	15	(45)	
Premises	6,425	6,355	(70)	(27)	
Other non pay	1,077	1,462	385	360	
Total Non Pay Costs	**16,841**	**17,016**	**175**	**90**	**(73)**

Table 5 Savings Scheme	2019/20 YTD Plan £k	2019/20 YTD Actual £k	2019/20 YTD Variance £k	2019/20 Annual Plan £k	2019/20 Forecast Outturn £k	2019/20 Forecast Variance £k	2019/20 Forecast Variance %
Estates	60	60	0	145	145	0	0%
Non Pay Inflation	144	144	0	345	345	0	0%
MSK Radiology	42	42	0	100	100	0	0%
IAPT - NR vacancies	25	25	0	60	60	0	0%
Dental - M&S Disposables	17	17	0	40	40	0	0%
ABU Non Pay	48	48	(0)	115	115	0	0%
Adults Community Geriatricians	35	35	0	85	85	0	0%
Infection control	6	6	0	15	15	0	0%
Interest received on cash at bank	25	25	0	60	60	0	0%
Contribution from new investments	375	375	0	900	900	0	0%
IT Kit	104	104	0	250	250	0	0%
Un-identified CIP agreed by SMT	83	0	(83)	200	0	(200)	-100%
Total Efficiency Savings Delivery	**965**	**881**	**(82)**	**2,315**	**2,115**	**(200)**	**-9%**

Table 6 Service Line	Annual Budget £m	Budget WTE	Actual Contract WTE	Variance WTE	YTD Budget £m	YTD Actual £m	YTD Variance £m
Specialist Services	40.0	725.8	726.6	0.9	17.4	17.3	(0.1)
Childrens Services	30.5	698.4	705.1	6.7	12.8	12.9	0.1
Adults Services	42.5	893.5	865.1	(28.4)	17.8	17.6	(0.1)
Ops Management & Equipment	1.7	58.2	52.3	(6.0)	0.7	0.7	(0.0)
Service Line Totals	**114.7**	**2,375.8**	**2,349.0**	**(26.8)**	**48.7**	**48.5**	**(0.1)**
Corporate Support & Estates	28.8	383.5	346.8	(36.7)	12.4	12.5	0.1
Total All Services	**143.5**	**2,759.4**	**2,695.8**	**(63.5)**	**61.1**	**61.0**	**(0.1)**

Table 7 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.1	0.3	0.2	0.6	0.6	0.0
Equipment/IT	0.0	(0.0)	(0.0)	1.0	1.0	0.0
Electronic Patient Records	0.2	0.1	(0.0)	0.5	0.5	0.0
Totals	**0.3**	**0.4**	**0.2**	**2.0**	**2.0**	**0.0**

Table 8 Statement of Financial Position	Plan 31/08/19 £m	Actual 31/08/19 £m	Variance 31/08/19 £m	*Opening 01/04/19 £m*	Planned Outturn 31/03/20 £m	Forecast Outturn 31/03/20 £m	Forecast Variance 31/03/20 £m
Property, Plant and Equipment	28.6	28.9	0.3	*29.3*	29.2	28.9	(0.3)
Intangible Assets	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Assets	**28.7**	**28.9**	**0.3**	***29.3***	**29.2**	**28.9**	**(0.3)**
Current Assets							
Trade and Other Receivables	9.2	8.3	(0.9)	*9.4*	9.2	9.2	0.0
Cash and Cash Equivalents	27.2	30.3	3.0	*26.5*	26.8	28.4	1.6
Total Current Assets	**36.4**	**38.6**	**2.1**	*35.9*	**36.0**	**37.6**	**1.6**
TOTAL ASSETS	**65.1**	**67.5**	**2.4**	***65.3***	**65.2**	**66.5**	**1.3**
Current Liabilities							
Trade and Other Payables	(11.8)	(12.4)	(0.6)	*(10.9)*	(10.9)	(10.6)	0.3
Provisions	(0.4)	(0.5)	(0.1)	*(0.6)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(12.2)**	**(12.9)**	**(0.7)**	***(11.5)***	**(11.3)**	**(11.0)**	**0.3**
Net Current Assets/(Liabilities)	**24.3**	**25.7**	**1.4**	***24.5***	**24.7**	**26.6**	**1.9**
TOTAL ASSETS LESS CURRENT LIABILITIES	**52.9**	**54.6**	**1.7**	***53.8***	**53.9**	**55.6**	**1.6**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	***0.0***	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**52.9**	**54.6**	**1.7**	**53.8**	**53.9**	**55.6**	**1.6**
TAXPAYERS EQUITY							
Public Dividend Capital	0.4	0.4	(0.0)	*0.4*	0.4	0.4	0.0
Retained Earnings Reserve	22.0	23.7	1.7	*22.9*	23.0	24.6	1.6
General Fund	18.5	18.5	0.0	*18.5*	18.5	18.5	0.0
Revaluation Reserve	12.0	12.0	(0.0)	*12.0*	12.0	12.0	(0.0)
TOTAL EQUITY	**52.9**	**54.6**	**1.7**	**53.8**	**53.9**	**55.6**	**1.6**

Table 9 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	99%	95%	G
By Value	98%	95%	G
Non NHS Invoices			
By Number	97%	95%	G
By Value	98%	95%	G

Table 10 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	60	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	5.2	1	20%	0.2
Underlying performance	I&E margin	1%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-28%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (61a)

Meeting: Trust Board 4 October 2019	**Category of paper** *(please tick)*	
Report title: Significant Risks and Board Assurance Framework (BAF) report	**For approval**	
Responsible director: Chief Executive **Report author:** Risk Manager / Company Secretary	**For assurance**	✓
Previously considered by: N/A	**For information**	

Purpose of the report:

This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks.

The report provides the Board with the current risk profile. It details the Trust's risks currently scoring 15 or above, after the application of controls and mitigation measures. It provides an analysis of all risk movement, presents the risk profile, identifies themes, and links these material risks to the strategic risks on the Board Assurance Framework (BAF).

The Board Assurance Framework (BAF) summary advises the Board of the current assurance level determined for each of the Trust's strategic risks.

Main issues for consideration:

There are no risks with a current score of 15 (extreme).

The risks currently on the risk register (both clinical and non-clinical risks) have been interrogated for this report.

The three strongest themes are:

- Staff sickness absence, vacancies, retention of staff
- An increased demand for services
- Work processes

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by the committees and the Board.

Recommendations

The Board is recommended to**:**

- Note the contents of the risk register
- Note the themes identified in this report
- Note the current assurance levels provided in the revised BAF summary

Significant Risks and Board Assurance Framework (BAF) report

1.0 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.

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). This report provides a description of risk movement since the last register report was received by the Board (2 August 2019), including any new risks, risks with increased or decreased scores and newly closed risks. The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk.

1.3 Summary reports (such as this one) are produced on a frequent basis and alert the senior governance structure (SMT, committees, and Trust Board) to important changes in the risk register. An in-depth (full) report is produced on a less frequent basis, and describes and analyses all risk movement, the risk profile, themes and risk activity.

1.4 This paper provides a summary of the current BAF and an indication of the assurance level that has been determined for each strategic risk.

2.0 Summary of current risks scoring 15 or above

2.1 There are no risks with a current score of 15 (extreme) or above on the Trust risk register as at 6 September 2019

3.0 New or escalated risks scoring 15+

3.1 Since the last report to the Board in August 2019, there have been no new risks scoring 15 or more.

3.2 There have been no risks escalated to 15 or more.

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

4.1 Since the August 2019 report, there have been no closed risks previously recorded at 15 or above.

4.2 No risks have been deescalated below 15 since August 2019.

5.0 Summary of risks scoring 12 (high)

5.1 High risks (scoring 12)

5.1.2 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.

5.1.3 The table below details risks currently scoring 12 (high risk).

Table 1 High risks (scoring 12)

ID	Description	Rating (initial)	Rating (current)	Rating (Target)
224	Prevalence of staff sickness	16	12	6
913	Increasing numbers of referrals for complex communication assessments in ICAN service	15	12	3
957	Increase in demand for the adult speech and language therapy service.	15	12	3
975	Capital affordability and Business case approval of CAMHS Tier 4 Development	15	12	6
976	Affordability of revenue costs of new CAMHS Tier 4 service in new building	16	12	3

6.0 Summary of all risks currently scoring 8 or above

6.1 The following sections aim to apprise the Board of risks with a current score of 8 or above (after the application of controls and mitigations).

6.2 At present, the Trust's risk register comprises of 30 risks at risk score 8 or above assigned to the Trust's three business units and all directorates providing corporate and headquarters functions. This is the same number of risks as the previous report.

6.3 Risks scoring 8 or above

6.3.1 The chart below shows the number of risks by area of the business, logged on the Trust's risk management database (Datix) as at 6 September 2019.

Table 2 risks by area of the business

Directorate	**Risks scored 8-12 High**	**Risks scored 15+ Extreme**	**Totals by directorate**
Adult Services	**6**	0	**6**
Children's Services	**8**	0	**8**
Specialist Services	**6**	0	**6**
Operational Support Services	**2**	0	**2**
Corporate & HQ functions	**8**	0	**8**
Totals by risk severity	**30**	**0**	**30**

7.0 Current risks scoring 8 or above by theme

7.1 For this report, the current material (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 higher level risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

7.2 Themes within the current risk register are as follows:

- Six risks are related to staff capacity due to an increase in service demand
- Six risks are concerned with staff absence due to sickness and maternity leave
- Four risks are about work processes and arrangements (working with others in an integrated way)
- Four risks concern vacancies, including staff retention and difficulties recruiting staff to posts
- Four risks relate to the CAMHS Tier 4 development

7.3 The emergence of material risks could mean that the controls in place on the Board Assurance Framework to manage strategic risks are not sufficiently robust. The strongest themes within the current risk register, and their links to BAF strategic risks are as follows:

Table 3.

Theme / BAF Risk(s)
Risk register theme: Staff sickness absence, vacancies, retention of staff BAF Risk 3.1 having suitable and sufficient staff capacity and capability RISK 3.2 the scale of sickness absence
Risk register theme: Increase in demand for services BAF Risk 2.4 retaining existing viable business and/or win new financially beneficial business tenders BAF Risk 3.1 having suitable and sufficient staff capacity and capability
Risk register theme: work processes (lack of integrated systems with other service providers, inconsistent criteria) RISK 4.4 having sufficient capacity across the Trust to deliver the key workstreams of system change programmes Risk 4.5 ensuring there are robust agreements and clear governance arrangements for partnership arrangements

8.0 Risk profile - all risks

8.1 There are 15 open clinical risks on the Trust's risk register and 38 open non-clinical risks. The total number of risks on the risk register is currently 53. This is the same number that was reported in the previous in-depth risk register report. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk:

Table 4 Risk profile across the Trust.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	0	0	0	0	0
4 - Major	1	0	1	0	0	2
3 - Moderate	0	14	20	5	0	39
2 - Minor	0	1	7	3	1	12
1 - Negligible	0	0	0	0	0	0
Total	1	15	28	8	1	53

9.0 Board Assurance Framework Summary

9.1 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.

9.2 Definitions:

- Strategic risks are those that might prevent the Trust from meeting its strategic goals and corporate objectives
- 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)

9.3 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.

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

9.5 The BAF summary **(appendix 1)** gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by committees and the Board, in line with the risk assurance levels described in **appendix 2** (BAF risk assurance levels).

9.6 Since the last BAF summary report to Trust Board in August 2019, the current level of assurance for the following BAF risks has been adjusted as follows:

9.6.1 ***Positive movement (indicating an improved situation)***

- BAF risk 1.1 (effective systems for assessing quality) Quality Committee received reasonable assurance from the Quality Challenge+ year-end report and from the Clinical Audit programme 2018/19 report.
- BAF risk 3.1 (suitable and sufficient staff capacity) The Guardian for Safety Working Hours and the Workforce Strategy quarterly report both received reasonable assurance from the Business Committee.

9.6.2 ***Negative movement (indicating a worsening situation)***

No negative movement has occurred since the last BAF report to the Board in August 2019.

10.0 Risk management activity

10.1 An audit was undertaken on Risk Management by TIAA; this resulted in 'reasonable assurance'.

10.1.1 There were three observations resulting from the Risk Management audit:

- The Trust needs to ensure all concerns raised at Committees, performance forums or CCG contractor meetings are an integral part of the Trust's risk management process.
- Narrative explaining the risks does not routinely include analysis to confirm how frequently the risk event had previously occurred or an estimate to the probability that the event may occur in the future.
- The current controls and update sections of the risk register do not routinely provide SMART performance information.

10.1.2 An action plan to address the three observations has been approved by the Audit Committee.

10.2 The Health, Safety and Risk training course continues to be delivered as part of the Essential Management programme. This course ensures that managers understand their roles and responsibilities for managing risks in relation to the health, safety and wellbeing of their direct reports and other persons affected by the Trust's work activities.

10.3 Support in completing risk assessments and adding risks to the register continues to be provided to staff. New staff receive an overview of the organisation's approach to risk management at the induction sessions.

10.4 The summer edition of Risky Business was published in July 2019. Articles in this edition included:

- Protecting skin from sunburn
- Clinical governance; asking for help with clinical audits
- Five steps to risk management
- Lessons learned from posting a complaint response to an incorrect address
- Fraudulent sick pay claims by an NHS employee (not LCH)
- What the Duty of Candour is
- Abbreviations on medicines administration charts, putting patients at risk

11.0 Impact

11.1 *Quality*

11.1.1 There are no known quality issues regarding this report. Risks recorded on the Trust's risk register are regularly scrutinised to ensure they remain current. Risk owners are encouraged to devise action plans to mitigate the risk and to review the actions, risk scores and provide a succinct and timely update statement.

11.1.2 There is a robust process for ensuring the risk register is effectively reviewed and kept up to date. An automated system reminds risk owners to update their risks where a review date has passed. The Risk manager produces a monthly quality assurance report and if the risk remains outstanding, further reminders are sent personally by the Risk Manager. Any risks remaining out of date by more than a month are escalated to the relevant director for intervention. Following requests for risk owners to update these risks, no risks are overdue.

12.2 Resources

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

12.3 Risk and assurance

12.3.1 This paper seeks to advise the Board that there is a robust process in place in the Trust for managing risk. Evidence that risks are proactively identified and managed in the Trust can be seen in the shifting profile of the risk register, with new risks being added and subsequently updated, risk scores amended and risks being closed.

13 Next steps

13.1 A number of developments are planned to ensure that the Trust's risk management framework continues to mature.

13.2 The Risk Manager will discuss the outcomes of the Risk Management audit with relevant risk owners to ensure that the relevant observations from the audit report are addressed.

13.3 The Risk Manager continues to monitor risk review dates and remind risk owners of their responsibility to review and update risks appropriately.

13.4 Risk development workshops continue to be held with services to ensure that risk assessments are suitable and sufficient.

14.0 Reporting schedule

14.1 Set out below is the risk register reporting schedule to which this report conforms:

14.2 **Risk register reporting schedule**

		Month											
		Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Meeting	**RRG**	FULL			FULL			FULL			FULL		
	AC							Report					Report
	SMT	FULL	SUM	SUM	SUM	FULL	SUM	SUM		FULL	SUM	SUM	
	QC	FULL		SUM		FULL		SUM		FULL		SUM	
	BC	FULL	SUM	SUM	SUM	FULL	SUM	SUM		FULL	SUM	SUM	
	Board		FULL	SUM			FULL		SUM		FULL		SUM

Key	
FULL	= In-depth report
SUM	= Snapshot report
↳	= Information flow

15.0 Recommendations

15.1 The Board is recommended to:

- Note the contents of the risk register
- Note the themes identified in this report
- Note the current assurance levels provided in the revised BAF summary

Board Assurance Framework (summary) 2019-20

Appendix 1

Details of strategic risks (description, ownership, scores)								Level of Assurance					
Risk		Risk ownership		Risk score				Current Level of Assurance (denoted by ◆).					
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	SL	QC	3	4	12				◆		Quality Challenge+ 2018/19 annual report (reasonable assurance).Clinical Audit 2018/19 report (reasonable assurance)	→
	RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then it may compromise patient safety, and may experience intervention or damage to reputation and relationships.	SL	QC	2	4	8				◆			
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny	SL	QC	2	3	6				◆		Pressure ulcers investigation update (limited assurance). Quality Priorities update (reasonable assurance)	
	RISK 1.4 If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage.	SL	QC	3	3	9				◆		Friends and Family Test (reasonable assurance)	
Provide sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	2	3	6				◆		Change Board update (reasonable assurance)	
	RISK 2.2 If the Trust does not deliver contractual requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	2	3	6				◆		CAMHS waiting list update - service support session (reasonable assurance)	
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	BM	BC	3	3	9				◆			
	RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3	4	12				◆		Business development strategy update (reasonable assurance)	
	RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance.	BM	BC	2	4	8				◆			
	Risk 2.6 If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage.	BM	AC	2	4	8				◆			

Recruit, develop and retain the staff we need now and for the future	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services.	AH	BC	4	4	16						Guardian for Safe Working Hours (reasonable assurance). Workforce Strategy update on Resourcing (reasonable assurance).	→
	RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	JA/LS	BC	4	3	12							
	RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services.	TS	BC	4	3	12						Workforce quarterly report (reasonable)	
	RISK 3.4 If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing .	JA/LS	BC	3	3	9							
Work in partnership to deliver integrated care and care closer to home	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership (ex STP) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc.	TS	BC	3	3	9							
	RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners and scrutiny board then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust .	TS	TB	2	4	8							
	Risk 4.3 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships	BM	BC	3	3	9							
	RISK 4.4 If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered.	TS	BC	3	3	9							

Appendix 2

Glossary- BAF risk assurance levels

Risk assurance levels	Definition
Substantial	Substantial assurance can be given that the system of internal control and governance will deliver the clinical, quality and business objectives and that controls and management actions are consistently applied in all the areas reviewed.
Reasonable	Reasonable assurance can be given that there are generally sound systems of internal control and governance to deliver the clinical, quality and business objectives, and that controls and management actions are generally being applied consistently. However, some weakness in the design and / or application of controls and management action put the achievement of particular objectives at risk.
Limited	Limited assurance can be given as weaknesses in the design, and/or application of controls and management actions put the achievement of the clinical, quality and business objectives at risk in a number of the areas reviewed.
No	No assurance can be given as weakness in control, and/or application of controls and management actions could result *(have resulted)* in failure to achieve the clinical, quality and business objectives in the areas reviewed.

NHS
Leeds Community Healthcare
NHS Trus

AGENDA ITEM 2019/20 (61b)

Meeting: Trust Board 4 October 2019	**Category of paper** *(please tick)*	
Report title: Mid-year proposed revisions to Board Assurance Framework (BAF) 2019-20	**For approval**	✓
Responsible director: Chief Executive **Report author:** Company Secretary	**For assurance**	
Previously considered by: SMT 11 September 2019, Quality Committee 23 September 2019, Business Committee 25 September 2019	**For information**	

Purpose of the report

The content of the BAF has been reviewed by the Chairs of the Audit, Business and Quality Committees at their meeting on 8 July 2019, which was also attended by the Executive Director of Finance and Resources and the Company Secretary. Some changes have been proposed to the descriptions and risk scores for some strategic risks. Individual directors have also reviewed the risks they hold responsibility for and have suggested additional description changes. This report advises the Board of those suggested changes.

Main issues for consideration

Following the mid-year review of the 2019/20 BAF, the following changes to the BAF are recommended:

- Rewording of BAF risks 1.2, 1.3, 1.4, 2.1 and 4.2. Please see the main report for the rationale for these changes. Changes made to the BAF are also indicated on the summary diagram at appendix one.

- Rescoring of ten BAF risks. Please see summary table.

- The Board should also consider the addition of two suggested BAF risks. These are proposed to be BAF Risk 1.5 clinical governance arrangements for partnership working and BAF Risk 3.5 staff health and safety – see main report for rationale.

An additional consideration is whether risk 4.1 should be reassigned to Trust Board from Business Committee

The Quality and Business Committees have reviewed and are supportive of all these proposed changes.

Recommendations

The Board is recommended to:

- Approve the mid-year amendments to the BAF risks for 2019/20
- Consider and confirm reassignment of risk 4.1 to Trust Board
- Consider whether there are other strategic risks that should be included on the BAF

Mid-year proposed revisions to Board Assurance Framework (BAF) 2019-20

1. Introduction

1.1 The Board should assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively. The BAF fulfils this function.

1.2 The BAF is a live document that should capture the Boards' thinking around the management of strategic risks. The Board should consider risks to the Trust's strategic goals and corporate objectives, focussing on gaps in control and gaps in assurance.

1.3 This paper provides the Board with sight of the proposed changes to BAF strategic risks and asks the Board to approve these changes.

2. Background

2.1 The Board Assurance Framework (BAF) is a significant tool in helping the Board hold itself to account, understand the implementation of strategy and the risks that might impede delivery of its strategy and brings together:

- The Trust's strategic goals as set out in the Trust's longer term plans, its annual operational plan and the strategic priorities of business units
- Strategic risks that might prevent the Trust from meeting its strategic goals and corporate objectives; their causes and effects
- Controls and sources of assurance in place to manage risk and so support the delivery of those goals and objectives
- Actions to remedy gaps in controls or assurances

3. Controls and sources of assurance (definition)

- 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 i.e. success is been realised (or not).

4. Proposed mid-year changes to BAF 2019-20

4.1 Rewording of risk descriptions

4.1.1 *To reword BAF Risk 1.2*

Original risk wording: 'If the Trust does not implement and embed lessons from internal and external reviews and reports, then it may compromise patient safety, and may experience intervention or damage to reputation and relationships'.

Suggestion: Amend the risk description to indicate that patient safety is the more serious impact, and that there are additional but less significant impacts. Recommend BAF Risk 1.2 is worded as 'If the Trust does not implement and embed

lessons from internal and external reviews and reports, then patient safety may be compromised, leading to harm. The Trust may also experience intervention or damage to reputation and relationships'.

4.1.1 ***To reword BAF Risk 1.3***

Original risk wording: 'If the Trust does not maintain and continue to improve service quality, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny'.

Suggestion: Amend the risk description to take the emphasis off the CQC rating and emphasise quality of care. Recommend BAF Risk 1.3 is worded as 'If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm'.

4.1.2 ***To reword BAF Risk 1.4***

Original risk wording: 'If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage'.

Suggestion: Amend the risk description to be about engaging with people in order to improve the quality of services, rather than to be about Trust decisions and transacting change. Recommend BAF Risk 1.4 is worded as 'If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve'.

4.1.3 ***To reword BAF Risk 2.1***

Original risk wording: 'If the Trust does not achieve principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised'.

Suggestion: Amend the risk description to be about delivering, rather than achieving projects. Recommend BAF Risk 2.1 is worded as 'If the Trust does not deliver principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised'.

4.1.3 ***To reword BAF Risk 4.2***

Original risk wording: If the Trust does not maintain relationships with stakeholders, including commissioners and City Council then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust.

Suggestion: Amend the risk description to include other types of organisations and to make reference to the long term plan. Recommend BAF Risk 4.2 is worded as 'If the Trust does not maintain relationships with stakeholders, including commissioners, health organisations, City Council and third sector organisations, then it may not be

successful in developing and implementing new models or care as outlined in the NHS Long Term Plan. The impact is on the Trust's reputation and on investment in the Trust'.

4.2 Reassignment of BAF Risk 4.1

4.2.1 BAF Risk 4.1: 'If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership (ICS) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc'.

Suggestion by responsible director: as a number of sources of assurance are received at Trust Board it is suggested that this risk should be assigned to Trust Board.

4.3 Rescoring of current risk scores

Risk scores have been reviewed and the suggested amendments are in red text below, with an arrow indicating the proposed risk direction (increased or decreased risk score).

Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement
RISK 1.1 If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	SL	QC	3	4	12	
RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then patient safety may be compromised, leading to harm. The Trust may also experience intervention or damage to reputation and relationships	SL	QC	2 (3)	4	8 (12)	
RISK 1.3 If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm	SL	QC	2	3 (4)	6 (8)	
RISK 1.4 If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve	SL	QC	3 (4)	3	9 (12)	
RISK 2.1 If the Trust does not deliver principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	2 (3)	3	6 (9)	
RISK 2.2 If the Trust does not deliver contractual requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	2	3	6	
RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	BM	BC	3	3	9	

RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3 (2)	4 (3)	12 (6)	
RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance.	BM	BC	2	4 (3)	8 (6)	
Risk 2.6 If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage.	BM	AC	2 (3)	4	8 (12)	
RISK 3.1 If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services.	AH	BC	4	4	16	
RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	JA/LS	BC	4 (3)	3	12 (9)	
RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services.	TS	BC	4 (3)	3	12 (9)	
RISK 3.4 If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing .	JA/LS	BC	3	3	9	
RISK 4.1 If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership (ICS) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc.	TS	BC (TB?)	3 (2)	3	9 (6)	
RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners, health organisations, City Council and third sector organisations, then it may not be successful in developing and implementing new models or care as outlined in the NHS Long Term Plan. The impact is on the Trust's reputation and on investment in the Trust	TS	TB	2	4	8	
Risk 4.3 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships	BM	BC	3	3	9	
RISK 4.4 If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered.	TS	BC	3	3	9	

4.4 **Additional risks proposed**

4.4.1 *To include a BAF Risk concerning clinical governance of partnerships*

The recommendation is to add a further strategic risk concerning clinical governance of partnerships, to be overseen by the Quality Committee. This would be BAF Risk 1.5 and the suggested risk wording is 'As the new care models develop and evolve, there is a risk that there may not be robust clinical governance processes to ensure the safety of patients and quality of care provided'. This would be assigned to Executive Medical Director and overseen by the Quality Committee.

The rationale for adding this risk is to strengthen the focus specifically on clinical and quality governance within partnership arrangements in a similar way to those described in BAF Risk 4.3 (which is overseen by the Business Committee).

4.4.2 *To include a BAF Risk regarding staff health and safety*

It was also suggested that an additional strategic risk regarding staff health and safety be included in the BAF. This would be assigned to Executive Director of Finance and Resources and overseen by the Business Committee.

This would be BAF Risk 3.5 and the suggested wording is 'If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related death, injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention'.

The Board may wish to consider whether the inclusion of this risk should be deferred until the Health and Safety Executive inspectors' report is received.

5.0 Recommendations

5.1 The Board is recommended to:

- Approve the mid-year amendments to the BAF risks for 2019/20
- Consider and confirm reassignment of BAF Risk 4.1 to Trust Board
- Consider whether there are other strategic risks that should be included on the BAF

Appendix 1. BAF (2019-20) strategic risks (in draft) – amendments are indicated to risk description wording

Strategic Goals	Deliver outstanding care	Use our resources wisely and efficiently	Ensure LCH's workforce is able to deliver the best possible care in all our communities	Work in partnership to deliver integrated care and care closer to home
Strategic Risks	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective **(Exec Director of Nursing / Quality Committee)**	**Risk 2.1** If the Trust does not (remove achieve) (change to) deliver principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised **(Exec Director of Operations / Business Committee)**	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services **(Director of Workforce / Business Committee)**	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership (ICS) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc. **(CEO / Business Committee)**
	RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then patient safety may be compromised, leading to harm. The Trust may also experience intervention or damage to reputation and relationships **(Exec Director of Nursing / Quality Committee)**	**RISK 2.2** If the Trust does not deliver contractual requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability **(Exec Director of Operations / Business Committee)**	**RISK 3.2** If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure. **(Director of Workforce / Business Committee)**	**RISK 4.2** If the Trust does not maintain relationships with stakeholders, including commissioners, health organisations, City Council and third sector organisations, then it may not be successful in developing and implementing new models or care as outlined in the NHS Long Term Plan. The impact is on the Trust's reputation and on investment in the Trust. **(CEO / Board)**
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm **(Exec Director of Nursing / Quality Committee)**	**RISK 2.3** If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of accurate performance information, then it may fail to retain a competitive market position **(Exec Director of Finance and Resources / Business Committee)**	**RISK 3.3** If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services **(CEO / Business Committee)**	**Risk 4.3** If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships. **(Exec Director of Finance and Resources / Business Committee)**
	RISK 1.4 If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage. (suggest) If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve **(Exec Director of Nursing / Quality Committee)**	**RISK 2.4** If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable **(Exec Director of Finance and Resources / Business Committee)**	**RISK 3.4** If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing **(Director of Workforce / Business Committee)**	**RISK 4.4** If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered. **(CEO/ Business Committee)**
	Possible new Risk 1.5 (suggest) As the new care models develop and evolve, there is a risk that there may not be robust clinical governance processes to ensure the safety of patients and quality of care provided'**.(Exec Medical Director / Quality Committee)**	**RISK 2.5** If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance **(Exec Director of Finance and Resources / Business Committee)**	**Possible new Risk 3.5** If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related death, injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention. **(Exec Director of Finance and Resources / Business Committee)**	
		RISK 2.6 If the Trust does not maintain the security of its IT infrastructure then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, financial loss and reputational damage. **(Exec Director of Finance and Resources / Audit Committee)**		

Appendix 2. Existing 2019- 20 BAF strategic risks (original risk description wording)

Strategic Goals	Deliver outstanding care	Use our resources wisely and efficiently	Ensure LCH's workforce is able to deliver the best possible care in all our communities	Work in partnership to deliver integrated care and care closer to home
Strategic Risks	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective **(Exec Director of Nursing / Quality Committee)**	**Risk 2.1** If the Trust does not achieve principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised **(Exec Director of Operations / Business Committee)**	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services **(Director of Workforce / Business Committee)**	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership (ex STP) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc. **(CEO / Business Committee)**
	RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then it may compromise patient safety, and may experience intervention or damage to reputation and relationships **(Exec Director of Nursing / Quality Committee)**	**RISK 2.2** If the Trust does not deliver contractual requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability **(Exec Director of Operations / Business Committee)**	**RISK 3.2** If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure. **(Director of Workforce / Business Committee)**	**RISK 4.2** If the Trust does not maintain relationships with stakeholders, including commissioners and City Council then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust . **(CEO / Board)**
	RISK 1.3 If the Trust does not maintain and continue to improve the quality of all services, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny **(Exec Director of Nursing / Quality Committee)**	**RISK 2.3** If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of accurate performance information, then it may fail to retain a competitive market position **(Exec Director of Finance and Resources / Business Committee)**	**RISK 3.3** If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services **(CEO / Business Committee)**	**Risk 4.3** If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships. **(Exec Director of Finance and Resources / Business Committee)**
	RISK 1.4 If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage. **(Exec Director of Nursing / Quality Committee)**	**RISK 2.4** If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable **(Exec Director of Finance and Resources / Business Committee)**	**RISK 3.4** If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing **(Director of Workforce / Business Committee)**	**RISK 4.4** If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered. **(CEO/ Business Committee)**
		RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance **(Exec Director of Finance and Resources / Business Committee)**		
		RISK 2.6 If the Trust does not maintain the security of its IT infrastructure then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, financial loss and reputational damage. **(Exec Director of Finance and Resources / Audit Committee)**		

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (62)

Meeting Trust Board 4 October 2019	**Category of paper**	
Report title: Organisational Priorities Month 5 position report	**For discussion and decision**	
Responsible director Executive Director of Finance and Resources **Report author** Business Planning Manager	**For assurance**	√
Previously considered by SMT 18 September 2019 Business Committee 25 October 2019	**For information**	

PURPOSE OF REPORT

This report provides the Trust priorities position at the end of month 5 and year-end forecast.

MAIN ISSUES FOR CONSIDERATION

The 2019/20 Operational Plan sets out 15 organisational priorities which will drive achievement of the Trust's 4 strategic goals and support delivery of system priorities.

At the 2 August 2019 meeting, Trust Board received a report on delivery of the Trust priorities at the end of quarter 1. To enable Board to receive a timely position report (in October), this report presents the position at the end of month 5, rather than the end of quarter 2.

We continue to make good progress in delivering the agreed priorities. The report reflects little change from the quarter 1 report. At the end of quarter one:

- 12 of the 15 priorities rated green for both the quarter 1 position and year-end forecast
- 2 priorities were rated amber for the quarter 1 position, green for the year-end forecast
    - priority 2 relating to strengthening recruitment, particularly for hard to recruit roles
    - priority 14 relating to understanding and reducing unwarranted variation
- 1 priority was rated red for both the quarter 1 and year-end position: priority 12 relating to progressing the CAMHS Tier 4 build and service model to the agreed time-frame

At the end of month 5 there are changes in the RAG ratings of 2 priorities:

- Priority 12 relating to progressing the CAMHS Tier 4 build and service model to the agreed time-frame.
  Change from red to amber for both the position at the end of month 5 and the year-end forecast as July Business Committee accepted the request to revise the time-frame for gaining Board approval of the full business case to reflect intelligence about likely time-scales for NHSI/E to approve the business case.

- Priority 15 relating to implementing the digital and estates strategies.
  No change to the year-end forecast: green, however the YTD position has changed from green to amber reflecting slight delay in bringing the Digital Strategy to Business Committee and then Board for approval: to be submitted to Business Committee in October and then December Board for approval.

In relation to priority 9: engaging in the development of LCPs, NMoC and pathway redesign; as the year progresses SMT are reflecting further on which of the New Models of Care / developments we are able to focus on and develop at speed. SMT proposes to reflect further on this, including additional / alternative success measures.

Since the last report we have secured additional funding to provide wrap-around support and additional capacity to free up LCH staff to engage in LCP / PCN development and initiatives including the Population Health Management programme. We continue to impress on commissioners and partners that any further developments impacting on Business Units and / or corporate teams will require investment in additional capacity.

RECOMMENDATIONS

Trust Board is recommended to:

- Receive the report
- Note areas of achievement and those still to progress

Strategic Goal 1: Ensure LCH's workforce is able to deliver the best possible care in all our communities

Priority 1	**Improve overall engagement levels across the organisation through initiatives on creating the working lives that we want: Health & Well Being, Diversity & inclusion, cultural initiatives, leadership & management development, training & development**

What we aim to achieve in FY 19/20

- There is a clear health and wellbeing offer for staff to access.
- The Board's knowledge and understanding of experiences and challenges BAME staff from different backgrounds face, is increased.
- Equality & Diversity training offer to LCH staff is improved
- Sickness absence levels remain within tolerance, achieving an equal or improved position by the end of 19/20 compared with 18/19
- #peoplebeforeprocess and #justandfairculture concepts are understood and in use across the organisation
- LCH's new Leadership & Development programme is fully implemented
- Learning & development opportunities are increasingly aligned with organisational need
- There is clarity over access to development

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)	Not achieved/expected to achieve

Progress update. Overall: good progress across all workstreams.

Progress overview

Sickness absence: remains lower than in previous years at 4.8%. At the end of month five there have already been three months where overall sickness absence has been below 5%, compared to no months below 5% during 2018/19.

Disability: At the Trust Board in August the Workforce Disability Equality Standard (WDES) action plan was approved. Monthly delivery of Reasonable Adjustment Awareness for managers. The Disability and Wellbeing Network group met in August and will meet again in Sept.

Race: WRES action plan in place: designed to support increase in BME staff across all levels of the workforce. Bands 8/9 increased from 9.6% to 9.8% in Q1 and to 9.9% at the end of month 5. Band 8/9 and VSM increased from 2.7% to 3.3% in Q1 but decreased marginally to 3.2% at the end of month 5

Sexual Orientation: NHS Rainbow badge launched in Q1: 600 badges have been allocated and 150+ colleagues await further supply. Badge holders have been invited to the Rainbow Ambassadors meeting on the 29 October to contribute to the Stonewall Workplace Equality Index, Leeds Pride and to test the appetite for an LGBT+ & Allies staff patient network / support group.

The TIAA EDI audit provided "reasonable assurance"; an action plan is in place to address identified areas.

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
Sickness absence <5.8%		
Improvements in HWB staff survey question results		
Improvements in experience of BAME staff: staff survey results		
WRES: Increase (%) in BME staff in workforce		
WRES: increase (%) in BME staff in Band 8-9,VSM		

Priority 2	**Further strengthen recruitment, particularly for hard to recruit roles, and produce an organisational workforce plan underpinned by future organisational design principles aligned with operational business plans that sets out resourcing requirements and plans to meet these by profession**

What we aim to achieve in FY 19/20

- Organisational workforce plan aligned with BU operational plans and clear resourcing plan to support BUs in identifying and addressing resourcing needs
- Continued implementation of e-rostering to plan
- Fill rate for roles is higher, number of "hard to recruit" roles is reduced and vacancy rates are reduced
- Apprenticeships are aligned with workforce needs and plans
- Development of Talent Management approach

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **AMBER** reflects ongoing challenges in delivery of the recruitment service. Recovery plan being implemented which we now expect will enable the rating to revert to green for quarter 3 (was quarter 2)

Progress overview

Recruitment: There has been a 20% increase in the number of posts advertised in quarter 4 '18/19 and Quarter 1 '19/20. Recruitment activity remains high in month 4 & 5 with over 230 posts currently in the recruitment process. This number includes posts at all stages of the recruitment process. In Quarter 1 we reported over 200 posts in the recruitment process, the actual figure following further work to fully understand the situation was 346. Robust processes and monitoring are now in place. A recovery plan is being implemented and the situation has begun to stabilise with some positive customer feedback. Scoping underway to establish the resourcing service's future requirements

Recruitment to 'hard to recruit' roles: 19 newly qualified nurses have been recruited since the start of quarter 1: a further 3 due to be interviewed in month 6. This is above target at 63%. LCH has been shortlisted for a Nursing Times award for its innovative approach to recruiting newly qualified nurses.

0-19 service has continued to meet its contractual staffing requirement (>95%) in months 4 and 5.

Digital marketing expertise is being sourced to help with recruitment to 'hard to recruit' roles.

Retention: turnover up to month 5 is 13.1%, down from 14.2% for the same period last year. Staff turnover rate with <12 months service is17.9%, below target. From further analysis we now know there is high turnover in clerical roles: proposal developed to introduce apprenticeships for entry level clerical posts

E-rostering: on track. Following the successful pilot, e-Rostering has been rolled out to West NTs. The remaining NTs are scheduled for completion by the end of December. There are 481 staff accounts to access Employee Online, with 57% opting for the Allocate Me app.

Workforce Planning: Development of a new LCH approach to Workforce Planning is progressing, methodology agreed.

Success Measures	Month 5 RAG	Yr-end Forecast
Drop in vacancy rates	Report from Q3	
Improvement in fill rate for 'hard to recruit' roles: baseline 60%	Report from Q3	
improve retention in less than 12 months service: <20%		

Priority 3	Leadership: implement and further develop a revised leadership and management development offer for the organisation

What we aim to achieve in FY 19/20

- Increasing numbers of leaders and aspiring leaders have the skills to lead across LCH and wider system
- Embedding and expanding the new Leadership & Management development offer.
- Launch of LCH Leadership Competency Framework

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	
	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **GREEN;** Good progress continues this quarter. Whilst the Leadership & management programme continues to embed, there has been a specific focus on engagement with our talent management approach.

What we aim to achieve in 19/20: progress overview

Leadership & Management:

- Well on track to exceed the baseline target of participation by 180 leaders: 105 leaders undertook training in the first 5 months of 2019/20. 39 leaders participated in 'Leading by Example' in July.
- The Shadow Board development programme commenced with 11 leaders in September.

Talent Management

- The suite of tools to support talent management and the embedding of a development culture has been shared with a number of key stakeholders during this quarter, prior to SMT sign off in September. This includes the Leadership Competency Framework. Work is underway with the ABU to test implementation of the Talent Management approach in Q3
- LCH has successfully participated in an early implementer pilot of the Talent management Diagnostic Assessment Tool, on behalf of the Northern Regional Talent Board.
- A Talent Pool for Project Management was launched in quarter 1. 50 staff are currently on the programme: 5 staff have been placed on stretch projects and the 1st learning session taken place
- The focus on Appraisals continues this quarter. Training has increased both through bespoke sessions with teams and a module in the Essential Management course. Work will continue in Q3 on assuring high quality appraisals. There is further improvement in the Appraisal rate – now 87.2%

Statutory & Mandatory Training Compliance Project

- Compliance dropped to 87% from 94% average April – July principally reflecting the impact of the continuing work on training requirements and the phased configuration of ESR to ensure compliance with the national Core Skills Training Framework which commenced with IPC, progresses to Adult Safeguarding in September and other areas in Q3. There is a likelihood that compliance rates will dip temporarily as the remedial work is undertaken over the next few months. This will be closely monitored.

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
Increased leadership training uptake: baseline 180		
Stat mand training compliance improves: 95% or higher		
Improvement in staff survey leadership questions results		

Priority 4	Work effectively as a system partner in the development and implementation of workforce and HR strategies, systems and plans across Primary Care, the city of Leeds and the West Yorkshire and Harrogate ICS

What we aim to achieve in FY 19/20

- Leadership & launch of Leeds citywide statutory & mandatory training project; to smooth flow of workforce across organisational boundaries
- Design and delivery of GP Confederation employment / engagement model
- Introduction of bank arrangements for GP Nurse / HCA opportunities
- We will be instrumental in the development and delivery of the Leeds One Workforce Strategic Priorities
- Strong Leeds voice in WY&H workforce considerations

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **GREEN**. This priority remains on track, with support to the GP Confederation and PCNs making particularly strong progress during Q2

Progress overview

GP Confederation:

The LCH Employ/Deploy SLA for PCNs has been through a process of engagement with interested PCNs. Final version will be complete by end of Q2. One PCN has definitively confirmed it will take up the offer; others are expected to follow when the final SLA is circulated.

LCH continues to support the GP Confederation in exploring the most appropriate employment arrangements for core staff engaged to deliver services on their behalf. Dedicated HR support for the GP Confederation and the LCH support offer to PCNs (2.2 wte) commenced as planned in Q2

Leeds One Workforce:

Statutory & Mandatory training PID (LCH DoW is Strategic Lead) was approved by the relevant citywide group in Q2. Engagement is progressing well with WY&H Streamlining Project leads in order to bring the Stat & Mand element of streamlining in Leeds under the banner of the PID.

LCH has engaged at city and ICS levels in the development of workforce plans and narrative associated with the NHS Long Term Plan.

Success Measures	**Month 5 RAG status**	**Yr-end RAG Forecast**
Delivery of GP Confed / integration initiatives / programmes of work		

Strategic goal 2: Deliver outstanding care

Priority 5	**Maintain quality across all services & aim for outstanding rating by CQC & in services' Quality Challenge+**

What we aim to achieve in FY 19/20

- Timely implementation of action plans to address improvement requirements from external reviews
- Review Quality Challenge + process to ensure it is fit for purpose and provides required information.
- Systemisation of outcome measurement and reporting and robust processes for central oversight.
- Strengthen and embed internal QIA process and work with commissioners on joint process

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	
	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)	Not achieved/expected to achieve

Progress update

Overall: **GREEN**. We expect the CQC to publish its report imminently following LCH submitting feedback about factual accuracy. The Outcome development project manager started in post in August. Revised Quality Challenge + process on track to deliver targets.

Progress overview

- **Quality Challenge Plus**: The new Quality Challenge+ process has been embedded within Business Units: positive feedback has been received. 49 self-assessments received, 43 services rated themselves Good, 2 Outstanding and 4 Requires Improvement. All self-assessments and Improvement Plans have been quality assured by BU Quality Leads and the Clinical Audit & Effectiveness Manager and areas of good practice and things that could be even better shared with the service. Since June 15 Quality Walks have been undertaken: all have been rated 'good'.
- Good progress in increasing the pool of Quality Walkers: in Q1 28 new Quality Walkers signed up. New quality walker training continues and shadowing opportunities being prioritised by QPD colleagues who lead and coordinate Quality walks.
- SMT received a report which identified ratings, themes and key learning from Quality walks undertaken since commencing the new process.
- **QIAs**: QIAs are being routinely undertaken in line with guidance. Amber reflects focus in quarter 2 on ensuring QIA KPIs are routinely monitored by services and escalated via the BU performance review process. SMT to receive an implementation report this month
- **Outcome development**: amber reflects the pace of developing an organisational plan. The project manager started in post in August and additional BI resource has been recruited. Project support recruitment is ongoing. While the project manager becomes established in the role, outcome measure work within the business units continues to develop. The initial focus will be developing an organisational plan.

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
Implementation of external review action plans		
At least 80% of services rated good / outstanding following QC Walk visit		
Increase in number of actively engaged peer reviewers		
QIAs are timely & monitoring embedded in performance review process		
Outcome development against plan		

Priority 6	**Develop and embed continuous quality improvement which engages staff and service users**

What we aim to achieve in FY 19/20

- Identify and share the learning from QI projects
- Further develop the culture of Continuous Quality Improvement (CQI) through:
  - Delivery of QI training, evaluation training, Effective decision making and compassionate leadership sessions
  - Increase in numbers of staff attending training in house and with the Improvement Academy
  - Stronger connection and commitment at all levels organisation-wide to our CQI approach to ensure this underpins development & improvement work
  - Develop the interface with QPD, Business teams, Research & Development Team , to align all involved in CQI
  - Review and strengthen audit and quality challenge plus processes in collaboration with QPD to ensure CQI is underpinning philosophy

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update: Overall: **GREEN** reflecting extensive work progressed in quarter 2. The Quality Improvement Strategy was approved by Quality Committee and Board (September).

Progress Overview:

- **Staff survey**: FFT 5% increase in Q1 in staff feeling able to contribute to improvements
- **ICAN Transformation Programme**: QI Rapid Improvement approach is being used: 2 events to date, 3 events planned for quarter 3 with participation of patients and key stakeholders. Learning from this and other QI projects is being shared via the QI Steering Group
- **QI Training**: on track. At the end of August 34 staff had attended in-house QI training, 16 staff booked to attend in September and 1 booked to attend external Improvement Academy training.
- **Ensuring QI underpins audit, R & D & quality monitoring and align QI resource**: good progress made with a CEG workshop in Q2 focussing on better alignment of QI resource. A Quality Forum is being established to support better alignment between QI and quality assurance: terms of reference TBA
- Analysis of QI capacity available organisation-wide is progressing, with external support from the Improvement Academy.
- **Hits on Elsie QI hub**: on track: 157 hits to date: 49 were unique views which demonstrates return hits.
- **Sharing improvement stories:** Making Stuff Better viral campaign to launch on 12 September on Elsie, social media and in Community Talk, sharing improvement stories from across the Trust. QI Communications Plan finalised and a staff survey promoted across the Trust to assess baseline measures.

Success Measures	**Month 5 RAG status**	**Yr-end Forecast RAG**
staff survey - increase in staff reporting feel able to influence improvement		
Increased flow, capacity & patient experience in ICAN as a result of QI methodology in the Transformation Programme		
Train 60 people in QI		
Increase in QI projects initiated through audit, R & D & quality monitoring		
100 hits per quarter on Elsie QI hub & increasing trend of return hits		
Regular sharing of improvement stories via a variety of media / fora		

Priority 7	Strengthen organisational approach to service user engagement and experience at all stages of care delivery

What we aim to achieve in FY 19/20

- Strengthen strategic focus on patient engagement and experience with appointment to a new patient engagement lead role.
- Development of a Patient Engagement and Experience (PEE) strategy and delivery plan once new staff in place
- Experience and Engagement framework in place to measure progress
- Work with our partners to support and benefit from engagement work across the City
- Consider how we ensure patient engagement in the incident investigation process
- Organisation-wide roll out of 'Hello my name is…' Campaign
- Phased approach to implementing 'Always Events' in all 3 Business Units

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **GREEN** reflecting that the Patient Engagement Strategy is due to be submitted to Quality Committee in September and to Board in October for approval. The work to develop a supporting framework and implementation plan is on track. Strong organisational focus on the 'Hello my Name is…' campaign in the run up to the AGM on 17 September

Progress overview

- **Patient Engagement strategy:** once the strategy has been agreed work will continue on developing an operational implementation plan, processes and support structures. A framework structure based on NHSE guidance is being tested over Q1 and Q2.
- **Patient Engagement Staff Champions** continue to be identified to represent all services across the Trust. The 4th meeting will take place in September.
- **'#Hellomynameis**…' is the theme for the AGM on 17th September with Chris Pointon (Ambassador) as the key note speaker. Patient and staff stories have been shared in Community Talk and on social media in the run up to the event. A working group will focus on embedding the initiative across the organisation post-AGM.
- The **Always Event** for ABU will be identified using patient and staff feedback at the CUCS patient celebration event in September. A working group meeting is arranged for September to explore Always Event areas for CBU and SBU.

Success Measures	Month 5 RAG status	Year-end Forecast RAG
By end of Q2 develop PEE Strategy; process & support structure; implementation plan. By end of Q4 agree process & support structure to facilitate patient / carer involvement in incident investigations		
Implement PEE Frame-work by end of Q3		
Develop PEE service staff champion role & quarterly meetings		
Celebration of 'Hello my name is…' campaign roll-out at AGM		
By end of Q4 agree focus of 'Always Event' for 1 service in each BU		

Priority 8	**Ensure quality is maintained or improved when developing and implementing new models of care and new ways of working and working across boundaries - including integrated pathway development, service developments, tenders and sub-contracting arrangements**

What we aim to achieve in FY 19/20

- Successful implementation of new contracts e.g. dental, 0-19 and effective oversight of quality governance within these.
- Integrated care pilots and pathways established and effective oversight of quality governance within these.
- Identifying all sub-contracting arrangements within the organisation and ensuring robust governance processes are in place.

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**	**Year-end Forecast**

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **GREEN.** Good progress being made in developing processes to ensure robust Quality governance framework when working across boundaries

Progress overview

- **QIA's** routinely undertaken for service developments and tenders providing assurance about anticipated impact on quality. No post completion reviews undertaken yet.
- **Clinical governance structures fully functioning when service delivery commences:**
  - Clinical Governance Framework sets out the clinical governance requirements for different types of contractual arrangement and is embedded in LCH's Partnership Governance Standards. In tenders, the framework, informs development of service models / bids. Where we have partnership arrangements, LCH's Partnership Governance Standards (once approved by the Board) will be embedded in MOUs signed off with partners at their respective Partnership Boards. PHINS has retained existing clinical governance systems.
  - Integrated care pilots and pathways - quality governance: Respective organisational governance standards and frameworks are currently being used. To realise wider integration and collaborative working opportunities common standards and frameworks are required. The Integrated Care Steering Group has established a Governance Task & Finish Group with representation from LCH clinical staff and quality leads and primary care practice manager and nursing leads to develop and test partnership working standards, focussing on integrated nursing. The standards will build on LCH's Partnership Governance Standards. Learning will be scaled up and applied to other integrated work and inform future strategy.
- **Sub-contracting**: LCH Partnership Governance Standards will apply to sub-contracts: the clinical governance framework is embedded in the partnership standards. Robustness of clinical governance is being reviewed and where not sufficiently robust, fit for purpose governance arrangements will be put in place. A contract database has been developed and standardised authorisation, contract governance and performance management arrangements finalised. This has been implemented in Specialist BU and will be implemented in Childrens & Adult BUs in Q3. Standard Operating Procedure will be finalised in Q3 & contract management training incorporated in the Business Masterclass.

Success Measures	**Month 5 RAG status**	**Year-end RAG**
QIA / post completion review indicates quality maintained / improved		
Clinical governance structures fully functioning when service delivery commences • Agree model • Implement model for all developments & tenders since 1.4.19		
Clinical governance structures fully functioning across all sub-contracts		

Strategic Goal 3: Work in partnership to deliver integrated care and care closer to home

Priority 9	**Engage fully as a key partner in the development of LCPs and their plans and ensure service responsiveness in implementing new models of care and pathway redesign**

What we aim to achieve in FY 19/20

- Engage fully in LCPs, PCNs and Family Health Hubs and support their development including the PHM approach
- Engage fully in the development of integrated care pathways: stroke, diabetes, respiratory, neuro, cardiac, gynae
- Ensure the development and implementation of FCP, UTCs, the Virtual Frailty Ward and further development of the Virtual Respiratory Ward

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)	Not achieved/expected to achieve

Progress update Overall: **GREEN.** LCH fully engaged in LCPs. Funding secured to support LCH staff to engage effectively with LCPs in implementing PHM. The pace of LCP development has been impacted by the forming of PCNs. Good progress with development of integrated pathways and implementing new models of care.

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
FCP model in place in line with agreed implementation plan		

Progress overview

- **LCP development**: NTs continue to engage with LCPs and are supporting the 4 PHM Programme wave 1 LCPs in implementing interventions for selected patient cohorts. Early evidence of impact encouraging. Wave 2 (7 LCPs) to implement from October.
- **Child & Family Health & Wellbeing Hubs**: CAMHS, 0-19 service and Community Paediatrician are each engaged with a Hub. All 3 have agreed a focus: 1 is well established. The Hubs enable joined up working from a patient perspective and shared knowledge across all partners.
- **MSK FCP model**: now operating in 3 PCNs: project team currently evaluating impact to date. Medical
- Director is leading discussions with LCH, GP Confed and the CCG regarding funding and future FCP model(s) due to GP affordability concerns (GP 30% cost pressure plus overheads)
- **Virtual Respiratory Ward** now operating citywide. Service evaluation currently underway. The service is sharing learning working with the **Virtual Frailty Ward** project team: business case for phase 1 implementation approved, to start in October focussed on admission avoidance.
- **Community Stroke**: Recruiting to additional posts. Ongoing cross organisation work and development around community care bed pathways cross organisation rotations, better utilisation of band 3 workforce and improving Stroke Association integration across the pathway. Leeds Stroke Pathway shortlisted for an HSJ award and highly commended in LTHT Time to Shine awards.
- **Community Neurology** the Community Neurological Discharge Team has been operational for 8 months: completing an evaluation. Initial results show a positive impact on patient experience and a reduction of bed days for patients with a traumatic brain injury.
- **Diabetes**: Diabetes SPA project went live September 2019 and is being closely monitored which is a major step forward supporting delivery of the Leeds Integrated Diabetes Strategy. LCH and LTHT joint presentation to LTHT Chief Exec's 'report-out' was very well received.
- **Therapy Led Discharge trial** to enable LTHT patients known to NT to be discharged earlier being implemented

Priority 10	Increase service and organisational focus on prevention, early intervention, pro-active care and self-management to keep people well in the community and enable left shift

What we aim to achieve in FY 19/20

- NT self-management roll out depending on success of transformation fund bid
- 0-19 contract implementation
- Successful outcome of IAPT procurement
- Continue roll-out of health coaching and motivational interviewing across services
- Develop a 3rd sector strategy to support and drive closer working with the 3rd sector

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **GREEN.** On track reflecting evidence that NT Self-Management Facilitators positively impacting on patient activation and good progress mobilising CHAT health and other elements of the PHINS service that support prevention and self-management.

Progress overview

- **NT self-management roll out**: on track. We have recruited 22 Self-Management Facilitators: aim for them to be in post by November. Emphasis across NTs on increasing patient activation: discussing in cluster handovers how interventions and conversations can be tailored to improve effectiveness and patient activation. To report level of activation at the end of Q2. Participating in city-wide discussions about developing use of Patient Activation Measurement as a tool to understand the needs of a person, supporting the city-wide commitment to providing personalised care.
- **0-19 PHINS mobilisation** on track. ChatHealth has been very well received. All Leeds high schools have received electronic and hard copy literature; 141 messages received from service users to date. 72 HENRY groups now booked, 60 alongside Children's Centres, 25 will be delivered by LCH out of Health Centres due to reduced capacity in Children Centres and LCC Family Outreach Workers.
- **IAPT tender:** the contract has been awarded and mobilisation is now well underway and progressing positively with the new service going live 1st November
- **Rolling-out health coaching across services**: 39 staff have participated in health coaching training since April: no change since the Q1 report. The Health Coaching Steering Group agreed that the organisational plan needs to encompass the range of strengths based coaching approaches, Better Conversations, Restorative Practice, Motivational Interviewing, as well as Health Coaching.
- **Develop a 3rd sector strategy**: 3rd sector engagement event in August hosted by Forum Central well attended. Engaging with staff in September and October. To present the strategy to SMT by November.

Success Measures	Month 5 RAG status	Year-end Forecast RAG
self-management roll out against plan		
0-19 mobilisation		
success measure TBA re Better Conversations once organisation-al plan agreed		

Priority 11	Focus on all opportunities to develop integrated working & provision between Primary Care & LCH.

What we aim to achieve in FY 19/20

- Roll out integrated models
- Progress development of integrated pathways
- Work with the GP Confed to develop a different organisational model to support Primary Care Network and LCPs

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **GREEN** Integrated care work programme is on track: clear project plan developed with deliverables and timescales. The steering group meets bi-monthly and now has a number of task and finish groups working on specific areas of work. Enabling work streams have commenced.

Letter from CCG received in quarter 1 setting out a high level timeline for delivery of a different organisational model. Good continued collaborative working with the GP Confederation on a programme of work to allow us to submit a response to the CCG in mid-November.

Progress overview

Key areas of progress are:

- Developing joint clinics: project lead appointed and work progressing across the city. Integrated clinics beginning to develop in Meanwood and Seacroft; other areas to follow in the coming months.
- Wound care formulary launched across primary and community care. Developing joint templates and wound care guidance
- Catheter care work stream is in the early stages, focussing on how we work better with LTHT and ensure the right care is delivered in the community.
- OT first contact practitioners now working out of two primary care settings and showing early signs of good outcomes for patients. Funded until October 2019; working to ensure ongoing funding.
- Scoping a GPN/community bank. Presenting to practice managers across the city in September on next steps.
- Preceptorship programme developed and ready to launch. Successfully recruited leads who will be in post by mid-July when work will commence to recruit to the preceptee posts
- Integrated pathways progressing well, Work in Holt Park and Otley focusses on overlap between practice nursing and community nursing and efficiencies from working differently.
- Investment in posts to support primary care engagement and the Ambulatory Oxygen service
- Several digital projects being progressed e.g. SystmOne and EMIS electronic alert about to go live raising awareness that women of child bearing age who have diabetes at high risk during pregnancy

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
Tangible examples of more effectively working together & using clinical capacity & skill across the partnership		
Different organisational model with the GP Confed to support PCN & LCPs under-stood & being developed		

Strategic goal 4: Use our resources wisely and efficiently

Priority 12	**Develop an innovative and viable model for the new CAMHS Tier 4 service to the agreed time-frame**

What we aim to achieve in FY 19/20

- Achieve all milestones to enable contract award and contractor mobilisation by March 2020

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved / expected to achieve

Progress update

Overall: **AMBER** the business case remains complex but it is still intended to present to Board for approval in November following which it is expected NHSE/I could take at least 4 months to approve. The rating amber reflects this uncertainty.

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
FBC approved by NHSI by end of quarter 4		

Priority 13	Mobilise the 0-19 PHINs service, Community Dental service, Liaison and Diversion and Tier 3 Weight Management service, and other successful bids

What we aim to achieve in FY 19/20

- By 1 April 2019 operationalise: 0-19 PHINs service, Liaison & Diversity service, Tier 3 Weight Management service
- Watching brief to ensure all 3 services are embedded
- Consultation on dental bid April – June 2019 and operationalise by 1 October 2019
- Continue with negotiations in relation to IAPT April - June 2019 to develop an effective, integrated and viable model and, if successful, operationalise by 1 October 2019
- Mobilise services from other successful bids and maintain watching brief to ensure service embedded

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **GREEN**: PHINS, IAPT, Tier 3 Weight Management, Liaison and Diversion and Community Dental services mobilisations on track; commissioners pleased with progress. The 0-19 PHINS contract commenced 1 April. Tier 3 weight management and Liaison and Diversion services went live as planned on 1st April. IAPT mobilisation is progressing well and on track to go live 1 November

Progress overview

0-19 PHINS: phase two of mobilisation is progressing well and drawing to a close as the service launches in September and moves to business as usual. The main outstanding workstream is co-location which will be implemented as a standalone project. LCH has submitted a proposal to LCC for Children's Centres to be the primary sites for clinical care and the main base / touchdown space for 0-19 practitioners with Health centres being used as secondary sites where this is not currently possible. Over time, the aim is to co-locate fully with Children Centres

Liaison and Diversion and Tier 3 weight management: mobilisations are progressing well. Both services have phased in delivery in line with staffing capacity. Delays due to difficulties in recruiting and in recruitment processes have been addressed.

IAPT: mobilisation is now well underway and progressing positively. The new service is on track to go live 1 November

Community Dental Service: work progressing well to transition to the new specification by March 2020

Success Measures	Month 5 RAG status	Year-end Forecast RAG
Services up and running by contract start dates		

Priority 14	Understand and reduce unwarranted variation

What we aim to achieve in FY 19/20

- Agree an approach for identifying unnecessary variation in services
- A programme of work to identify and reduce waste of resources across the Trust

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)	Not achieved/expected to achieve

Progress update

Overall: AMBER reflecting pace of progress having been slower than planned. The steering group has been reconvened and is reviewing the focus and work plan recognising the necessity to agree an approach going forward that can be progressed at a reasonable pace and will deliver contribution to CIP. CBU are developing a standardised BU approach to setting benchmarking activity within services or pathways.

We have committed to engaging staff and managers in a wider conversation about productivity / CIP. This started through focussing on it at Leaders Network in quarter 1.

Success Measures	Month 5 RAG status	Year-end Forecast RAG
Clear examples of identified waste or variation within an action plan to tackle it		
Contribution to CIP as a direct result of the approach		

Priority 15	**Implement digital and estates strategies**

What we aim to achieve in FY 19/20

- By September 2019 refresh both the Digital and Estates strategies consistent with Trust strategy and supporting 'Creating the Working Lives that we Want'
- Commence implementation once strategies approved

Overall RAG Status - may differ to RAG status of the success measures	**Month 5**		**Year-end Forecast**	

	On track		Slight under performance &/or risk of not achieving priority (where relevant: 5% adverse variance)		Not achieved/expected to achieve

Progress update

Overall: **AMBER** reflects slippage in bringing the draft Digital Strategy to Business Committee and then Board for approval. It will be submitted to the Committee in October. The Estates Strategy is being presented to September Business Committee for approval before being submitted to Board.

- **Estates strategy**: an amended draft Estates strategy is being presented to September Business Committee, and if approved will be submitted to October Board. An implementation plan and associated business cases will be subsequently developed and presented to Business Committee.
- **Digital Strategy**: a draft document has been produced following good engagement with services; however it is not yet ready to present to Business Committee. We are confident that the Strategy will be ready to submit to the Committee in October and then to December Board for approval. Following Board approval, an implementation plan outlining the costs of the main areas will be developed.

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
Strategies approved by Board		
KPI TBA once strategies approved		

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (63i)

Meeting: Trust Board meeting. 4th October 2019.	**Category of paper** *(please tick)*	
Report title: Engagement Strategy.	**For approval**	✓
Responsible director: Executive Director of Nursing and Allied Health Professionals. **Report author:** Patient Experience and Engagement Lead.	**For assurance**	
Previously considered by: Senior Management Team meeting 18th September. Quality Committee meeting 23 September 2019	**For information**	

Purpose of the report

The final draft of the Engagement Strategy is presented to the Trust Board for approval.

Main issues for consideration

This strategy has been coproduced and is formulated around 6 main priorities:

- Culture of Engagement
- Working with others
- Leadership
- Listening to everyone's voice
- We are ALL experts
- How we do what we do

Work will continue with patients, staff, carers, partners and communities to develop a one-page strategy document.

A detailed operational plan, including identification of key indicators, will be developed to support the implementation of this strategy.

The success and implementation of this strategy will be monitored through the Quality Committee, PSEGG and CEG.

There are risks to the delivery of this strategy if there is not sufficient resource allocated to it; this will require continued and dedicated resource to staff capacity, specific budgets and staff roles.

Recommendations

The Board/Committee is recommended to:

- Approve this Engagement strategy
- Consider the resource required to deliver this strategy

Engagement Strategy 2019-2022

1. Introduction

The Patient Engagement strategy provides a framework for Patient Experience and Engagement work within the Organisation for the next 3 years (2019-2022).

2. Background

Following an external review of Patient Experience and Engagement within Leeds Community Healthcare NHS Trust by Healthwatch Leeds, we have developed a Patient Engagement strategy for the Organisation.

3. Current position

The strategy has been developed in partnership with Volunteers, Staff, Partners (Healthwatch, CCG, NIHR Biomedical research centre), Patients and Carers. The development process has included consultation with Clinical and Quality leads, Trust Directors and the Chairman of the Trust Board. This higher level engagement has supported the development of a robust and aspirational strategy document.

The Patient Engagement strategy provides a framework for Patient Experience and Engagement work within the Organisation for the next 3 years (2019-2022). This includes a shared vision for Patient Experience and Engagement, Key priorities for the next 3 years, and clear aims and objectives within each of the following priorities:

- Culture of Engagement: Engagement will be embedded within our culture and underpins everything that we do.

- Working with others: We work to improve the whole patient journey; working with people to maximise their strengths, reduce health inequalities and link with our partners across the city.

- Leadership: There will be leadership from every voice- We are accountable to our citizens as well as the Trust board.

- Listening to everyone's voice: We will listen openly to a diversity of voices; and consider how we learn from each and every experience.

- We are ALL experts: We recognise the skills and experience that each person can bring.

- How we do what we do: We have efficient systems and processes in place to maximise the potential of our engagement and the influence of the people's voice.

We will continue to engage with our working group and others to create a one-page version of this strategy with the aim of being accessible to all.

The successful implementation of this strategy will rely on the development of a detailed and coproduced operational plan including the identification of appropriate measures.

The strategy and accompanying operational plan (once developed) aim to make sure that in 3 years we have all of the systems and processes in place to truly capture and

4. Impact:

4.1 Quality

The Engagement strategy operational plan will be presented to the Quality committee 2 months after approval by the Trust Board.

The implementation of the operational plan will be monitored through relevant forums; PSEGG and CEG.

4.2 Resources

There will need to be continued and dedicated resource to support the strategy; the Patient experience team are equipped to lead on this, however more resource will need to be allocated across the business units.

4.3 Risk and assurance

Risk	How do we manage the risk?
Organisation-wide belief in the Engagement strategy: Failure to achieve full buy-in of staff to the strategic priorities and aims will mean that the strategy's aims are less likely to be achieved.	As an organisation we have a commitment to fostering a fair and just culture and one in which our staff are engaged, seeking at all times to embody the Leeds Community Healthcare values and behaviours. This will support the embedding of an engagement culture across the organisation. We have visible and committed leadership of senior managers. Appropriate training is developed and delivered.
Capacity of workforce: If there is insufficient capacity across the Trust to deliver the strategy then the Trust's other priorities could take precedence. The impact will be that services may not reflect the needs of the population we serve and the strategy will not be sustained and embedded.	Budget and resourcing conversations to take place; identify resource opportunities to support the organisation-wide implementation of this strategy and workstreams within it. Trustwide communication- all communication must make it clear that engagement within the plan has to take place and services will be held to account for delivery. This strategy is designed to provide tools and resources to support working towards the aims providing more high quality experience and engagement throughout the organisation; building the skills of our workforce will in turn increase our efficiency and aid capacity.
Capability of workforce: If the skills and abilities within our workforce are not developed the impact will be that the quality of engagement will be low and the patient voice will not be present in transacting change, and there is potential that we will not engage people in delivering the best possible care in all our communities.	This strategy is designed to provide tools and resources to support the development of skills within the existing workforce, and to support recruitment of staff that is experience in this field. Training will be geared to ensure that delivering the strategy will not impact on frontline duties/performance. To provide more high quality experience and engagement throughout the organisation; building the skills of our workforce will in turn increase our efficiency and aid capacity.

5. Next steps

- Engagement strategy to be approved by the Trust Board
- Operational plan to be developed and delivered to the Quality Committee 2 months after Board approval
- Action plan of key indicators to be agreed with the appropriate people- to be delivered with to Quality Committee 2 months after Board approval.

6. Recommendations

The Board is recommended to:

- Approve this Engagement strategy
- Consider the resource required to deliver this strategy


PARTNERS
STAFF
COMMUNITIES
CARERS
PATIENTS
LCH PATIENT
EXPERIENCE +
ENGAGEMENT

Contents:

Appendices:

Glossary

Within health services and particularly within NHS Trusts there are often many acronyms used. This glossary identifies and explains the terminology used in this strategy, and each term used from the glossary will be written in **green** throughout the document to help make them easily identifiable.

Acute trust footprint- Regional footprints are the areas that NHS England and NHS Improvement regional offices are based, these align with Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to support integrated working

ABU/CBU/SBU- Adult Business Unit/Children Business Unit/Specialist Business Unit

CCC- Claims, complaints and compliments

Commitment to Carers-The Leeds Commitment to Carers has been produced by members of the Leeds Carers Partnership to raise awareness and encourage action so that Leeds is the best city when it comes to identifying, recognising and supporting carers.

CQC- Care Quality Commission

Duty of Candour- Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress

Elsie-Leeds Community Healthcare NHS Trust Staff intranet website

ESR- Electronic staff records

Feedback loop- Our methodology for involvement focuses on the feedback cycle: Gather views, Review what's been said, Plan and implement change, Feedback changes.

FFT- Friends and family test

GP Confederation/Collaborative- The Leeds GP Confederation is a 'not for profit social enterprise,' working to improve the health of the people of Leeds by strengthening and sustaining primary care.

ICS-Integrated care systems

Incident- An instance of something happening; an event or occurrence

LCH- Leeds Community Healthcare NHS Trust

Local authority- An administrative body in local government

NICE- National Institute for Health and Care Excellence (UK)

PE- Patient engagement

PEG- Patient engagement group- a group of staff champions who lead on patient experience and engagement within Leeds Community healthcare services

PSEGG-The Patient safety, experience and governance group meeting (PSEGG) is a subgroup of LCH's Quality Committee. The PSEGG will review and scrutinise data and information relating to learning in relation to: Patient safety, Inquests/claims, Complaints, concerns, Patient, carer and public engagement and involvement, Infection prevention control, Safeguarding, Learning from excellence from across the organisation in order to identify themes, trends, actions for quality improvement, learning, and how themes and learning from Business Unit and corporate teams will be shared.

Trust Board-The Board of Leeds Community Healthcare NHS Trust leads the organisation. The Board will set the tone and will establish the vision, values, culture and strategic direction of the new organisation. The Board will manage and nurture talent; and set in place business processes to secure safe and effective care for patients. In doing so, the Board will deliver value for money.

Quality and Assurance Framework-The Quality Assurance Framework describes the approach used by Adults' Services to ensure that the work we do is of the highest quality. Our staff are expected to be ambassadors for health and social care practice.

Quality Committee-The Quality Committee is a sub-committee of Leeds Community Healthcare NHS Trust Board and has delegated authority from the Board to assure high standards of quality, safe and effective care and appropriate quality governance arrangements.

1. Foreword:

Dear all,

Welcome to the Leeds Community Healthcare NHS Trust Engagement Strategy, 2019-2022.

Nationally there is a drive to ensure patient engagement becomes central to everything we do and giving more control to people with regards their health and wellbeing. Our vision is to provide the best possible care to every community we serve and to do this successfully we need to engage and work with the people that use our services. In addition to this strategy the Trust has invested in a new team to lead this work and ensure it becomes embedded within business as usual for the organisation.

Leeds Community Healthcare NHS Trust is committed to ensuring we engage patients and the public in everything that we do and this strategy aims to outline to the organisation how we will achieve this. This includes engagement from board level to front line services, to ensure the patient voice is loud and clear in all we do. There has been a lot of great work over recent years from individual services to ensure we engage with patients whenever possible and we are keen to build on this to create an organisational culture that engages patients and the public in all that it does.

This strategy sets out how the Trust will ensure patient engagement becomes embedded across the whole organisation to ensure that the patient voice is central to everything that we do. . We propose to achieve the aim of the Engagement Strategy by focusing on the following key priorities:

- Culture of Engagement
- Working with others
- Leadership
- Listening to everyone's voice
- We are ALL Experts
  How we do what we do

With thanks,
Steph Lawrence, Executive Director of Nursing and Allied Health Professionals

1.1 A message from our contributors

“Hi, I’m Kath a volunteer who has been lucky to be part of the team involved in the Leeds Community Healthcare Engagement strategy. Like all of us in Leeds my family and I have been supported by the NHS and Leeds Community Healthcare services to keep fit and well. I have always believed the NHS & community services are one of the cornerstones of our society & feel passionate that engaging with patients, carers, etc., enhances services and gives hard working staff a real sense of achievement. The aims of the Engagement Strategy are to build on existing practices and embed even further into processes and procedures the means and use of patient feedback. I feel strongly this will help provide better and more patient focused services and will enable those involved to continue the cycle of improvement. I have thoroughly enjoyed the work so far and look forward to providing any further appropriate assistance.” **Kath, Volunteer**

“I feel flattered to be invited to contribute a “patient’s view” foreword to this initial Leeds Community Healthcare NHS Trust Engagement Strategy – and am pleased to be to totally two-faced in doing so (i.e. seeing things from both the patient and the NHS point of view):-

- Face 1: I’ve lived in the Leeds area for around 45 years, have got to know and love the place, and have contributed to many consultation projects. I consider myself to be a ‘normal’ Leeds citizen who has had cause to call on various NHS services over the years.
- Face 2: Following retirement from a career centred around designing processes and systems in both the NHS and local government in Leeds, I’ve spent the last two years being closely involved as a Volunteer with Leeds NHS **CCG** ensuring that the patient point of view is taken fully into account.

Leeds is working to improve care provision for its citizens through the integration of services from the NHS, Leeds City Council, and third party organisations – with an emphasis on a local level. This should mean much more co-ordinated services and each person being treated as an individual with individual needs – instead of like a number of separate “someones” being treated separately by different services. These changes should result in fewer stays in hospital, fewer “clashes” of different treatments, and an understanding of the whole individual by everyone providing support to them. Given the range of services they provide within the community, LCH will be right at the heart of achieving this. So, what has all that got to do with this Engagement Strategy? The short answer is “Everything”. The full answer is that, for this joined up approach to work, all those involved – including LCH – need to know (and respond to) the priorities of the people likely to use their services. To achieve this, they need to have a clear and robust approach and commitment to engagement – i,e. this strategy.” **John, Volunteer.**

2. Vision, Values & Behaviours:

The **Leeds Community Healthcare NHS Trust's** Vision, Values and Behaviours, **"Our Eleven"**, inform how we engage. Our objectives within each of the six priority areas identified have each been tested against them; making sure that each contributes to our one **vision** and operates in line with our three **values** and our **magnificent seven behaviours**.

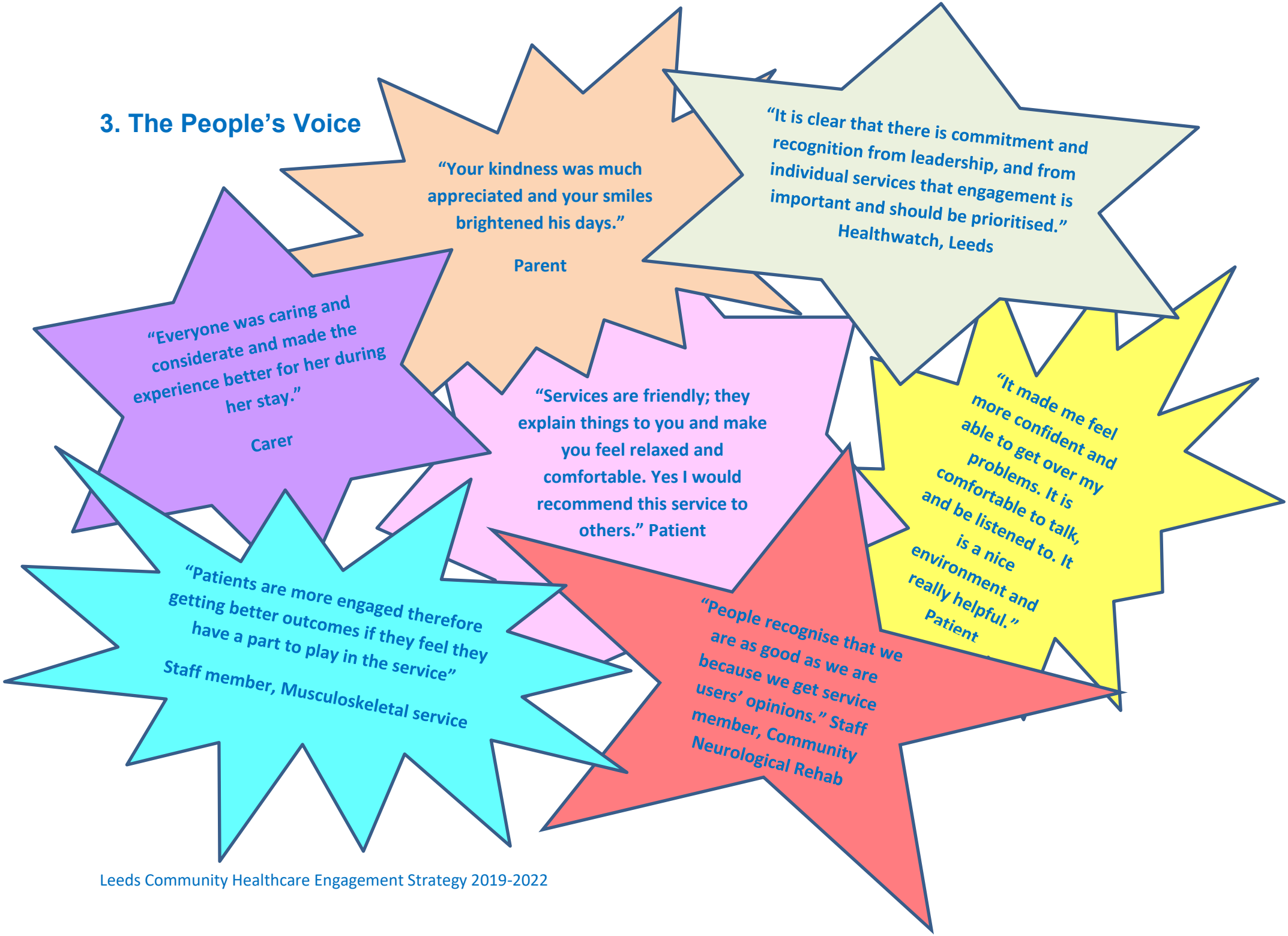
The **LCH** vision is underpinned by its values to:

- Be open and honest and do what we say we will

- Treat everyone as an individual

- Continuously listen, learn and improve

3. The People's Voice



4. Setting the Scene:

Throughout this strategy document we will use the term ‘Engagement’ but we are aware that the terms listening to people, Membership, Involvement, Participation, Patient Experience, Coproduction, Feedback and Information sharing, are also commonly used and can refer to different aspects of the engagement process. We will refer to patients, carers, families and the public throughout this document and will use the term ‘people’ to represent these groups.

The aim of this strategy is to ensure that through genuine engagement Leeds Community Healthcare NHS Trust is **able to deliver the best possible care in all our communities,** adapting and responding to feedback, engaging the communities we serve and responding to requirements, challenges and opportunities. We aim to be an outstanding Trust in how we engage with people to improve the patient experience and our services; the people’s voice is at the heart of all we do and drives our Organisation.

In developing this strategy to achieve our aims, we have considered in detail the context within which **LCH** works now, and how we may work in the future to enable a flexible approach to respond to change over time and conflicting priorities.

4.1 The National Scene

The NHS Long Term Plan commits to doing things differently and giving more control to people over their health and wellbeing. The plan has been developed with patients, staff, families and experts with the aims of giving people the best start in life; to deliver world-class care for major health problems as well as improving the recognition and support given to carers, and helping people to age well.[i]

The NHS Long Term Plan is dedicated to tackling health inequalities by increasing its contribution to dealing with some of the most significant causes of ill health. The plan highlights the need to create genuine partnerships between professionals and patients, it commits to training staff to be able to have conversations that help people make the decisions that are right for them. There is also a commitment to increasing support for people to manage their own health which forms part of a broader cultural change, moving towards what is described as ‘shared responsibility for health'. [ii]

NHS Improvement have developed a framework to support organisations assess how well patient experience is embedded within the culture and leadership of their organisation and identify areas for improvement in line with **CQC** inspection regime. **NICE** have published guidelines on patient experience including transition between hospital and community. The Health and Social Care Act

2012 places a duty of care on health service providers to involve people- whether directly or through representatives- from the beginning in the planning and the provision of services, in the development and consideration of proposals for change in the way the services are provided and in decisions to be made by the body affecting the operation of services.[iii]

4.2 The Local Scene

Leeds Community Healthcare NHS Trust (**LCH**) is one of three NHS providers which, along with primary care colleagues in the Leeds **GP Confederation**, the Yorkshire Ambulance NHS Trust and an increasing number of non NHS providers, delivers NHS services to the population of over 750 000 across Leeds and its local environs.

The publication of the NHS Long Term Plan recently highlighted the important role Community services will have as part of Primary care networks, the bedrock upon which NHS care is delivered. Leeds Community Healthcare NHS Trust is currently working very closely with Leeds **GP Confederation**, supported by the Leeds Clinical Commissioning Group (**CCG**), with a view to developing a strong and progressive partnership aimed at transforming the delivery of primary care services in the city.

Regionally health and social care is being developed through West Yorkshire and Harrogate Integrated Care System (**ICS**). The experience of people using services and of carers is central to the development and achievement of the plans. Voluntary services are active partners in this. The **ICS** plan puts places at the centre of what is to be achieved enabling each place to develop what is right for them; a 'place' can be defined by a **Local Authority**, **CCG**, **Acute Trust footprint** or the geography of a town or city[iv].

Leeds has a local commitment to hearing the voice of everyone; there is a city-wide People's Voices Group; a group set up by the Leeds Health and Wellbeing Board and co-ordinated by Healthwatch Leeds. Members of the group include engagement and involvement leads from all statutory commissioners, health and care providers and representatives from the Leeds 'Forum Central' network. The group aims to encourage and lead shared engagement and participation in Leeds. [v]

Within the Yorkshire and Humber area we have the Improvement Academy that aims to improve care and safety by working with frontline services, patients and the public. They have developed a patient experience toolkit that is based around 5 principles of patient experience: active listening; using feedback to celebrate and improve; making experience a priority for all staff; using all types of feedback and visibility of actions as a result.

Individual organisations within the system have data that they collect either as part of national data submissions or as bespoke service data sets. Most services also have engagement and experience plans and will collect patient stories to share in governance meetings. Healthwatch Leeds has been actively working with organisations in Leeds to help them understand their approach to patient experience including support for the identification of areas for improvement.

4.4 Setting OUR Scene:

LCH is one of only 20 distinct NHS Community Care provider Trusts in England. As the largest provider of community services in Leeds, with an annual budget of approximately £150m each year, **LCH** employs approximately 3000 people across 58 services and 120 sites. We receive 215,000 referrals and deliver 2 million patient contacts every year.

The services provided by Community Care Trusts are distinct in that they are delivered in "non acute" community settings and were not aligned initially around the delivery of acute mental health care. Characteristics of community trusts are that their "core business" is focussed upon delivery of care in patient/client homes, community based clinics or local community based non acute facilities

We work in all parts of the city, and deliver some services across a broader geographical footprint (notably our Criminal justice services). We are privileged to work with many thousands of people in their own homes, as well as in a full range of other health and care settings.

Our **LCH** vision is *'We provide the best possible care to every community'* and this is underpinned by our 3 values and 7 behaviours. Within this context for 2019-2021and as part of our Trustwide strategic priorities , **LCH'**s second strategic goal is to 'Deliver outstanding care' by strengthening organisational approach to service user engagement and experience at all stages of care delivery.

The Engagement Strategy works alongside other key organisational strategies and plans, including the Primary Care strategy, Workforce strategy and Quality improvement strategy.

In 2018 Healthwatch Leeds completed a Leeds Community Healthcare engagement review report; this was aimed at establishing the effectiveness of our current approach to engagement and indicating where improvements can be made. The report informs this strategy document.

5. Priorities for delivery:

The Engagement Strategy has 6 key priorities; each priority has an overarching aim. The underpinning objectives and initiatives to achieve each aim are set out in Section 5.1-5.6.

The subsequent six pages set out how each of the Engagement Strategy's 6 priorities will be delivered.

We have used our **LCH magnificent seven behaviours** icons throughout **Sections 5.1-5.6** to indicate which behaviours are crucial to achieving each priority and will be demonstrated by each priority's achievement.

Key: The following icons are used to show how each priority aligns with the **LCH** Values and Behaviours (shown in full detail on page 7);

CULTURE OF ENGAGEMENT

AIM: Engagement will be embedded within our culture and underpins everything that we do

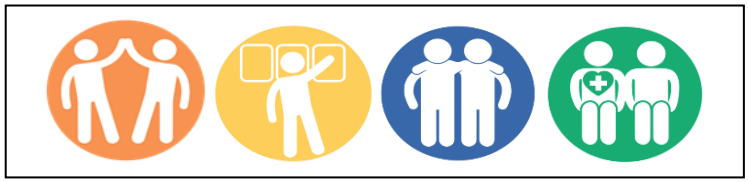
5.1

What we plan to achieve	How we will achieve it	How will we know we've achieved it?
The people's voice drives our organisation	- We will implement processes to hear the people's voice within all areas of the organisation - We will develop an infrastructure that enables this voice to have a much bigger influence - We will measure the impact of the people's voice	- There is an increase in breadth of experience data we capture - The people's voice is considered as part of all organisation decision making and is embedded within processes - We are able to demonstrate how engagement has impacted on services and the organisation as a whole
We listen to people and learn from their experiences	- We will create opportunities to reflect on feedback and this will be embedded within our processes - We will proactively challenge and strive to continuously improve - We regularly audit to measure how learning is sustained	- We have fostered an open, honest and reflective culture for patients and staff – the staff survey and feedback reflects this - There is evidence to show that our learning from experience makes things better
Engagement is everyone's responsibility	- Engagement is a part of all roles - We will follow guidance from NHS England and NHS Improvement around engagement	- Engagement is embedded within recruitment processes - Engagement forms part of the staff appraisal process - We are working within an evidence-based framework

5.2 WORKING WITH OTHERS

AIM: We work to improve the whole patient journey; working with people to maximise their strengths, reduce health inequalities and link with our partners across the city

What we plan to achieve	How we will achieve it	How will we know we've achieved it?
Establish our approach to a People's Network within the organisation	- We will define the aims and objective of an **LCH** people's network - We will work closely with existing networks in the city - We will develop our offer for involvement	- We have developed a network of people to contribute towards organisation improvement - Our network is linked within wider City networks - We have an organisation-wide approach to involvement
Develop and sustain links with our partners across the City	- By building positive working relationships with key partners across the city - We will feed into city-wide developments as part of the Leeds Plan - We will work together to improve the patient journey in the city	- Partner relationships are effective and productive and support positive outcomes - We are linked to all city-wide developments - Our patient feedback captures the whole patient journey
Demonstrate a Commitment to Carers	- We will sign the Leeds Commitment to Carers initiative - Providing support to staff members who are working carers - Providing carer awareness training to staff	- **LCH** is part of the city-wide commitment to carers - Staff awareness and knowledge around carers is improved



LEADERSHIP

AIM: There will be leadership from every voice- We are accountable to our citizens as well as the Trust board.

5.3

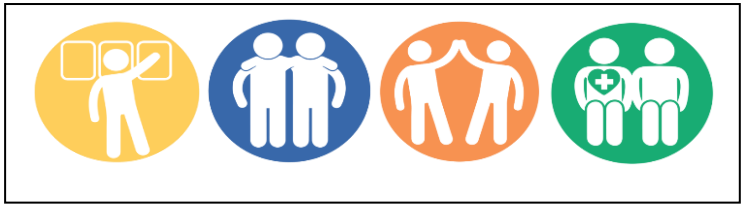
What we plan to achieve	How we will achieve it	How will we know we've achieved it?
The people's voice has influence throughout the organisation	- We have representation of the people's voice within our quality and assurance frameworks; at the Patient safety and engagement group meeting (**PSEGG**) and at our public board meetings - We improve how we involve people as part of the serious incident review process	- We have patient/carer/family representatives at the monthly **PSEGG** meetings with clear structure to these roles - There is patient representation embedded within the serious incident process - The Trust Board regularly listen to, and interact with, the people who access our services through a range of ways
Engagement will be role-modelled and embedded across the organisation	- Patient Engagement Group staff champion roles - Dedicated staff roles; central **PE** Team and within Business units	- All services have a **PEG** staff champion - Champions are leading on experience and engagement within their service and feed into the central **PE** team - There is allocated and sustained resource within each business unit for a **PE** staff role - Measured through performance reviews and the appraisal process
We lead by example	- Senior Leaders, Board Directors and Senior Management Team live and breathe this approach in their daily activities - The people's voice will be present at Trust Board Meetings	- We can demonstrate the impact of the patient voice across organisation structure - All leaders are ambassadors for patient experience and engagement - The Trust board is sighted on whether the strategy aims are being delivered through the Quality Committee

LISTENING TO EVERYONE'S VOICE

AIM: We will listen openly to a diversity of voices; and consider how we learn from each and every experience

5.4

What we plan to achieve	How we will achieve it	How will we know we've achieved it?
Our services are accessible to all	- Working with our partners and community groups to increase our reach - We will review the patient experience information we use to make sure this is in line with the Accessible Information Standards - Our networks and groups will reflect the communities we serve	- The data we collect reflects a much wider audience demographically - We are engaged with relevant community groups - The information/correspondence we produce is available in different languages and formats when required - We promote inclusivity through our information sharing; this is accessible to everyone
We learn from all experiences	- We will review our complaints, concerns and compliments processes to ensure learning from this feedback is implemented and shared	- Revision of **CCC** process to provide stronger evidence of the impact of engagement
We engage at every opportunity	- Engagement will be embedded within organisation-wide policy, process and approach, e.g. Business development. - Policies will align to allow joint working	- Services provide engagement information as part of reporting structures - Services are confident in engaging with patients and families and do this regularly



WE ARE ALL EXPERTS

AIM: We recognise the skills and experience that each person can bring

5.5

What we plan to achieve	How we will achieve it	How will we know we've achieved it?
We use a strength based approach	- We will recognise the value that someone brings to their own care - The patient's view of their own care is critical - We will develop and implement processes that enable us to fully incorporate the people's voice in designing their treatment, services and organisation-wide change	- There is evidence to show that decisions are made based on all available information and experience – this is evidenced through our feedback data and through audit processes - Feedback demonstrates that people feel their views have been taken into account
Our staff have the skills, knowledge and confidence to engage	- Staff training needs are identified as part of the appraisal process - Training is delivered across the organisation as required and available - Learning is shared through engagement forums, newsletters, within team meetings and at other relevant forums - We use city-wide forums to share learning with our partners	- Annual and six-monthly appraisals and review, monthly one-to-one meetings -Ongoing attendance and contribution to city-wide forums; the People's voices group, Complaints sub-group and others
We are all human	- **Duty of Candour** is followed; we inform people when they have been harmed as a result of care/treatment they have received from **LCH** - We always acknowledge when things do not go well and say sorry when needed	- **Duty of candour** is considered for each complaint and incident investigation as part of process

HOW WE DO WHAT WE DO

AIM: We have efficient systems and processes in place to maximise the potential of our engagement and the influence of the people's voice

5.6

What we plan to achieve	How we will achieve it	How will we know we've achieved it?
Effective systems	- Ensuring our systems are robust and fit for purpose to capture experience and feedback - Our reporting structures enable us to showcase our engagement activity - Review our data collection approaches, incl. **FFT**	- There will be an increase and variation of our data collection - We will have an increased capacity to capture the people's voice - We are able to demonstrate learning and change from feedback and engagement activity
We have a protected resource to support experience and engagement activities	- Development of an engagement toolkit - We will Implement standardised processes across the organisation Each business unit will utilise an engagement budget - There will be clear guidance on expenses and reimbursements	- Staff are confident and have what they need to lead engagement in services - There is consistency in how we engage - Experience and engagement activity has a clear rational and is meaningful to all involved
Resources	- There is a defined budget for engagement; centrally and for each business unit - There is an increase in capacity within the Patient experience team; with specific roles held either centrally or within each Business Unit - Patient engagement staff champions; there is allocated time and resource to lead on engagement within service	- There will be an increase in engagement activity Trustwide across a wider scope - The organisation is sufficiently resourced to achieve its' aims around experience and engagement

6. Risks to Delivery: There are a number of risks to delivery of the priorities and aims set out in this Strategy, set out in the table below; together with actions we can take to reduce these risks.

RISK	How likely is the risk?	How severe is the risk?	Risk level	How do we manage the risk?
Organisation-wide belief in the Engagement strategy: Failure to achieve full buy-in of staff to the strategic priorities and aims will mean that the strategy's aims are less likely to be achieved.	**2**	**3**	6 (Moderate)	As an organisation we have a commitment to fostering a fair and just culture and one in which our staff are engaged, seeking at all times to embody the Leeds Community Healthcare values and behaviours. This will support the embedding of an engagement culture across the organisation. We have visible and committed leadership of senior managers. Appropriate training is developed and delivered.
Capacity of workforce: If there is insufficient capacity across the Trust to deliver the strategy then the Trust's other priorities could take precedence. The impact will be that services may not reflect the needs of the population we serve and the strategy will not be sustained and embedded.	**3**	**3**	9 (High)	Budget and resourcing conversations to take place; identify resource opportunities to support the organisation-wide implementation of this strategy and workstreams within it. Produce Business case for bespoke posts centrally or for **ABU** and **SBU.** Trustwide communication- all communication must make it clear that engagement within the plan has to take place and services will be held to account for delivery. Training will be geared to ensure that delivering the strategy will not impact on frontline duties/performance.

				This strategy is designed to provide tools and resources to support working towards the aims providing more high quality experience and engagement throughout the organisation; building the skills of our workforce will in turn increase our efficiency and aid capacity.
Capability of workforce: If the skills and abilities within our workforce are not developed the impact will be that the quality of engagement will be low and the patient voice will not be present in transacting change, and there is potential that we will not engage people in delivering the best possible care in all our communities.	**2**	**3**	6 (moderate)	This strategy is designed to provide tools and resources to support the development of skills within the existing workforce, and to support recruitment of staff that is experience in this field. Training will be geared to ensure that delivering the strategy will not impact on frontline duties/performance. To provide more high quality experience and engagement throughout the organisation; building the skills of our workforce will in turn increase our efficiency and aid capacity.

7. Implementing the strategy

The strategy implementation will be supported by an engagement framework to help measure progress within each business unit and service area. Operational plans for each business unit and service will be devised in collaboration to identify how we will achieve our priorities and aims. The strategy implementation will be monitored through the Quality Committee with escalation to the Trust Board where directed. The strategy implementation will also be monitored and supported by the Patient Engagement Staff Champion Group (**PEG**), the Patient Safety and Engagement Group (**PSEGG**), and through monthly monitoring and reporting structures. The most important measure of our success will be the feedback that we gather from our patients, carers and networks.

8. Acknowledgements

This strategy has been developed through engagement with a strategy development working group made up of Healthwatch Leeds and the Leeds Clinical Commissioning Group (**CCG**), **LCH** clinical staff, Volunteers from the **CCG** network, colleagues from the NIHR Leeds Biomedical Research Centre (LBRC), the **LCH** Patient Experience Team and the Assistant director of Allied health Professionals and Patient Engagement. The strategy has also been through a number of forums for comment and feedback at different stages of the process, these include; the **LCH** Youth Board, the Neurology Users and Carers forum, the Patient Engagement Staff Champion Group, **LCH** Quality Committee, and **LCH** Trust Board members.

9. Conclusion

The Patient Engagement Strategy you have just read aims to support us to achieve our main aim of becoming a Trust that truly and honestly engages with each and every experience and voice. We are dedicated to delivering person-centred services that provide the best possible care in every community.

We believe that this strategy will help to strengthen our patient experience and engagement offer and put us in a position to achieve our aspirations.

We are confident that our engaged and talented workforce, combined with strong organisational leadership and the expertise of the citizens in Leeds, puts **LCH** in the best possible position to deliver on the priorities set out in this strategy, enabling positive and tangible improvements to the care we deliver.

Appendix A: References, Helpful documents and links

[i] The NHS Long Term Plan. 7 January 2019.

[ii] https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained

[iii] Health and Social Care Act 2012, Department of Health and Social Care, June 2012

[iv] A year of integrated care systems, Reviewing the journey so far. The King's Fund; Anna Charles, Lillie Wenzel, Matthew Kershaw, Chris Ham, Nicola Walsh. September 2018. (https://www.kingsfund.org.uk/sites/default/files/2018-09/Year-of-integrated-care-systems-reviewing-journey-so-far-full-report.pdf).

[v] https://healthwatchleeds.co.uk/our-work/pvg/

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (64i)

Meeting: Trust Board 4 October 2019	**Category of paper**	
Report title: Workforce Strategy 2019-2021: Progress & Delivery - Health and Wellbeing	**For approval**	
Responsible director: Director of Workforce	**For assurance**	✓
Previously considered by: Business Committee 25 September 2019	**For information**	

Purpose of the report

To provide Trust Board with an update on progress and delivery on the Health and Wellbeing workstream within the Workforce Strategy.

Main issues for consideration

Significant progress has been achieved during the last 6 months:

- Sickness absence rates below 5% for three months since April, compared with no months below 5% during 2018/19
- 16 staff have been trained as Mental Health First Aiders (MHFA)
- Workforce Disability Equality Standard (WDES) Action plan was developed with input from a Trust Board Development Workshop, and subsequently approved by the Board
- Training around the Equality Act 2010 and Reasonable Adjustments to equip managers with skills and increase knowledge
- Power of personal staff stories continue; sexual and physical assault and mental health
- Media interest in work we are doing around HWB
- Part of NHSi HWB Programme

Recommendation

The Board is recommended to:

- Note the progress made on Health and Wellbeing since April 2019
- Endorse the approach identified for this workstream during 2019/20

Workforce Strategy 2019-21: Progress and Delivery

Ensuring LCH's workforce is able to deliver the best possible care in all our communities

Leadership & skills **Resourcing** **Wellbeing** **Diversity & Inclusion** **Integration & Partnership** **Proactive analytics**

1. Introduction

The LCH Workforce Strategy 2019-21 was approved by the LCH Board on 1 February 2019. It was agreed that the Board would receive an update on one of the Strategy's 6 priorities at each of 2019/20's Public Board meetings, and regular updates on Health and Wellbeing would be provided to Business Committee,

This report provides the Board with an update on the progress made on the delivery of the **Wellbeing** priority during the period April 2019 – August 2019.

Details of the other 5 priorities and the associated schedule of dates for their updates to be presented at Board are at Appendix 1.

2. Health and Wellbeing

Priority's Aim	Our staff at LCH are more likely to be well and at work as well as more engaged with work irrespective of service or geographical location than in 2016-18.	On target

Health and Wellbeing is one of the 6 x priorities within the Workforce Strategy. Whilst sickness absence is going down, we are also seeing positive movement on some other areas of our work, such as improvements in engagement scores and lowering of turnover rates, which cumulatively give an indicator of how staff are feeling. Since April 2019, significant progress has taken place in Health and Wellbeing, which is described in more detail in section 3 below.

Progress has been primarily delivered by members of the HWB Engagement group, which is made up of staff, managers and staffside representatives, who bring with them the passion and enthusiasm to make a difference to staffs health and wellbeing.

A full summary of the 2019-21 objectives associated with the Health and Wellbeing priority is at ***Appendix 2***.

3. Progress: Health and Wellbeing

There has been significant progress on health and wellbeing since April 2019 which is beginning to demonstrate an impact. Sickness absence remains lower than in previous years, at 4.8%. At the end of month 5 of 2019/20, there have already been three months where overall sickness absence has been below 5%, compared with no months below 5% during 2018/19:

- LCH is attracting **media interest** about some of our innovative approaches around retaining staff and supporting their resilience, health and wellbeing. The recent conversations about mental health were particularly singled out by the Guardian and most recently the Nursing Standard
- 16 staff trained as **Mental Health First Aiders (MHFA)** and first group supervision session taken place
- A **Workforce Disability Equality Standard (WDES)** Action plan in place which was developed with input from a Board Development Workshop and subsequently signed off at Board.
- First meeting taken place with 10 staff keen to be involved in establishing **Disability network,** for staff with Disabilities, both visible and hidden
- It is encouraging that 30 Managers have already attended the **Reasonable Adjustment/Equality Act Training**, which was launched in Q1 and is currently over-subscribed
- Bi-monthly training is provided for managers around **attendance management**. However due to low uptake, options being explored as to a more be-spoke offer out in teams
- Momentum around the HWB agenda is maintained through the **HWB Engagement Group/HWB Steering Group,** which reports on progress through the Business Committee, to Trust Board.

- As part of the **NHSi HWB Programme**, progress updates are provided against an Action Plan; a key focus for Q3 onwards is on physical wellbeing
- A full range of HWB support continues to be offered for staff to access, under the **Feel Good pledge** brand
- As the **people before process** culture of the organisation grows, where **open conversations/stories** from staff about their HWB issues is "the norm", **leaders are equipped and upskilled** to work in an inclusive and compassionate way and increasing their knowledge base around "disability", are all contributory factors leading to improving staffs health and wellbeing, and a reduction in sickness absence rates.
- The **power of staff stories** continues, with staff feeling confident and supported to talk about and share their personal experience and the support they received from the organisation.

Extracts taken from staff stories:

"In October 2016 I was diagnosed with Borderline Personality Disorder (BPD) and was admitted to Becklin centre after my second suicide attempt. *From Negatives to positives* *Halfway through my treatment, I successfully gained a post at LCH; I declared I had BPD on my medial declaration form which was scary as I thought nobody would want a member of staff with a mental health problem. I was offered the role and had a Wellness Action plan put in place which is a practical way to support your own mental health, and if you are a manager, they help you to support the mental health of your team members. I've really had to work hard to get to where I am today, it hasn't always been plain sailing, and there have been misunderstandings along the way, but I've learnt that you have to be open and honest"*
"One night in 2016, I fell victim to a sexual and physical assault at the hands of a friend. While I physically survived that night, emotionally I did not think I would. The unbearable pain I suffered from that night has made me feel depressed, lonely, scared, angry and suicidal. On two such occasions I attempted suicide, the last time being in 2019. Shortly after the assault I moved teams at work. With this move I had many questions, should I tell my new team? Do I need to tell my manager? How do I get time off for meetings with the police or appointments with my support worker? I felt panicked about the move, but I didn't need to, told a colleague who supported me with speaking to my new manager, who was amazing. I met with Thea to discuss difficulties I had faced and she asked what my manager had done to help me feel supported and my answer was simple, she gave me space to breathe".

Question Are you proud to be working in an Organisation where staff feel comfortable to share these type of stories?

4. Risks to Delivery:

A couple of key risks to the Health and Wellbeing work stream is set out below, together with mitigating actions

Risk	Mitigation
Capacity to deliver: The significant work agenda associated with the HWB work stream is dependent upon a small number of staff volunteering and being released from their day job, to be part of the HWB Engagement Group and associated work streams	• Ensure anyone interested in driving specific HWB work streams are supported by their Manager and released to attend meetings and progress the work outside of meeting, if required • Split the work into specific time limited work streams – such as Task and Finish approach, which will also keep the membership "fresh" with new ideas
We become complacent due to the reduction in sickness absence and turnover	• HWB needs to continue to be part of the Trusts overall priorities and as such remain being led by Senior leadership through the HWB Steering Group and Board Champion

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5. Recommendations

The Board is recommended to note the significant progress which has been made in the area of **Health and Wellbeing** and endorse the continuing work programme as set out within the Workforce Strategy.

Appendix 1: LCH Workforce Strategy Priorities & Board dates

Priority	Priority's Aim	RAG status	Planned update to LCH Board
Leadership & Skills	We support the development of our leaders to ensure that every individual at LCH experiences good or excellent leadership and has access to appropriate training and development, regardless of where in the organisation they work.		**May 2019**
Resourcing	We recruit the right people with the right skills and deploy them to deliver the best possible care in all of our communities for now and for the future.		**August 2019**
Health & Wellbeing	Our staff at LCH are more likely to be well and at work as well as more engaged with work irrespective of service or geographical location than in 2016-18.		**October 2019**
Diversity & Inclusion	Each member of the workforce is treated as an individual, with particular regard to advancing equality for those with a protected characteristic.		**December 2019**
Integration & Partnership	We work effectively as a system partner in the development and implementation of workforce and HR strategies, systems and plans across primary care, the city of Leeds and the West Yorkshire & Harrogate Integrated Care System (ICS)		**February 2020**
Proactive Analytics	Workforce systems including the Electronic Staff Record are improved by a newly-created Systems & Intelligence function, delivering sophisticated workforce data and analytics that drive impactful business decisions.		**March 2020**

Appendix 2: Health and Wellbeing Objectives (from the LCH Workforce Strategy 2019-21)

Priority's Aim:	Our staff at LCH are more likely to be well and at work as well as more engaged with work irrespective of service or geographical location than in 2016-18.

What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Objectives	**Initiatives**	**Outcomes**
A reduction in staff sickness absence between 18/19, 19/20 and 20/21 resulting in declining resourcing challenges.	Delivery of all associated objectives and initiatives. Sickness absence project to understand better measurement and reporting + getting people back to work.	Reduction in sickness absence percentage. Reduction in incidents of absence – including within long term sickness absence.
Support leaders and managers to create positive workplace cultures – improve morale and wellbeing and eliminating bullying and harassment.	Design and develop the principles of "people before process". Focus on anti-bullying at defined points throughout the year. Leadership development programme.	Sickness absence rates improve or remain within tolerance. Positive impact on related Staff Survey questions. On-going "temperature" checks of staff engagement demonstrating improvement.
Staff feel supported when ill and upon return to work and that support comes in part from excellent leadership. New leaders understand the competencies and behaviours expected.	Management and leadership skills requirements incorporated into part of new leadership programme.	Reduction in formal people processes. Leadership programme evaluation. Staff Survey and other engagement initiatives indicating achievement.
Clear health and wellbeing offer for staff to access.	HWB Engagement Group established which reports to a HWB Steering Group and in turn Business Committee on progress. Focus throughout the year(s) on particular areas e.g. mental health, bullying and harassment, MSK.	Feedback from staff stories. Statistics on numbers of staff accessing services at start of "feel good pledge" are increasing. Improvements in HWB staff survey questions Achievement of HWB CQUIN

This priority aligns with the following organisational behaviours:

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (65i)

Meeting Trust Board – 4 October 2019	**Category of paper** *(please tick)*	
Report title Learning lessons to improve our people practices following an Independent Inquiry, Amin Abdullah	**For approval**	
Responsible director Jenny Allen/Laura Smith **Report author** Ann Hobson/Helen Williams	**For assurance**	
Previously considered by SMT and Business Committee – 25 September 2019	**For information**	X

Purpose of the report

To update the Trust Board on the findings from an Independent Inquiry and NHS England and NHS Improvement Task and Finish Advisory Group, into a tragic event that occurred at a London NHS Trust. Amin Abdullah was the subject of an investigation and disciplinary procedure, and was summarily dismissed on the grounds of gross misconduct. Shortly before an appeal hearing Amin took his own life. The reports conclude, that in addition to serious procedural errors throughout the process, Amin was treated very poorly, to the extent that his mental health was severely impacted and that sadly his experiences are far from unique.

Main issues for consideration

NHS England and NHS Improvement has now formally written to all NHS Trusts asking that HR Teams and the Board review the guidance and recommendations and assess against their current procedures and processes, and importantly, make adjustments where required, to bring the organisation in line with best practice.

Review and consider the RAG rated self-assessment against the recommendations and whether this is an accurate position for the organisation.

Comment on the appropriateness of widening this scope of work from solely looking at closing the gaps within our disciplinary process, to one which encompasses working with managers, HR and staffside, around the practical application of a wider “people before process” approach across a range of “people” experiences, by way of some type of workshop.

No timescales have been set from NHS England and NHS Improvement, however, we have set indicative timescales, SMT/Business Committee is asked to comment on these.

Recommendations

Trust Board is recommended to:

- Note the key points from the Independent Inquiry and NHS England and NHS Improvement
- Review and comment on the RAG rating self-assessment
- Comment on the suggested next steps and associated timescales

Item 65ii

Learning lessons to improve our people practices following an Independent Inquiry, Amin Abdullah

1. Background

1.1 An Independent Inquiry at a London NHS Trust looked into a tragic event where Amin Abdullah, who was the subject of an investigation and disciplinary procedure, was summarily dismissed on the grounds of gross misconduct, and shortly before an appeal hearing, took his own life. The report concluded that serious procedural errors had been made, and that throughout the investigation and disciplinary process, Amin was treated very poorly, to the extent that his mental health was severely impacted.

2. Introduction

2.1 NHS England and NHS Improvement subsequently established a "task and finish" Advisory Group to consider to what extent the failings in Amin's case were either unique to that Trust or more widespread across the NHS, and what learning can be applied. The Advisory Group found that Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. The analysis highlighted several key themes, principal among these were; poor framing of concerns and allegations; inconsistency in the fair and effective application of local policies and procedure; lack of adherence to best practice guidance; variation in the quality of investigations; shortcoming in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals, and an over-reliance on the immediate application of formal procedure, rather than consideration of alternative responses to concerns.

2.2 NHS England and NHS Improvement has now formally written to all NHS Trusts asking that HR Teams and the Board review the guidance and recommendations and assess against their current procedures and processes, and importantly, make adjustments where required, to bring the organisation in line with best practice.

2.3 Whilst the focus of this paper is primarily around the Amin Abdullah case, it is also worth noting that further reports were published around the same time, with

recommendations which overlap and are inter-related (further details can be found at Appendix 1 of this report)

3. RAG rating against the 10 x Recommendations

3.1 HR has reviewed the recommendations and produced a RAG rated self-assessment against current practice.

RAG rating	Recommendation	Rationale
	Investigation and disciplinary procedures should be informed and underpinned by best practice from ACAS, GMC, NMC	All policies/processes are under-pinned with best practice and in line with legal requirements
	Investigation and disciplinary procedures must be consistent with 'Just Culture' principles – looking for informal and alternative action to a formal process and hearing & using a decision making methodology.	The current Disciplinary Policy and Procedure encourages managers to deal with issues informally in the first instance. As we develop our "people before process" approach, this will re-inforce informal routes and the introduction of some sort of decision making tool.
	Concern for the health and welfare of individuals involved is paramount. Continually assessed and appropriate support/interventions should be offered.	Staff are given contact details and information for wide range of HWB support services, including Occupational Health and Counselling. If a member of staff is suspended more regular communication takes place.
	A communications plan should be established for all those involved. Communication should be timely, comprehensive, unambiguous, sensitive, compassionate and wherever possible face-to-face or verbal and followed up in writing.	We do not produce a Communication plan as part of the Terms of Reference. Traditionally, contact would either be by phone or writing rather than face-to-face
	If person involved in the investigation suffers physical or mental harm – this should be treated as a 'Never Event' and be subject to an independent investigation.	We do not currently do this. This could be interpreted that when someone subsequently goes off sick, whilst being subject to an investigation process, an independent investigation should take place.

	All case managers and case investigators should be independent and objective. This requires continual assessment and includes conflict of interest.	A list of Case Managers and Case Investigators is retained by HR team and individuals chosen in discussion with relevant GM/Head of Service to reduce potential conflict of interest
	All case managers and case investigators and or panel members should have received up to date comprehensive training (in areas such as best practice and principles of natural justice and appreciation of race and cultural considerations)	Some individuals received comprehensive training some time ago by an external legal company. They do not however continue to receive up to date training around such topics as race and culture
	All case managers and case investigators and other individuals assigned must be provided with sufficient resources that will fully support the timely and thorough completion of these procedures.	Once Case Managers and Case Investigators are selected they are not released from their day to day duties and are expected to undertake this role in addition to their “day job”.
	Suspension decisions should be a last resort and only applied when there is full justification for doing so. Decision should not be taken by one person alone and not by anyone who has a conflict of interest. Suspension/exclusion should be subject to senior level opinion and oversight.	Suspension is not taken lightly and is taken at GM/Director level and never in isolation
	Comprehensive data should be collated, recorded and openly reported at Board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt	Detail on the number/type of formal ER cases, including suspension and information from the Freedom to Speak up Guardian is provided to the Private Section of Trust Board to identify themes. It does not include information around impact on patient care and employees and lessons learnt

4 Indicative time scales and associated action

4.1 To make the changes required to ensure that we are fully compliant with the above recommendations from the RAG rated self-assessment, we believe the best action is to actively engage with managers, HR and Staff Side, which will enhance everyone's understanding of the wider application of "people before process/just culture".

4.2 This work is in line with our developing culture to become a more "people before process" organisation and builds on work that has already taken place, such as, engagement sessions with SMT, Leaders Network and a Board workshop. Compassionate and inclusive leadership approach has also been incorporated into our leadership development programme, as well as clinical and patient safety "just culture" practices and processes.

4.3 We therefore propose to run two pieces of work concurrently within the following timescales:-

5 By 20 December 2019 to have undertaken the following:-

5.1 Consult on new disciplinary policy/process/framework in response to address the "gaps" identified from RAG self-assessment and make changes suggested.
Engage with and consult with Management, HR and Staff Side representatives in the format of a Task and Finish Group. (Provisional date set of 4 November 2019). Inform the group of RAG self-assessment ratings and understand from the stakeholders attending how to best address the gaps.

5.2 Scope out what the content of "people before process" training could look like.
Engage with and consult with Management, HR and Staff Side representatives in the format of a Task and Finish Group. (Provisional date set of 4 December 2019). The output could be for workshop-type sessions to take place, which encompasses working through some people management scenarios using Just Culture/restorative practice frameworks, to training around Unconscious bias or practical tools such as Courageous conversations to name a few.

6. During January 2020 - March 2020

6.1 Development of specific training to upskill those who may be involved to undertake any part of the disciplinary process.

6.2 General training/awareness on "people before process" will also be developed during this time frame.

6.3 Delivery of training is expected to commence during the same January 2020 - March 2020 timeframe. Timescales for completion of training delivery will be determined by the task and finish group based on the size of the target cohort and the nature of the training developed.

6.4 Timescales for training delivery are expected to extend no later than 30 September 2020 for the cohort to be trained; and the task & finish group will determine whether repetition of the same training should be planned as a regular occurrence.

6.5 In the intervening period, consideration will be given by the Workforce Directorate to the use of suitably qualified and experienced external investigators for formal employee relations investigations on a case-by-case basis, subject to availability and to the identification of relevant funding arrangements.

6.6 Progress against these actions will be reported to the Business Committee via the Quarterly Workforce Report

7. **Recommendations**

7.1 The Board is recommended to

- Note the key points from the Independent Inquiry and the NHS England / NHS Improvement Review;
- Review and comment on the RAG rating self-assessment
- Comment on the suggested next steps and associated timescales

Appendix 1

Further background reading

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action the NHS workforce - NHS Workforce Race Equality Standard Strategy – WRES

This focused on recommendations and models of good practice relating to reducing the overall likelihood and number of staff entering the formal disciplinary process for both white and BME staff.

https://www.england.nhs.uk/publication/a-fair-experience-for-all-closing-the-ethnicity-gap-in-rates-of-disciplinary-action-across-the-nhs-workforce/

Independent review of gross negligence manslaughter and culpable homicide: Commissioned by the General Medical Council

This independent review was commissioned after the tragic death of a child and a subsequent conviction for GNM of the senior paediatric trainee involved. There are 29 recommendations coming from this report.

https://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/supporting-a-profession-under-pressure/independent-review-of-medical-manslaughter-and-culpable-homicide

Fair to Refer: Reducing disproportionality in fitness to practise concerns reported to the GMC.

This research was commissioned to understand why some groups of doctors are referred to the GMC for fitness to practice concerns more, or less than others and what can be done about it. There were four main recommendations arising including further support for doctors and creating working environments that focus on learning and accountability rather than blame.

https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (66i)

Meeting: Trust Board: 4 October 2019	**Category of paper**	
Report title: Draft Estate Strategy	**For approval**	✓
Responsible director: Bryan Machin	**For assurance**	
Previously considered by: Business Committee: 25 September 2019	**For information**	

Purpose of the report

The Business Committee previously considered a draft estate strategy at its meeting in July 2019. As a result of the Committee's deliberations and a follow up meeting with the Chair of the Committee the Strategy has been substantially rewritten.

The revised draft was presented to Business Committee on 25 September 2019 and the Committee agreed that the Strategy should be put forward to the Board for approval.

Main issues for consideration

The aim of the Estate strategy, aligned to the Trust's overall aim, is to: *Support the delivery of the best possible care to every community we serve by delivering affordable, sustainable, fit for purpose and appropriately located health facilities that meet the community requirements of all care pathways for both today and tomorrow.*

The Estate Strategy responds to the requirements of the people of Leeds and others who depend on our services and our staff who provide that care and support.

The future picture of Leeds is one of a growing city, with a greater demand for primary care and community services, in line with plans to offer alternatives to hospital care wherever possible.

Our staff are going to make more and more use of digital innovations to deliver care, both in a patient's home and also from all sorts of different buildings within the city. They need much more than an office full of desks and computers. They require access to space to meet up with colleagues and help maintain a team ethos. Our staff will also work closer to staff in partner agencies. The importance of sharing buildings, sharing approaches, working across organisations will see new demands for opening up buildings for all health and social care staff in Leeds.

This document gives a strategic overview of the current LCH estate and describes the way forward over the next 5 years in delivering the estate required to enable these things to happen. Working closely with Partners, especially GPs, in this transformation of Local Communities in creating One Public Estate, all organisations deliver more from the public assets which will help in our collective aim to reduce health inequalities.

Within LCH, we aim to fully engage with our staff in developing the plans that will compliment this strategy.

Recommendation

The Board is recommended to approve the revised draft Estate Strategy.

Estate Strategy 2019-24 (new draft V3 Sept 2019)

Contents:

Appendices:

1. Aim and Vision of the Estates Strategy

Welcome to the Leeds Community Healthcare NHS Trust (LCH) Estate Strategy. Its aim, aligned to the Trust's overall aim, is to:

Support the delivery of the best possible care to every community we serve by delivering affordable, sustainable, fit for purpose and appropriately located health facilities that meet the community requirements of all care pathways for both today and tomorrow.

Our vision is to ensure that the estate is of the best possible standard and is fully utilised in order to support the delivery of health and social care services.

The estates strategy responds to the requirements of the people of Leeds and others who depend on our services and our staff who provide that care and support.

The future picture of Leeds is one of a growing city, with a greater demand for primary care and community services, in line with plans to offer alternatives to hospital care wherever possible.

Our staff are going to make more and more use of digital innovations to deliver care, both in a patient's home and also from all sorts of different buildings within the city. They need much more than an office full of desks and computers. They require access to space to meet up with colleagues and help maintain a team ethos. Our staff will also work closer to staff in partner agencies. The importance of sharing buildings, sharing approaches, working across organisations will see new demands for opening up buildings for all health and social care staff in Leeds.

This document gives a strategic overview of the current LCH estate and describes the way forward over the next 5 years in delivering the estate required to enable these things to happen. Working closely with Partners, especially GPs, in this transformation of Local Communities in creating One Public Estate, all organisations deliver more from the public assets which will help in our collective aim to reduce health inequalities.

Within LCH, we aim to fully engage with our staff in developing the plans that will compliment this strategy.

2. LCH Vision, Values and Behaviours

The LCH Vision, Values and Behaviours, **"Our Eleven"**, permeate this Strategy. Our objectives within each of the six priority areas identified have each been tested against them; making sure that each contributes to our **one vision** and operates in line with our **three values** and our **magnificent seven behaviours**.

We have used the **magnificent seven behaviours** icons in **Section 7** to indicate which behaviours will be key to helping to deliver this Strategy's threepriorities.

3. Context and Background

The Trust's strategy for its estate was defined in LCH's 2012 – 2017 Strategic Estates Plan (SEP). It was refined in the Estate Implementation Programme (May 2016 – 2018) which reflected upon the changed strategic and business environment; aligning the SEP with changing national policies, the Five Year Forward View and the Carter Report, and local business development and transformation plans.

This Estates Strategy incorporates similar aspirations and initiatives and is launched at a time when the community and primary care services are recognised as key to achieving better outcomes for communities as set out in the NHS Long Term Plan, January 2019. It acknowledges that there are some new and important policy initiatives, such as Primary Care Networks (PCNs) and Local Care Partnerships (LCPs) with 6 Priority Neighbourhoods in Leeds, that may impact significantly on how and where LCH delivers services in the foreseeable future. However, there is a strong element of continuity from the previous Strategy.

It is not a detailed operational plan and each initiative or project will be submitted as a separate business case or implementation plan including the priorities for an Asset Management Plan for 2019/2020 and maintenance required between 2020 to 2023. It is designed, as far as possible, to reflect other extant and developing Trust strategies, Business Units and service plans across the Trust and it anticipates increased integration with health and primary care partners across the city of Leeds.

This Strategy covers the 5 year period to 2024 to provide a medium term vision as well as short term initiatives which begin the journey and link to the Annual Business Plan and other LCH Strategies, including Digital, Human Resources, etc.

The overall LCH vision and priorities are outlined previously but detailed discussions will be required with the relevant directorates to achieve this transformation by integrating plans and delivering change with services across the 3 Business Units, adopting new ways of working and relocating services as necessary.

3.1 The National Context

The Carter Report of 2016 outlined an expectation that **by 2020** all NHS providers will have balanced their books and released significant efficiency savings, maximising value for patients and improving the quality of care. LCH operates from too many sites to meet the effective and efficient use of space recommended and therefore a reduction in the overall accommodation is required. Another major element of this guidance is to ensure that the estate is well utilised and available 24/7 in an acute setting. In a community setting this translates to 8.00am to 8.00pm, Monday to Friday and potentially weekends. To realise this will require significant changes in the way LCH services are planned and delivered.

It expected that the estate will be **better utilised in line with local Sustainability and Transformation Plans**. As identified in the LCH Annual Plan 2019, plans need to achieve a reduction in CO_2 emissions for energy, waste and business travel. The overall reduction in estate will contribute to these targets.

3.2 The Leeds Context

The Leeds Health and Social Care system continues to change, promoting population based models of health delivery with wrap around community and secondary care services taking shape as the GP sector evolves. LCH plans to develop a strong role with the GP Confederation in developing the future service initiatives in all localities. The **Leeds Health and Social Care Plan** will have a significant influence on how the estate is to be provided and managed in future with services designed around **19 Primary Care Networks (PCNs)** (**Appendix D**). Primary Care and the Community Services will work closer together with services indistinguishable between the two organisations and this will mean that LCH will require **one main facility in each of the 19 PCNs, identified as the Hub plus buildings**, **supported by Hub local sites** with potential additional mobile/pop up clinics as necessary for that location. The current properties within the Trust Estate are not necessarily adequate or in the right location for future LCH services ; services will need to establish their future requirements in each PCN in order for the exact estate requirement to be established.

It is also envisaged that the **creation of Primary Care Networks (PCNs)** will result in additional staff working in primary care with an associated need for additional space in buildings, many of which are shared with LCH. To this end,

LCH plans to work with the GP tenants in the 9 freehold buildings to regularise their leases and to develop flexible working arrangements to accommodate these additional services.

All statutory health and social care partners in the city have agreed to develop a **Community Estate Strategy (CES)** which outlines principles by which the system will develop proposals, make decisions and operate services across the Leeds health and care estate. This CES strategy will reflect a locality/ PCN model, will be clear that not every existing building will be retained and make decisions that will be prioritised and evidenced in terms of benefits to partners and customers. The CES will identify challenges and risks, barriers to collaborative working such as culture and finance, and make proposals for reinvestment of any capital or revenue receipts. It is intended to agree projects prioritised by the type of accommodation, geography, need and opportunity to drive change across the care system for both clinical and office facilities under the direction of the Strategic Estates Group (SEG).

Increasingly, all partners in the city consider this Trust's and others' estate as part of **One Public Estate**, the actual owner of a building being irrelevant for the delivery of services.

NHS Leeds Clinical Commissioning Group (CCG) also has an aspiration that **"places" of healthcare delivery remain fluid between providers** and do not pose a barrier to change. In this context, commissioner re-procurement plans also have the potential to impact on the amount and type of estate required and the way it is occupied in the future.

The future provision of services also needs to respond to the expected population growth in Leeds of up to 100,000 additional residents and support the Leeds City Council (LCC) focus on priority neighbourhoods to address areas of deprivation, improving the health of the poorest the fastest.

In the longer term, the 10 LIFT Lease Plus Agreements will terminate between 2030 and 2040. LCH will need to assess the viability of each site to establish if the Trust wishes to buy the facility, walk away or take out new leases at the end of each term.

3.3 The LCH Context

LCH spends £150m each year, employs 3000 staff across 58 services and operates from 120 sites across the city. Over 215,000 referrals are received and the services deliver around 2 million patient contacts every year.

The estate managed by LCH comprises 50 properties under direct control or ownership and these are covered by this Strategy. LCH staff also work in a large number of other facilities such as schools, GP premises and LCC accommodation which increases this figure to around 120 sites overall: these sites are managed by other provider partners. The schedule at **Appendix C** details the properties that are owned, leased or occupied under a management agreement. The estates Asset Management Plan will address the future of all these sites and will be submitted as a separate Business Case.

LCH is an ambitious organisation and will seek to **develop new services and respond to new service commissioning opportunities**, often in partnership with other organisations, when it makes sense to do so. LCH has been successful in winning tenders to provide new or enhanced services in the years prior to this Strategy including the new Leeds Mental Wellbeing Service (LMWS)tender commencing on 1st November 2019. It is also planned to extend services as part of a retender for the Leeds Community Pain Management Service.

LCPs and PCNs will be key to transferring the focus away from the acute services to primary and community services as signalled in the NHS Long Term Plan (January 2019). Other initiatives are being embraced to reduce the length of stay of patients in hospital, transferring care to community services at earlier stages, as well as in some cases avoiding admissions altogether. The Estates Strategy must respond to this 'left-shift', to new pathways of care, with innovative ways of maximising the use of existing accommodation, developing facilities for flexible working in a suitable environment for both community and primary care.

New Models of Care and Integrated Care Partnerships will require LCH to share estate with other Partners. This further supports the requirement to relocate services from the acute sector to the community setting in line with One Public Estate intentions.

Currently, the office accommodation for LCH staff is spread across the city in a wide range of facilities. Recent initiatives to enhance the Trust Headquarters at Stockdale House which provides a base for around 350 staff (over 4 floors), providing centralised services or who are not aligned to a specific locality for the delivery of services, has greatly improved the facilities and working arrangements as part of the vision for the NWoW for office accommodation . As explained later the 4 leases for Stockdale House all terminate in 2023 and therefore the future headquarter requirements are highlighted in this strategy.

Typically, there are office spaces in all LCH buildings and these are used by a variety of clinical teams/ services; the neighbourhood teams are the biggest of these services involving between 800 and 900 staff based across 13 localities with teams in both LCH and LCC accommodation. How all these teams work will have a major influence on the office asset required in the future and a **change in culture is necessary in the way office facilities are used to deliver effective utilisation.** This Vision will be developed gradually, engaging staff in the best way to support clinical services and consolidate headquarter requirements.

4. Challenges anticipated in the Estates Strategy

The key challenges for LCH are identified below and described in further detail in subsequent pages. LCH will need to respond to the future development of services, allow the introduction of New Ways of Working (NWoW) in terms of offices and patient care spaces and improve the estate to enable these changes.

Service challenges

- Increased demand
- Ageing population
- Priority neighbourhoods where more support is required
- Increased space for partners
- Responding to new service tenders/ different service models
- Tackling deprivation
- Coordination of national guidance/ strategies
- Linking to other city wide strategies
- "Left shift" from acute settings
- Increased number and range of preventative services

Require new ways of working

- Flexible spaces that can be adapted for multiple needs
- More break out and meeting facilities for staff/ teams
- Digital innovations/skype developments for both patient services and back office/ meetngs
- Promote the reduction of car travel
- Increase shared touch down spaces
- Consolidation of headquarters for all staff who don't need to be in a clinical setting.
- Align with workforce strategy, particularly around extended openings

Reuire an Estates response

- Improved utilisation to around 60% in short term and 75% long term
- Estate appropriately located, good condition and fit for purpose
- Investment to improve flexibility of both clinical and back office areas
- Manage a growing amount of backlog maintenance
- Rationalise an imbalance in the location and quality of sites throughout the city
- Develop solutions for ome sites beyond economical repair
- Ensure all occupancy is regularised and covered by apropriate agreements
- Reduce non clinical space where apropriate

Service challenges

- Specific service delivery plans based on the needs identified in the 17 Local Care Partnerships (LCPs) and 19 Primary Care Networks (PCNs). As the city becomes more localised around these specific communities, it is likely that both the clinical delivery strategies and office bases for locality based teams will be aligned to these new boundaries. As and example Appendix D provides a draft list of possible bases, hubs and delivery sites for PCNs which has been drawn up for the new Leeds Mental Wellbeing Service tender. It is likely that this type of analysis will identify gaps in current LCH service provision, and the organisation will be need to be ready to manage this new demand.
- New services will be commissioned offering LCH the opportunity to further support people living with conditions and illnesses that can now be treated in community instead of hospital. All of this new demand will create a pressure for patient care space in buildings and space for staff to work from. Service delivery strategies will need to change, and adapt to a new infrastructure model of Hub plus, Hub local and mobile/pop up venues.
- Hub plus sites will offer a large range of services to the communities of Leeds. These centres may be buildings that LCH owns, leases, shares or potentially shares with partner organisations. These main hubs will be called Hub plus buildings, as they will offer a broader range of services than other sites.
- There will be a particular focus on services within the 6 Priority Neighbourhoods of the city to meet the needs of the most deprived communities in Leeds.
- The Hub plus buildings will be supported by Hub local type buildings, where a smaller range of services might be delivered – probably targeting a specific community. Once again, these buildings will be a mixture of LCH buildings and partner buildings.
- These key buildings need to provide the best accommodation possible that will be appropriate and suitable for the future developments. This will require investment to reconfigure spaces to meet the needs of service challenges by creating flexible facilities that are “fit for purpose” and of a high quality.
- If there is a service need in a community, and there are no LCH or partner buildings in that area – a network of mobile/pop up type clinics will be established.

Requirement for new ways of working

- Our staff are the most valuable resource that the organisation has, and it is really important that our buildings adapt and change to create improved staff facilities to support the changes in the way our services are working.
- Clinical rooms will need to be able to connect digitally to patients and other clinicians working in the city.
- Partner agencies will require access to room bookings as easily as our own staff do to meet the needs of defined communities.
- Office areas need to be flexible enough to cope with large teams of staff coming together, often at the same time.
- Conversely some staff will take the opportunity to not travel to meetings/ discussions, and will instead require a dependable way of communicating digitally.
- There is a need for flexible spaces that can respond to the changing needs of staff and patients.
- The principle of sharing space will become crucial. Sharing of buildings between organisations is a central pillar of the Leeds Estates Strategy (One Public Estate). Similarly, our own services will need to share their "own" space to ensure that everybody's requirements can be met from the buildings we are using.

Requirement for an Estates Response

- Inevitably the service drivers and the new ways of working will create pressure on the LCH estate. Utilisation rates are already rising, and it will not be long before some sites are full. Therefore the new Hub plus/ Hub local/ Hub mobile/ pop up modelling will need to be established as quickly as possible.
- Some sites will need to open longer. Hub plus buildings should open 7 days a week to cope with demand, and ideally open from 8.00am till 8.00pm.
- Where sites serve as both a staff base and a clinical site, reviews should take place to ensure that the presence of offices is not restricting the development of crucial clinical services. Better offices can often be found in bespoke office parks, rather than clinical buildings.
- Inevitably some sites will not be suitable for the sort of demand that will be placed on that building, and therefore LCH will need to release properties that are no longer economically viable to bring up to the required standards.

- LCH will need to invest in key LCP properties to improve flexibility and utilisation in line with the above requirements.

Taking the national and local context into account, and in order to ensure that the LCH estate is able to meet the changing demands placed on it, **3 key priorities** have been identified:

1. **Provide appropriately located, high standard, fit for purpose facilities for patient care services.**
2. **Provide appropriately located, fit for purpose facilities to enable NWoW.**
3. **Invest in our estate and ensure effective governance and management of buildings.**

5. Estate Strategy Priorities:

The Estates Strategy has 3 key priorities, responding to LCH's organisational goals, the context in which the Trust works, and the risks and opportunities.

Each priority has an overarching aim, described below, with some examples of what that will mean in practice. A delivery plan for each aim is at **Section 7**.

5.1 Provide appropriately located, high standard, fit for purpose facilities for patient care services

Aim: Appropriately located clinical facilities, to the right standard (Category B – see Appendix F for definition), provided in each LCP or PCN supporting the delivery of high quality community services

Patient Care Facilities

LCH plans to invest in the Hub plus sites for each PCN area to ensure they can meet the needs for the future local service requirements, supported by the latest digital enhancements, by investing as required to ensure all this accommodation is fully functional for the new services in high standard, high quality estate.

It is also proposed to introduce the availability of patient care facilities for 3 sessions per day, Mon to Fri (8.00am to 8.00pm), as well as the potential for weekends if required, in the key LCP sites. It is predicted that this initiative will result in over 30% additional capacity or up to 50% when the current under-utilisation on some sites is taken into account. This will also provide the flexibility of additional space for 3rd party occupation, including space for GPs to deliver additional services. This 3 session model will improve flexibility and enable LCH or its partners, where appropriate, to offer evening sessions for some services. This will not only be convenient for a large number of patients but it will also give staff the opportunity to work more flexibly at the same time as using expensive estate more efficiently.

There will inevitably be a change in the specific service delivery strategies of most clinical services. Changes to care pathways and additional service provision will mean that current service provision will change. It is likely that these service changes will differ from PCN to PCN area, where local demands differ. Current delivery models are often based on where space was available instead of a desire to meet local needs therefore services will be increasing and decreasing services between areas simultaneously. This change, when supported by more efficient and effective use of the space

occupied, will have implications across the Trust as to how staff deliver their services. It is therefore our aim and a key benefit to the Trust to be in a position to deliver services more flexibly, in reduced space and at reduced cost. It will enable the assets to be used more efficiently and maximise the use of the key buildings required in each LCP. It will further enable the Trust to respond to future increases in demand for services as a result of demographic change or to reflect changes required by the sustainability agenda.

Some of the likely changes are already known, such as:

- There is a requirement as part of the new 0-19 Service contract to relocate these teams and the services they provide to LCC Children's Centres, and this will create significant vacant space both for clinical and office facilities across the LCH estate in the LIFT, leased and owned buildings. The impact of this change is being evaluated to establish how these facilities will be utilised in the future as part of the service reviews, although providing sufficient, suitable LCC accommodation is proving to be an obstacle.
- Leeds will see a significant increase in Mental wellbeing services over the next few years, with over 33% additional clinical capacity required.
- MSK/ Physio will be provided within GP practices as well as out of specialist MSK suites
- The new community pain service will increase the amount of sessions required in many communities

Some of the changes will happen organically as the mobilisation of services take place, but a strategic plan will also be required to ensure that allocation of space in LCH and partner buildings are used for key priorities.

5.2 Ensure office facilities support the new ways of working, and that team arrangements reflect the developing PCN boundaries

The current way in which office facilities are currently provided within the Trust will need to be reviewed. The development of localities and PCN's will mean that current geographical team arrangements will not always have the

necessary alignment. The diagram in Appendix B illustrates the current Locality Care Partnership boundaries. The PCN boundaries are similar but will see the city split in to 19 communities.

Much of the Trust office accommodation (which includes the places where clinical staff do their administrative work) is either old fashioned or inappropriately provided in rooms built for clinical delivery, or both. The Strategy signals the intention to introduce a new vision to the way office spaces are configured:

- Create a central headquarters providing all office facilities for staff who do not directly support a specific community to foster excellent working relationships between the Business Units.
- Create 4 hubs situated around the city serving several PCN areas with good access and parking to provide primarily conference type facilities (meeting and group rooms with a refectory). Although desks will be provided at the hubs, the requirement for desks will not be the primary purpose of these hubs, therefore the hubs will be supplemented by a network of touch down office spaces throughout Leeds.
- Establish spokes at each main clinical site in each LCP with touch down spaces for visiting clinical staff. All the existing accommodation will be reviewed to ensure that the facilities at the various sites are what they need to provide the best services in that locality.
- Encourage sustainable solutions and in particular reduce car travel
- Operate a clear desk policy to enable staff to use spare desks as required and maximise the available office space. Lockers will be provided for personal belongings and current working papers.

Over time this will entail a number of changes to the current arrangements for office accommodation:

- A possible relocation of the headquarters to meet this proposed capacity and in anticipation of the termination of the leases in October 2023 at Stockdale House.
- A strategy to move staff out of large offices in the LIFT buildings (and reconfigure for clinical facilities) as part of a long term process to maximise the use of this expensive estate primarily for clinical services. This will be a long term vision and subject to business cases to evaluate the redevelopment potential and advantages to the Trust.

- A reduction in the large number of offices currently distributed across the LCH estate, also removing “ownership” of these spaces. This, coupled with the initiative above to improve the utilisation of clinical facilities, will create potential surplus space for One Public Estate (OPE).
- To reduce the reliance on paper records and minimise storage.
- To reduce the overall space used for office accommodation across the Trust.

These proposed changes, which in all likelihood will be delivered over a period longer than this Strategy, will have significant implications for staff in terms of how and where they work, changing the way people work and embedded cultural norms. In line with the Trust’s Workforce Strategy (2019), this significant change programme will be underpinned by a commitment to a culture of engagement and a culture that is just and fair, seeking at all times to embody Our Eleven (1 vision, 3 values, 7 behaviours)

5.3 Invest in our estate and ensure effective governance and management of the facilities

Aim: Develop an Investment Programme for the Owned Properties to ensure that the clinical and office facilities are appropriate, safe, suitable and in the right location

The Estate Strategy will influence an Asset Management Plan for the current estate and an Investment Programme for the properties it is intended to retain. A future Business case will reflect the requirements for supporting Trust strategies and priorities, anticipate the requirements of LCPs and PCNs, recognise the importance of OPE in Leeds and respond to the changing needs of LCH staff as services develop and new technologies reduce the need for traditional fixed desk office solutions. The Trust will aim to make improvements to the accommodation retained to provide the highest possible standard of accommodation and the best environments for patients and staff, focusing on enhancing general reception and waiting areas in each centre as well as the clinical and office spaces.

Investment is not limitless, and therefore some prioritisation will need to take place to ensure that the investment offers the best value for the city. The decisions will be based on the state of the building, the opportunities to improve the

building and the requirements of the area. All services will be involved in this decision making, along with partner agencies and local PCNs.

Regularisation and management of occupation

One of the initiatives within this strategy is to further manage 3rd party occupation. This includes regularising all occupation of LCH accommodation by 3rd parties to ensure that the responsibilities for each party are clear and statutory compliance is assured. In this way, as Landlord, the occupation of space and the management of the buildings will be on managed professional and regulated basis. The Estates Team are working with GP's, LCC, Leeds and York Partnership Foundation Trust (LYPFT), CHP, NHS PS, and LTHT to regularise this occupation. Going forward, LCH needs to decide to what extent it wishes to act as a landlord for other service providers as the landlord obligations will become more onerous in future to support the new leases and licences introduced.

In terms of leases with other Landlords, LCH has agreed Under Lease Plus Agreements (ULPAs) with Community Health Partnerships (CHP) for the 10 LIFT buildings which document the current demise occupied. One of the terms of the new leases is the ability to hand back space to CHP that is surplus to requirements or to break the lease every 3 years if necessary.

The impact of a reducing occupation by LCH, and an increasing occupation by 3rd parties, is the need to manage this estate effectively for the benefit of the Trust and 3rd parties. Additionally, LCH is occupying estate, not controlled and provided by LCH such as schools, GP premises and LCC accommodation, from which services are delivered. This introduces a level of risk not evident in LCH controlled estate: LCH is reliant on partner organisations to ensure the premises that LCH staff occupy in these broader working partnerships are suitable and compliant operationally from a health and safety perspective. It is expected that all organisations in Leeds will increase the amount of sharing of estate in the future, therefore work will take place on establishing citywide agreements that can replace individual site agreements to reflect the One Public Estate principles.

Generally, it is proposed that the overall building area controlled by LCH to deliver its services will reduce during the period of the Strategy. Currently, LCH provides 42% of its total accommodation as offices with only 50% as clinical space and 8% for 3rd parties. Average utilisation measured in 2017 of the clinical space was only around 35-40% in most sites (based on the existing 2 session working model from 8.00 to 5.00). As a result of additional services required for the LMWS tender and an increase in 3rd parties occupying space this utilisation has increased but there is still the opportunity to reduce the space retained for sole LCH use. The Estate Strategy initiatives will address this balance to support the transformation of LCH services and promote a much improved utilisation of the estate, ensuring the best value for money as well as improving the facilities where patients are treated and staff work. It will also address the high proportion of office accommodation across the city, ensuring that it is utilised more efficiently and is well designed to meet the changing needs of staff.

LCH will introduce a room booking system for both clinical and meeting rooms to improve the accessibility for services and also tackle the problem of recording the actual utilisation of accommodation. Currently, rooms are booked by LCH staff but frequently the rooms are not used or only used for part sessions.

Investment in Owned Buildings

A 6 Facet Survey in 2018 identified the costs required for improving the owned properties to Category B standard in line with service requirements for the Hub plus sites. The 6 Facet Survey will be systematically updated after the current programme of works for 2019/20 to ensure that there is a live record of the costs to achieve Category B standard across the estate for the remainder of the period.

There are 16 owned buildings that will need to be assessed for future service needs and the 6 Facet Survey identified them as red (*at risk category C and below, requiring significant works, full refurbishment, redesign or replacement*), amber (*requiring investment to improve the risk category to B*) or green (*assessed as category B being fully compliant and suitable for services*) status.

Considerable capital funding will be required to address the red and amber rated buildings but, in order to fund the significant works identified over the next 3 – 4 years, a potential sum of £2.25m would be necessary. It is therefore proposed that a Strategic Outline Case is submitted by December 2020 for each of the sites that are considered as requiring full replacement .

There is a concern that some of the owned properties will deteriorate over the next 5 to 10 years and the sites currently rated green or amber will become red unless improvements are undertaken. The service strategy and PCN requirements is therefore important to identify plans for these buildings.

Once the Hub plus sites are finalised, a programme of investment will be necessary to improve the patient care facilities and reconfigure spaces to meet service changes, by creating flexible accommodation suitable to the majority of services. This will also support the objectives to manage the buildings more efficiently and only provide patient services in high standard, fit for purpose accommodation. An initial estimate of this reconfiguration, particularly following the relocation of the 0-19 Service, would be in the order of £600k.

A further assessment will be required to consider the investment for office accommodation to deliver the changes identified earlier in section 4 for NWoW and the reorganisation of office facilities.

Leased Properties

There are 3 leased clinical properties that are not necessarily identified in the LCPs but there are still a number of years left on each lease.

Other than the 3 LIFT properties supporting specialist and wedge based services, there are 7 LIFT sites within the LCPs which may require investment to reconfigure vacated office accommodation or to redesign patient care rooms in order to maximise clinical utilisation.

The remaining properties listed in Appendix C (within the total of 50) are occupied by LCH under a management agreement, service level agreement or licence to occupy. These arrangements will be under constant review to establish whether they are required for the future service provision in respect of both clinical and office facilities, and if investment is required to maintain appropriate standards.

5.4 Benefits for Key Stakeholders

The following table sets out the potential benefits when the 3 priorities are implemented.

Patients	Treatment closer to home if appropriate
	Working with communities to be healthier places
	Concentrate on the better buildings in the future
	Improved accessibility and flexible ways of working (eg skype consultations)
	Improved environments
	Facilities open later in the evening and on weekends
Staff	Office accommodation appropriate to the changing ways of working
	More space for team working
	Better meeting and kitchen facilities
	Opportunities for staff to work flexibly with extended sessions in the evenings
	Transformation of the way staff accommodation is provided
	Improved working environments
Partners	More shared use of space
	Better synergy between partner services
	Clear agreements for the use of space
	Flexible use of accommodation for the GP PCNs
	Charges once to the system
Sustainability	More home working
	Improved digital support to reduce travel
	Maximum use of a reduced number of properties
	Reduction in energy costs
	Effective use of assets

6. Making the Connections:

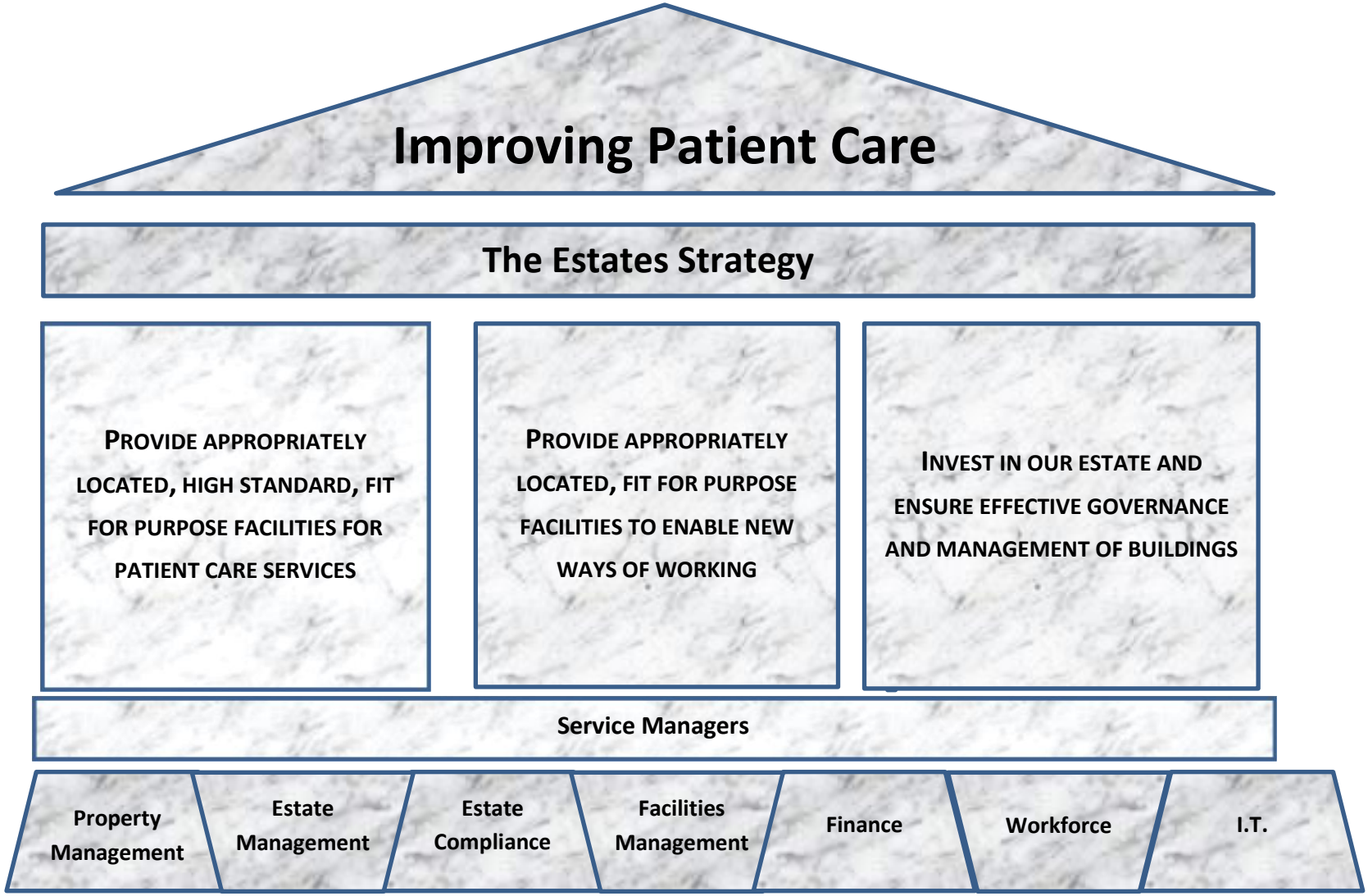
The Estates Strategy supports the activities of all staff working in the Trust. Many of our services are provided in people's homes or in the premises of partners, such as Custody Suites or schools. But the buildings that we own or lease to deliver care are vital for the delivery of high quality patient care and therefore this strategy connects to other Trust strategies and priorities.

The Strategy, through the identified Priorities supports the Trust's Strategic Goals:

Strategic Goal Themes	Estate Priorities		
	Provide appropriately located, high standard, fit for purpose facilities for patient care services	Provide appropriately located, fit for purpose facilities to enable new ways of working	Invest in our estate and ensure effective governance and management of buildings
Workforce	✔	✔	✔
Quality	✔	✔	✔
Partnership	✔	✔	✔
Resources	✔	✔	✔

Some of the proposals within this document will mean a significant change in the way that the Trust uses its buildings, and extensive consultation will be required to properly explain the benefits of the changes and understand any possible barriers. It is obvious that with such a big programme of change that a Trustwide approach will be required, with extensive support from Workforce/ Organisational Development/ IT, service management supporting Estates/ Facilities colleagues as shown in the following diagram:

Overall, this graphic shows the Estate Strategy supporting patient care whilst being itself supported by corporate teams. [DN probably lose this picture now]



A business case highlighting the benefits and resources required to deliver this programme will follow the approval of the strategy.

The Facilities Team within the Operations Directorate, along with the Workforce Directorate and Service Managers will manage the occupation at each site, following analysis of each service's requirements, and the ongoing building management to:

- deliver clinical functions from appropriate clinical facilities
- deliver office functions from appropriate office facilities
- achieve optimum utilisation of space for LCH services.
- Maximise opportunities for 3rd party use.

For many aspects of the programme the Trust will work with partners in the city on implementing the strategy. The health needs analysis for each PCN area will rely on work that has already been carried out by partners. Similarly public consultation around service provision will be done with all relevant partner agencies.

7. Priorities for delivery:

The subsequent pages set out how each of the 3 priorities will be delivered.

The following icons are used to show how each priority aligns with the LCH Values and Behaviours;

1. Provide appropriately located, high standard, fit for purpose facilities for patient services

Priority's Aim:	**Appropriately located patient care facilities, to the right standard (Category B), provided in each LCP and PCN supporting the delivery of high quality community services (Appendix C)**

What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Objectives	**Initiatives**	**Outcomes**
Support the Community Estate Strategy for the city to provide appropriate clinical space in the right location to tackle deprivation and increased demand.	Leeds Plan collaborative approach supported by LCH SMT and Board. Effective management/use of space by LCH services and 3rd parties to create facilities to support the "left shift".	80% occupancy of space on a 3 session model 8.00am and 8.00pm (Mon to Fri) as required. Increase in accommodation shared by all Leeds providers.
Hub plus sites agreed for each LCP or PCN.	Increase capacity as required by creating flexible clinical spaces and invest in key sites. Confirm service activity in each locality. Improve utilisation by enabling buildings to operate for 3 sessions per day 8.00am to 8.00pm Mon to Fri.	One main Hub plus will be operating in each LCP or PCN. Overall estate will be reduced by using our best estate to the maximum.
Pop up or secondary clinics to support the main site to operate alongside Hub plus sites.	Possible short term leases for appropriate space in right location or adaptation of the existing site.	Additional clinical space in support of the main Hub plus site will be fully utilised as necessary
Continue to provide specialist and wedge-based services in their current facilities.	Respond to the contracting environment to ensure all these services are in the appropriate location.	The right specialist services provided in the right location. Possible relocation of general services to create exclusive specialist sites.
Respond to new service tenders and provide additional patient care accommodation.	Identify priorities for the occupation of buildings to accommodate additional clinical sessions. Utilise the extra capacity created by operating the 3 session model.	LCH will provide additional services in well used properties and operate these new services.
Ensure the best possible access to patient care facilities for people with disabilities	Assess improvements required to the buildings necessary for the agreed services to ensure equality of access.	All properties being used for patient care are fully inclusive and accessible.
Enable the "left shift" to community-based services from hospital-based services which will increase demand on the estate.	Develop provider partnerships and joint use of facilities. Identify unused sessions for these services or create additional space by operating longer hours as the 3 session model proposed. Invest in the estate to create more flexible accommodation suitable for most services.	Facilities for community services maximised in line with government policy and space identified for 3rd parties to occupy. Buildings fully utilised by wide range of patient services.

Work with colleagues from the IT team to ensure that clinical buildings can provide the type of digital care that new technology opportunities bring	Work with “early adopter” services such as the Mental wellbeing service to test the practicalities of digitally delivered care.	Facilities in clinical rooms that allow clinicians to communicate (visual and audio) with patients, and other clinicians that are involved in the patients care/ treatment.

This priority aligns with the following organisational behaviours

2. Provide appropriately located, high standard, fit for purpose facilities for NWOW

Priority's Aim:	**Appropriately located office facilities, to the right standard (improved and appropriate office environments suitable for New Ways of Working (NWoW) and workforce requirements), supporting the delivery of high-quality community services.**

What do we plan to achieve?	**How will we achieve it?**	**How will we know that we've achieved it?**
Objectives	**Initiatives**	**Outcomes**
Appropriately located office facilities in the right place and to the right standard.	Assess existing facilities and their locations in line with the LCP and PCN service proposals.	Staff working in the appropriate location for the service they provide, reducing the amount of car travel. The overall space utilised for office accommodation will be reduced.
Appropriate facilities for office functions to meet the changing way services are provided and providing the best possible access for our staff with disabilities.	Introduce NWoW supported by a multi directorate Change Team: implement a programme of alteration or refurbishment as required.	Office functions set up for headquarters, 4 hubs across the city and touch down spaces in LCPs and PCNs to support NWoW.
Small touch down spaces in each LCP or PCN to enable clinical staff to work before or after their service delivery rather than return to the main hub.	A rolling programme of office reviews, converting offices that are currently "owned" by specific staff/ team in to offices that are shared around functional requirements such as computer room, break out space, meeting room.	Facilities will be provided close to where services are delivered for short term use with main bases in specially designed office Hubs and more break out and meeting facilities
All staff not delivering services to a community located in Trust HQ	Complete expansion to 4 floors at Stockdale, and complete refurbishment to enable NWoW.	Trust HQ operational with facilities for staff working centrally or for corporate services.
Introduce 4 Hubs across the city in addition to the Trust HQ providing office hubs appropriately located for non clinical functions.	Relocate large offices from the Hub Plus sites in the LCPs to the proposed 4 city Hubs. The vacated space released for redevelopment to clinical spaces for LCH or 3rd party services or to release space to OPE. Business Cases to be submitted to support these initiatives.	A reduction in the overall LCH office space (total m2) and increased utilisation but staff will be working in appropriate, fit for purpose facilities that are also in the right location.
Reduce office accommodation in LIFT buildings where there is a greater need for clinical space, and where better/ more economical offices can be provided locally	Rolling programme of reviews, working to the same timeline of the development of hubs.	No situations where offices take priority over clinical services in LIFT buildings
A plan for the future Trust HQ from 2023 for all staff not delivering services to a specific	Work with other partners in the city to ensure best value for a	Plan in place to show the future of the

community.	central office hub and encourage integrated working.	Headquarters from 2023 onwards.
Provide flexible spaces linked to digital and technical innovations as planned in the LCH Digital Strategy.	Improve facilities for skype and digital conversations in meeting room areas.	All services will be able to take advantage of technological developments to improve services.
Ensure LCH staff are fully involved in the implementation plans resulting from this strategy.	Launch a staff engagement initiative to develop proposals for the office and clinical spaces to ensure they meet the requirements of each service and link to the Workforce Strategy.	Staff will feel included in the future strategy and able to contribute to estate changes.

This priority aligns with the following organisational behaviours

3. Invest in our estate and ensure effective governance and management of the estate

Priority's Aim:	**Investment Programme for the Owned Properties to ensure that the clinical facilities are appropriate, safe, suitable and in the right location**

What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Objectives	**Initiatives**	**Outcomes**
Aim for all patient care facilities to be at Category B standard.	Carry out Investment and redevelopment programme to address 6 Facet Survey in Asset Management Plan – Business Case to be submitted for investment.	All clinical facilities meet the standard as required. Specific investment identified for redevelopment.
Clinical facilities that meet the required specification to provide flexibility of use in all accommodation and generally available to most services.	Assess all clinical rooms in the chosen sites against national guidance. Review against the 6 Facet Survey results and operational requirements.	Services will be able to utilise rooms more effectively and flexibly. Possible investment required in all estate including LIFT sites to increase and improve clinical facilities.
All patient care and office facilities are fit for purpose and of a high quality.	Once the service strategies are agreed, proposals will be produced to develop or adapt accommodation as required.	Investment will allow sites to be improved and upgraded to enable new ways of working.
Links with the LCH Digital Strategy to ensure all proposals for skype, digital conversations, etc. can be installed at all sites.	Working with the IT services, introduce the required technology to support clinical and office functions in the estate as necessary.	LCH services will operate in line with the proposed technological advances.
Investigate potential partnership solutions for inadequate buildings necessary for future services.	Establish criteria for investment for backlog maintenance, suitability for significant refurbishment and those for which only statutory works are undertaken pending release to OPE.	Only the best estate will continue to be utilised for LCH services.
All 3rd party occupants of LCH property will have suitable leases, licenses or agreements in place. Appropriate agreements will be reviewed for accommodation occupied by LCH but owned by other organisations.	Review each property to confirm the space occupied by 3rd parties and work with other organisations to update or introduce agreements.	All tenants will have clear agreements on the roles and responsibilities for the use of the accommodation and statutory compliance will be assured for staff working in non-LCH accommodation.
A programme to complete leases for all the GP practices in LCH owned buildings.	Agree revised rents with the CCG and NHSE following assessments by the District Valuer.	All GPs will have a current lease based on current market rents with agreed terms for each party's responsibilities based on the agreed BMA template.
Maximise the utilisation of the retained estate with an aim of 75% occupancy using a	Introduce a booking system and management process to maximise the use of accommodation. Include	All sites identified by the LCP and PCN for patient services will be fully utilised with a reduced

3 session model. All accommodation needs to be shared by services with very few spaces used exclusively by one service. Only the best estate will provide patient services.	initiatives to monitor the actual use of booked space.	incidence of clinicians failing to use booked spaces. All accommodation, both office and clinical, will be fully shared with an efficient use of resources.
Withdraw from sites that are beyond economical repair or are in the wrong location for services.	Evaluate the service requirements for LCPs and PCNs and assess the opportunity for transfer estate no longer required to OPE.	The remaining estate is fit for purpose, able to be used flexibly and in the right location. The backlog maintenance liability will be reduced as the majority of the estate will be to Category B standard.

This priority aligns with the following organisational behaviours

8. Risks to Delivery:

Several risks to delivery of the priorities described in this Strategy, are set out in the table below, together with mitigating actions. Quality impact assessments will be part of each Business Case.

Risk	Likelihood (RAG)	Severity (RAG)	Mitigation
The Strategy is focused on the evolving LCPs and PCNs. Changes in the development of these initiatives could impact on service delivery and the required estate.			Capacity of the estate needs to be responsive and flexible to change and service requirements reviewed regularly as the policies develop.
Insufficient capital investment funds to support the transformation of owned properties to Cat B Standard and the proposed Investment Plan			Review capital availability for each year of the strategy and organise investments to the funding availability each year.
The Organisational Development involved and workforce support across the 3 Business Units for change to working practices or clinical service delivery on an 8.00am to 8.00pm operation as required.			Trust decision and support but acceptance of additional running or staff costs to enable the eventual savings on the cost of the estate. Launch an engagement process with staff to evaluate the impact.
Support from the 3 Business Units and services for the Operational Plan to introduce NWoW (office)			Additional resources required for the Facilities Team to steer the process of change. Continue the engagement with staff and build upon the work at Stockdale.
Stakeholders not supportive of plans			Engagement plan for stakeholders to focus on the benefits to patient care and close collaboration with PCNs and GP Confederation.
Ability to work with other providers in the city to the same timescale			Planning and common goals to link the Strategies across OPE.

9.Conclusion

This Estate Strategy aims to support the delivery of the best possible care to every community we serve by delivering affordable, sustainable, fit for purpose and appropriately located health facilities that meet the community requirements of all care pathways for both today and tomorrow..

Appropriate, well located and fit for purpose facilities are key to the achievement of better, more sustainable and more cost effective health outcomes for communities. Over the 5 year period of this Estate Strategy, there will be significant change but an opportunity exists to realise these improvements.

We are confident that with strong leadership and dedication from across the Trust alongside the Estates and Facilities Teams, and other partners, LCH will be able to deliver the key priorities set out in this strategy, enabling positive and tangible improvements where care is delivered. Separate business cases and implementation plans will follow to deliver this strategy. The Organisational Development component and staff engagement for each priority will be assessed to establish what needs to be done to adapt and enable change to be achieved.

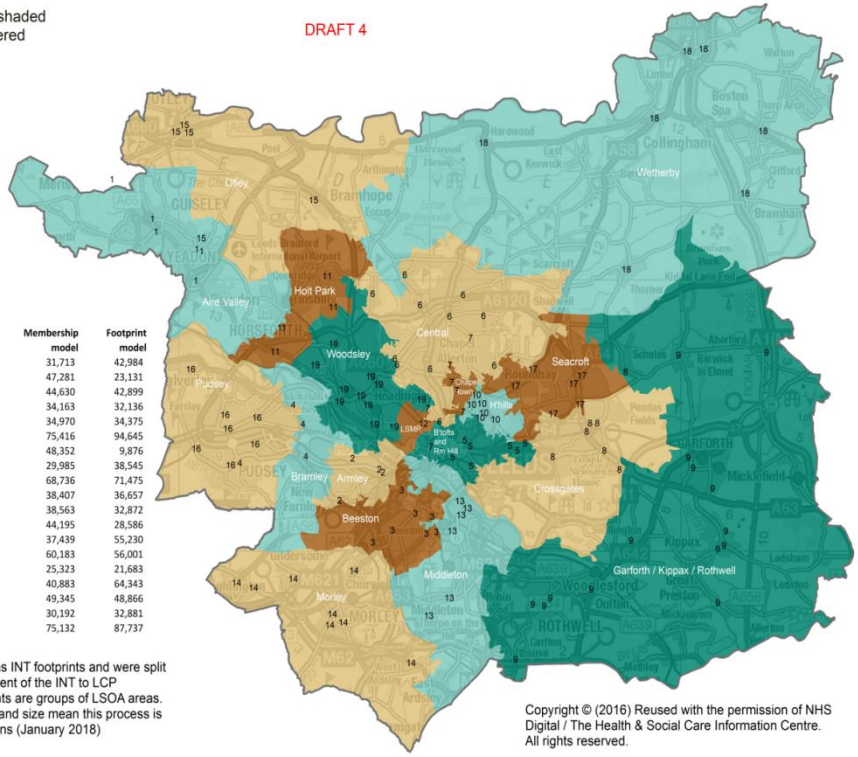
Appendix A

References and associated documents:

- LCH Strategic Goals and Priorities
- Leeds Plan – Local Care Partnerships
- Leeds Primary Care Strategy
- Strategic Estates Plan
- LCH IT / Technology Strategy
- LCH Workforce Strategy 2019-21
- NHS England Five Year Forward View next steps document (2017/18)
- Six Facet Survey 2018 (Owned Properties)
- Community Health Partnerships – Leases for 10 LIFT buildings
- Estates and Facilities transformation Programme 2018 – 2020 (OBC)
- LCH Operational Plan 2019 – 2020
- LCH Annual Report 2019 – Sustainability Performance

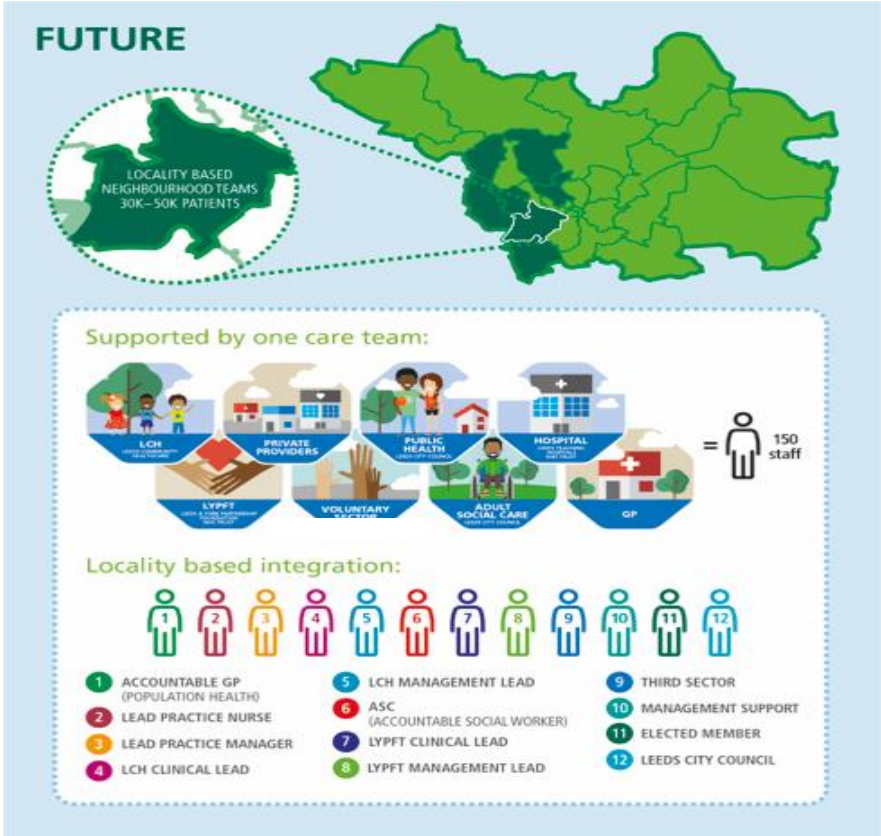
Appendix B: Local Care Partnerships CHECK UPDATE AND PCN MAP

2018 LCP footprints shaded
LCP practices numbered



Local Care Partnerships	Membership model	Footprint model
1 Aire Valley	31,713	42,984
2 Armley	47,281	23,131
3 Beeston	44,630	42,899
4 Bramley	34,163	32,136
5 Burmantofts & Richmond Hill	34,970	34,375
6 Central	75,416	94,645
7 Chapeltown	48,352	9,876
8 Crossgates	29,985	38,545
9 Garforth/Kippax/Rothwell	68,736	71,475
10 Harehills	38,407	36,657
11 Holt Park	38,563	32,872
12 LSMP	44,195	28,586
13 Middleton	37,439	55,230
14 Morley	60,183	56,001
15 Otley	25,323	21,683
16 Pudsey	40,883	64,343
17 Seacroft	49,345	48,866
18 Wetherby	30,192	32,881
19 Woodsley	75,132	87,737

LCP footprints originated as INT footprints and were split according to the development of the INT to LCP memberships. The footprints are groups of LSOA areas. Variations in LSOA shape and size mean this process is a little restricted. Populations (January 2018)



Appendix C: Property Schedule

LCH – SCHEDULE OF 50 PROPERTIES

LCH Owned	LIFT Leased CHP	Other leased	Agreements with L.C.C	LTHT Provider/Provider Agreement	LYPFT Agreements
Bramley Clinic	Armley Moor HC	Compton Centre	Killingbeck Court	Wharfedale Hospital	St Mary's Hospital
Burmantofts HC	Beeston Hill HC	Kippax HC	Merrion House	Seacroft Hospital	Little Woodhouse Hall
Chapeltown HC	East Leeds HC	Merrion Centre	Albion House Rawdon	Leeds General Infirmary	
Halton	Middleton HC	Park Edge	Suffolk Court	St James University Hospital	
Hannah House	Wetherby HC	Rutland Lodge	South Leeds Recovery Hub		
Horsforth Clinic	Wortley Beck HC	Stockdale House	North West Leeds Recovery Hub		
Holt Park	Parkside HC	Thornton	East Leeds Recovery Hub		
Hunslet HC	Reginald Centre HC	Wade House	Leeds Equipment Service		
Kirkstall HC	Woodhouse HC	Sunfield Medical Centre	St George's Centre		
Meanwood HC	Yeadon HC		Tribeca House		
Morley HC					
Otley Clinic					
Pudsey Health Centre					
Rothwell HC					
Seacroft Clinic					
Woodsley Road Clinic					
16	**10**	**8**	**10**	**4**	**2**

Appendix D: Glossary

Acronym / Abbreviation	Meaning
3 Business Units	Adults, Children's and Specialist Units in LCH
3rd Party Providers	Non LCH service providers occupying LCH property, including GPs
Category B Standard of Buildings	Buildings assessed as being fully compliant and suitable for the services delivered
CAMHS	Children's and Adolescent Mental Health Service
CCG	NHS Leeds Clinical Commissioning Group
CHP	Community Health Partnerships
CNRC	Community Neurological Rehabilitation Centre
ERIC	Estates Return Information Collection
ESIB	Estate Strategy Implementation Board
GP	General Practitioner
ISHS	Integrated Sexual Health Service
IT	Information Technology
LCC	Leeds City Council
LCH	Leeds Community Healthcare NHS Trust
LCPs	Local Care Partnerships
LMWS	Leeds Mental Wellbeing Service
LIFT	Local Improvement Finance Trust
LTHT	Leeds Teaching Hospitals NHS Trust
LYPFT	Leeds and York Partnership Foundation Trust
NHSE	NHS England
NHS PS	NHS Property Services
NWOW	New Ways of Working
OPE	One Public Estate
PCN	Primary Care Network
SEP	Strategic Estates Plan
SMT	LCH Senior Management Team
STP	West Yorkshire and Harrogate Sustainability and Transformation Partnership
SEG	Strategic Estates Group
Trust HQ	Trust Headquarters
ULPA	Underlease Plus Agreement
UTC	Urgent Treatment Centre

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (67i)

Meeting: Trust Board – 4 October 2019	**Category of paper**	
Report title: Safeguarding Annual report 2018-19	**For approval**	√
Responsible director: Executive Director of Nursing and Allied Health professionals. **Report author:** Debbie Reilly previous Head of Safeguarding and Lynne Chambers Interim Head of Safeguarding	**For assurance**	
Previously considered by: PSEG and Quality Committee	**For information**	

Purpose of the report

This document forms the Safeguarding annual report for Leeds Community Healthcare NHS Trust (LCH).

The aim of this report is to provide information and assurance to the Board that the Safeguarding Team and all staff within the Trust are committed to the safeguarding agenda and are compliant with current legislation, best practice and evidenced based care.

The report covers the period 1st April 2018 to March 31st 2019 and provides information on:

- Safeguarding Adults
- Prevent
- Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood (SUDIC)
- Children Looked After and Care Leavers

Main issues for consideration

- the setting and maintaining of quality standards
- responding to CQC recommendations following their Review of health services for Children Looked After and Safeguarding In Leeds (June 2018)
- delivering the safeguarding team restructure
- development of EPR templates to support best safeguarding practice and
- the essential development and maintenance of internal and multi-agency relationships and networks to ensure high quality service delivery with safeguarding of vulnerable children and adults remaining at the core of all we do.

Recommendations

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

Leeds Community Healthcare
NHS Trust

Safeguarding
Annual Report 2018-19

Authors:
Safeguarding Adults – Lynne Chambers
Prevent – Sharon Thomas
Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia – Kulvant Sandhu
Safeguarding Children – Wendy Brown and Tracy Taylor
Specialist Child Protection Medical Services – Dr Anna Gregory
Sudden Unexpected Death in Infancy and Childhood (SUDIC) – Shelagh Davenport
Children Looked After and Care Leavers – Deborah Reilly

Contents Page:

Introduction and Executive Summary

Leeds Community Healthcare NHS Trust (LCH) places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The Safeguarding Team ensure LCH meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005.

The purpose of this suite of reports is to provide the Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2018 – 2019 and outline key ambitions for 2019-20.

Team Structure

The Safeguarding Team based at Armley Moor Health Centre provides both corporate and operational functions and sits within the Quality and Professional Development directorate providing safeguarding advice, guidance, support, supervision and training for all LCH employees.

The team consists of Named and Designated Professionals, Lead Professionals, Safeguarding Advisors and Specialist Practitioners with responsibility for:

- Safeguarding Adults
- Mental Capacity, Deprivation of Liberty Safeguards and Dementia
- Prevent
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood
- Children Looked After and Care Leavers

Throughout 2018-19 the Safeguarding Team worked to restructure the service. We delivered a structure which offers the potential for career progression to safeguarding practitioners.

Another important motivator for change was to ensure we remain fit for purpose as we enter a time of significant change locally and nationally in response to the NHS Long Term Plan. The LCH Safeguarding Team will need to be agile in response as we move toward Integrated Care Systems which will impact on how we organise and respond to safeguarding issues both within the Leeds health economy and across the West Yorkshire and Harrogate footprint; and as we work in ever closer alliance with the Leeds GP Confederation.

Functions

Staff can contact the safeguarding team Monday to Friday for specific advice in relation to new and ongoing cases where a safeguarding concern is under consideration. The team also undertakes Health Needs Assessments (HNAs) and health interventions for Children Looked After (CLA) and Care Leavers for Leeds children and those children placed in Leeds from other areas across the country.

Partnership Working

The Team works closely with the designated and named professionals within community paediatrics, the Clinical Commissioning Groups (CCGs) and across other health care

providers as well as colleagues in Social Care to ensure our work force have the skills and support they need to safeguard all those in our care.

Governance Arrangements

The Safeguarding Team sit within the Quality and Professional Development unit under the Executive Director of Nursing and Allied Health Professionals (the board member with responsibility for safeguarding). The Safeguarding Committee, a subcommittee of the Quality Committee meets bi-monthly to both drive and oversee the safeguarding agenda

The Safeguarding Nurses meet with operational service lead practitioners on a bi-monthly basis (safeguarding operational groups) to develop and implement objectives identified in the safeguarding work plan. We have two safeguarding operational groups:

- Safeguarding Adults Champions, and the
- Safeguarding Children Operational Group

Safeguarding reports go on a quarterly basis to the Quality Committee via the LCH Safeguarding Committee. In addition outcomes from these groups are shared with Leeds Clinical Commissioning Group (CCG) through the Children's and Adults Advisory groups and with Leeds Safeguarding Children Partnership (LSCP) and Leeds Safeguarding Adults Board (LSAB) through the relevant sub-groups.

Safeguarding priorities are set down in an annual work plan which is regularly reviewed and updated through the Safeguarding Committee.

In June 2018 the CQC undertook a Review of health services for Children Looked After and Safeguarding In Leeds which highlighted a significant level of good practice within LCH services which came under scrutiny (CAMHS, School Nursing, Health Visiting, Sexual Health and Children Looked After and Safeguarding), as well a bringing focus to some areas for improvement which have been addressed through an action plan , owned by Leeds CCG with LCH elements overseen by our Safeguarding Team.

The Safeguarding Team is continually learning, improving and disseminating best practice. Through our contributions to LSCP practice audits, the continuous cycle of preparation for Ofsted Joint Targeted Area Inspection (JTAI), as well as through collaboration with agencies in the Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Leeds, we have scrutinised, analysed and identified practice learning points as we strive to ensure the people of Leeds receive the best possible care.

Key achievements in 2018 – 19 are set out at the head of each report

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Safeguarding Adults

Key achievements 2018-19: • **Developed and delivered a training plan with Safer Leeds to expand the use of Routine Enquiry in LCH services** • **Raised awareness of self-neglect, developed and delivered a self-neglect training package** • **Embedded the use of SystmOne safeguarding templates**
Key ambitions 2019-20: • **Raise awareness of "Talk To Me, Hear My Voice" principles and embed the 2019 safeguarding adults policy and procedures** • **Develop a safeguarding training resource for Level 3 staff in line with national guidance** • **Replicate the safeguarding templates in other EPR systems** • **Embed learning from the thematic review of rough sleeping in Leeds** • **Introduce a Domestic Violence "Telephone in the Toilet" helpline**

LCH works has a responsibility to prevent and stop all forms of abuse or neglect happening wherever possible and to keep vulnerable adults safe, meeting statutory obligations and our duty of care.

The LCH safeguarding team focuses on creating an environment where abuse is not tolerated and safeguarding is everybody's business.

The safeguarding team offer guidance, support and training to all staff in LCH to develeop a workforce with the confidence and capability to meet our duty to safeguard; we work with particularly with front line staff to ensure our patients can live free from abuse within their own homes.

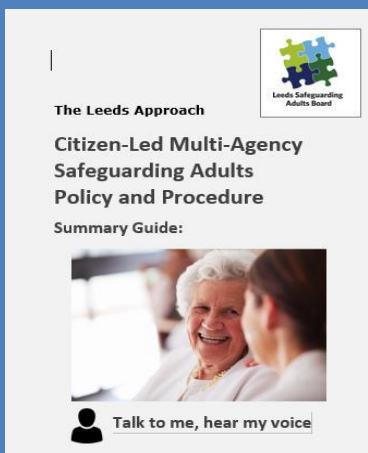
Multi-agency working is a crucial element of safeguarding and the safeguarding team works closely with colleagues in other provider organisations, Leeds CCG, Adult Social Care, West Yorkshire Police and voluntary and private sector organisations to safeguard and protect the people of Leeds.

We follow and promote the six safeguarding principles set out in the Care Act (2014):

- **Empowerment:** people being supported and encouraged to make their own decisions and give informed consent
- **Prevention:** it is better to take action before harm occurs
- **Proportionality:** the least intrusive response appropriate to the risk presented
- **Protection:** support and representation for those in greatest need

- **Partnership:** local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse

- **Accountability:** and transparency in safeguarding practice



Inter-agency Policy and Procedure
In response to the findings from a Safeguarding Adults Review, the Leeds Safeguarding Adults Board undertook a full review of inter-agency safeguarding policy and procedures; LCH as an LSAB partner was fully in engaged in the development of the new Leeds approach – "Talk To Me, Hear My Voice".

In 2019-20, LCH in partnership with the LSAB will embed the new Citizen–Led multi-agency policy and procedures launched on 1st April 2019.

Building on Making Safeguarding Personal (MSP) these procedures centre on the principles of citizen-led safeguarding, focussing on client perspectives, involving them and listening to the person's wishes and views on prospective outcomes.

Some people require more support than others to make choices and manage risks; therefore strong communication skills and mental capacity assessments remain key to ensuring a shared understanding of risk and action in the best interests of vulnerable adults.

Workforce Development
Safeguarding training is a mandatory requirement for all staff. LCH has robust e-Learning packages accessible to all staff members via ESR. In addition, during 2018-19, as a direct response to Domestic Homicide Reviews and Safeguarding Adult Reviews in Leeds we have worked with partners including Safer Leeds to develop and deliver bespoke training to address emerging themes, particularly coercive control.

The benefits of partnership working were that staff will received a well-rounded, balanced training package, promoting an integrated approach to safeguarding, with the aim of equipping staff with the confidence to broach safeguarding concerns with patients and better understand the roles of other professionals in adult safeguarding.

"Put yourself in my shoes and think about what it feels like for me to have someone else making decisions about me, and my life, and not listening to what I want to happen."
Touchstone Service User, Safeguarding Adults Group

Further safeguarding information is available on the intranet e.g. one minute guides, flow charts, Standard Operating Procedures and voice over PowerPoint presentations. Staff are also supported at coroner's court hearings, while giving police statements, through safeguarding supervision, 1-1 meetings and telephone support.

In 2019-20 we will move towards skype training which will support our Custody Suite colleagues across the region. Skype training will save time as well as cut down on travel

and parking expenses, while maintaining an interactive focus within training sessions. Innovative practice such as this enables staff to access training where it would otherwise have been difficult, but will be reliant on access to appropriate, dependable technology.

In 2018-19 we began an ongoing piece of work with colleagues in other provider organisations and Leeds CCG to develop a level 3 training resource in keeping with Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018).

The safeguarding team introduced safeguarding templates for use within our adult electronic patient records (EPR) in 2018-19 which mirrors the process for safeguarding children within our organisation therefore increasing consistency throughout the patient journey.

Acknowledging that some services do not use SystmOne, the focus for 2019-20 will be to replicate the templates in a suitable format for other LCH systems.

The safeguarding team is revamping and relaunching the safeguarding adult champion role; this is set to reach a wider audience and staff can learn by sharing identified cases, receive bespoke training and develop their knowledge and understanding of the wider safeguarding strategy and agenda.

Champions will attend bi-monthly meetings to share learning across the adult and specialist business units, discussing and addressing developing safeguarding themes. Safeguarding champions act as ambassadors for safeguarding imparting their enhanced safeguarding knowledge to their teams, ensuring safeguarding is on the agenda at team meetings, managing a safeguarding information board, and encouraging staff to maintain alertness to safeguarding in all that we do.

Learning from Reviews

Within the last 18 months it was identified that 9 people died while rough sleeping on the streets of Leeds. Rough sleepers are not always homeless; many have tenancies but choose street life for a myriad of personal reasons. The LCH safeguarding team took part in a thematic review of the lives of these 9 people with a view to ‘Improving Life Chances and Preventing Deaths’. As well as contributing to the overview report, we attended reference group reflection meetings where learning was shared. It is expected the report will be completed by the end of summer 2019; the report will inform national learning and identify the next steps for Leeds.

LCH continues an open and reflective contributor to Domestic Homicide Reviews (DHR) and Safeguarding Adults Reviews (SAR). Both processes allow for analysis of findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for improving future practice where this is necessary. Previous reviews highlighted the need for more knowledge and training around routine enquiry and the safeguarding team responded in partnership with Safer Leeds by providing training which has been tailored to address specific needs arising from DHR and non-statutory Learning Lessons Reviews. Training was delivered in partnership with Safer Leeds and Leeds and York Partnership Foundation Trust.

Innovation

The LCH takes learning from domestic homicides very seriously and in response, the safeguarding team is always looking for ways to keep patients safe.

Coercion and control pose significant risk within domestic abuse relationships: "*Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used* [by abusers] *to harm, punish, or frighten their victim'.* (Women's Aid)

This is borne out by themes drawn from DHR's in Leeds. The LCH safeguarding team encourages the use of domestic abuse information posters in the toilets in health buildings across Leeds but also looked for ways to expand on the effectiveness of this information. Some women (and men) may be so controlled by their partner that they may have no access to a telephone for use in private.

The 2018-19 work plan included an ambition to pilot the use of a telephone with a direct line to Leeds Domestic Violence Service (LDVS). After careful consideration and identification of an appropriate site along with technical support and guidance from Leeds Sexual Health Service and the LCH IT team a telephone now sits in the sexual health clinic in the Merrion centre.

The telephone is located in a safe space (a toilet) with a lock on the door beside a poster with information of how, when and why they should use it. In 2019-20 we propose to audit the use of the telephone looming at the number of outgoing calls and length of call (some may experiment with the phone picking up just to see what happens) however, our hope is that even one telephone call lasting several minutes will indicate a vulnerable person has reached out for help. We will be unable to trace what happens to that person but the knowledge that someone has successfully reached out for help is all the success we are looking for. A proposed review in 3-6 months will hopefully lead to expansion of the pilot.

Prevent

Key achievements 2018-19: • Maintenance of training compliance in excess of the NHS England target • Prepare and implement transition from local e-learning to the national e-learning package
Key ambition 2019-20: • Produce and disseminate a newsletter to inform staff across the health economy of developments in Prevent practice • Maintain involvement in local and regional forums to ensure LCH is informed of and engaged in continual practice development including revie of the training requirement • Develop an Elsie webpage to support staff in

Prevent is a strand of the Government's counter terrorism strategy known as CONTEST. The Prevent strategy aims to address radicalisation and safeguard those who hold radical views from being drawn into criminal activity. Prevent addresses all forms of extremism but prioritises these according to the terrorist threat they pose to our national security. Prevent is delivered in multi-agency partnership by a wide range of statutory and third sector organisations.

Safeguarding vulnerable people who may be at risk of being drawn into criminal extremism is an essential part of the Prevent Strategy. Nationally there is a requirement for Prevent local action plans to be in place, reflecting the support available to vulnerable individuals; the necessity for a robust training package to ensure LCH staff are appropriately aware of and supported to fulfil their Prevent duties stems from this national mandate.

Healthcare practitioners have a key role to play in the multi-agency planning and delivery of services to those at risk; ensuring access to a wide range of support from mainstream services, on through to specialist mentoring or faith guidance and wider diversionary activities.

With continued support and commitment across LCH we have maintained a high training compliance level between 95.6% at quarter 4 of 2018-19; well in excess of the NHS England 85% target.

2018-19 also saw the strengthening of Prevent support available to practitioners and partner agencies through the development of knowledge and skills within the Safeguarding Team in keeping with the Prevent local action plan which requires each partner agency to identify, as a minimum, a lead practitioner and deputy to ensure continuity of service delivery.

2019-20 will present some challenge to our high level of training compliance. To ensure comparable training is delivered nationally, NHSE England is exclusively promoting use of nationally developed e-learning resources which can be embedded on the Electronic Staff Record (ESR) and is therefore unwilling to offer further funding to maintain licensing of the Leeds local e-learning package.

Our local e-learning resource will therefore be withdrawn in early 2019-20. Work is already well in-hand to transfer compliance data and ensure staff are directed to the correct training (either Basic Awareness of Prevent (BAP) or Workshop to Raise Awareness of Prevent (WRAP)) via ESR.

There is likely to be a significant amount of data validation and staff support needed to ensure the new system is reflective of the actual organisational compliance position.

In 2019-20 NHS England along with partners in the Home Office will undertake a review of Prevent to ensure the programme is fit for purpose; this will include review of the training requirement.

Prevent is a multi-agency responsibility which includes engagement with partners to develop local action plans for Leeds as a whole as well as health providers and commissioners. Across the health economy agreement has been reached to, as far as possible, operate collegiately to inform staff of their Prevent duty and prepare them to fulfil it. A key strand is the publication of an annual newsletter to apprise staff of Prevent developments.

In 2019-20 LCH will produce the newsletter in partnership with Leeds and York Partnership Foundation Trust (LYPFT); Leeds Teaching Hospitals Trust (LTHT) and Leeds Clinical Commissioning Group (CCG) will take on this responsibility in 2020-21.

Another ambition for 2091-20 is to develop a dedicated Prevent section or page on Elsie a sa one-stop-shop for staff in relation to Prevent.

Mental Capacity Assessment (MCA), DoLS and Dementia

Key achievements 2018-19:

- Trust wide consent policy updated with consistent guidance across LCH
- Valid Consent data available on PIP allowing compliance monitoring and assurance
- Co-facilitation of two multi-agency self-neglect conferences incorporating the use of MCA
- Development and roll out of 3Ds (Dementia, Delirium & Depression) clinical frameworks
- Dementia awareness training made available to all staff in LCH through e-learning ('Barbara' video)

Key ambition 2019-20:

- Development of an EPR mechanism to capture and audit consent/MCA for under 18s and enhance DoLS reporting in inpatient settings
- Prepare for implementation of new Liberty Protection Safeguards (LPS)
- Build on the city-wide, multi-agency event organised to promote public awareness of Advance Decisions and their importance in care delivery
- Increase patients' knowledge of Lasting Powers of Attorney (LPAs) for health & welfare through involvement in the Office of the Public Guardian's Leeds based campaign
- Embed dementia quality standards through release of a SystmOne dementia template
- Implement a delirium pilot project in partnership with the NHS England Yorkshire & Humber Clinical Network for Dementia

The purpose of Mental Capacity Act (MCA) 2005 is "to empower people to make decisions for themselves whenever possible, and protect people who lack capacity by providing a flexible framework that places individuals at the very heart of the decision making process" (Lord Falconer, MCA Code of Practice, 2005).

LCH has a statutory duty to comply with the MCA (2005) when providing care and treatment to those who lack the capacity to give valid consent. The role of the Named Nurse for MCA & Dementia is to ensure this is embedded into clinical practice.

One mechanism for this is the well-established MCA champion's forum which meets bi-monthly. This group supports practitioners to enhance their knowledge of the MCA (2005); enabling them to support their teams with implementation of MCA processes. The Named Nurse for MCA & Dementia facilitates this forum providing vital MCA clinical supervision, case law updates and sharing of relevant learning from Safeguarding Adult Reviews (SARs) where mental capacity has featured.

Specialist Support

Specialist support from the Named Nurse MCA & Dementia has been provided to teams within the Adult, Specialist and Children's business units, helping to ensure clinical decisions and care delivery comply with the MCA (2005), is person-centred, and respectful of the patient's human rights (Human Rights Act, 1998).
In particular, Named Nurse support has been given to CAMHS who see young people aged 16 years onwards, who may fall under the remit of the MCA (2005); and Health Case Managers who undertake Community Deprivation of Liberty Safeguards (DoLS) work on behalf of the CCG. This involves in-depth capacity assessments and

determining best interests where a high level of restriction is placed on patients who lack capacity to give consent, within a community setting.

Named Nurse support has included telephone advice, one-to-one and group supervision, case discussion and analysis, team bespoke training, accompanying clinicians on patient visits, and facilitating multi-agency best interests meetings.

LCH is committed to sharing best practice and learning from evidence-based initiatives to improve care delivery and outcomes for those living with dementia.
The Named Nurse for MCA & Dementia ensures the strategic priorities for dementia within LCH are aligned with wider strategic groups e.g. the city's Dementia Board, specialist Dementia & End of Life group, and the NHS England Yorkshire and Humber Clinical Network for Dementia.

Key Achievements

Consent
Following the introduction of the Valid Consent to Care and Treatment template on SystmOne last year, the Named Nurse for MCA & Dementia co-authored the Trust's updated consent policy to provide consistent guidance across the organisation around consent for adults and children. Following this, a compliance standard has been set for the Adult and Specialist Business Units, which also allows services to evidence recording of valid consent, or completion of mental capacity assessment when providing care/treatment in someone's best interests. This data is available on PIP, enabling ongoing monitoring of compliance.

Audit
The 2019 annual MCA audit showed significant improvement in appropriate documentation of care/treatment delivered under MCA (2005) with70% of patient records audited showing evidence of appropriate capacity assessments and best interest decisions, compared to 40% in the 2018 audit. Contributory factors to the improvement include the introduction of the Valid Consent template on SystmOne and face-to-face MCA training to increase levels of practitioner knowledge and skill when working with those who lack capacity.

Multi-agency work
As a member of the Mental Capacity Act – Local Implementation Network (MCA – LIN) which is a sub-group of Leeds Adult Safeguarding Board (LSAB), the Named Nurse for MCA & Dementia co-facilitated at two multi-agency self-neglect conferences, incorporating the use of the MCA (2005) when managing complex cases. This brought together partner NHS Trusts, CCG, Adult Social Care, LSAB, Fire Service, Police and key third sector organisations. Both events evaluated well and resulted in plans to develop multi-agency self-neglect guidance for practitioners.

Priorities for 2019-20
Mental Capacity
Having co-facilitated a city-wide, multi-agency event to promote public awareness of Advanced Decisions, building on this will be a 2019-20 priority. Best interests decisions made under the MCA (2005) are strengthened when it is possible to establish the person's wishes prior to loosing capacity; Advance Decisions being a mechanism for this.

Another 2019-20 priority arising from the MCA-LIN will be increasing the uptake of Lasting Powers of Attorney (LPAs) for health and welfare. The Office of the Public Guardian (OPG) has chosen Leeds as the site for their next public awareness campaign and requested that members of the MCA-LIN be actively involved.

Preparations will be made for implementation of the MCA amendment bill (2019) which gained royal assent on 16th May 2019; the Department of Health & Social Care has announced plans to bring Liberty Protection Safeguards (LPS) into force from 1st October 2020. This new legislative framework will replace the current DoLS arrangements and means LCH will be required to authorise deprivations of liberty at in-patient settings such as Community Neurological Rehab Services and Hannah House (the new legislation brings into scope 16 and 17 year olds who lack capacity to consent to their deprivations of liberty). During 2019-20 focus will be given to ensuring LCH staff have the knowledge and skills needed, underpinned by robust governance structures to implement the new LPS process in October 2020.

Dementia

The Named Nurse for MCA & Dementia will continue to ensure dementia has a high priority within the Trust, embedding this further through implementation of the 3Ds (Dementia, Delirium and Depression) clinical frameworks which were launched recently with the aim of improving care delivery and outcomes for those living with dementia by:

- Enabling prevention, early identification and treatment of delirium; leading to,
- Avoidance of unnecessary hospital admissions.

This work has also involved re-establishing links with LYPFT's Older Adults Mental Health Services which were reintroduced in March 2019.

Following the release of the 3Ds clinical frameworks, a delirium pilot project is being considered in collaboration with the NHS England Yorkshire & Humber Clinical Network for Dementia to measure the impact of the frameworks; the pilot project is looking to start in autumn 2019.

Dementia training forms part of the Trust's statutory/mandatory programme; this continues to be evaluated highly by staff attending. In autumn 2018 NHS England set a mandate for all NHS staff to undertake dementia awareness training (level 1), a short video has been made available trust wide and been well received by staff.

The development and release of a dementia template on SystmOne will aid staff to incorporate the dementia quality standards into care planning and delivery for patients living with dementia. This template will also aid audit development, to look at ways of continuing to improve the patient experience for those living with dementia.

Safeguarding Children

Key achievements: 2018-19
• Initated Tripartite Supervision; a one minute guide for Tripartite Supervision is in draft for comment within the safeguarding team and across LCH children's services • Raised awareness of changes highlighted within the updated Working Together to Safeguard Children (2018) statutory guidance • Secured the engagement of CAMHS and Leeds Sexual Health Service managers in Multi-Agency Child Exploitation (MACE) meetings
Key ambitions 2019-20:
• Via supervison of supervisor sessions and attendance at service forums raise awareness of the new LSCP Multi-Agency Safeguarding Arrangements published in June 2019 for implementation in September 2019 – highlighting the impact LCH service • Raise awareness of the MACE framework for practitioners to use when assessing risk to children and young people • Imbed a restorative practice approach within children's services utilising our identified "Ambassador" and ensuring appropriate tools for practice are used • Increase awareness of valid consent within children's services and work towards implementing the consent template that ensures clarity within the Electronic Patient Record • To fully embed the new service structure though this be challenging in the early stages due to vacancy and planned sick leave

LCH is a strong and active partner of the Leeds Safeguarding Children Partnership (LSCP) contributing to multi-agency processes, policy and audits. Safeguarding children continues to be a golden thread throughout all our services.

Responsiveness to and organisational leadership on emerging safeguarding issues, whether identified through CQC review, Serious Case Reviews (SCRs), Domestic Homicide Reviews (DHRs), case work or national guidance is at the heart safeguarding team practice. Over the past year the team has been engaged in leading, developing and supporting practice across LCH and within the multi-agency partnership; examples over the past year include:

The LCH safeguarding team continue working to promote the safety and protection of children and young people in Leeds by :

- Ensuring safeguarding remains a golden thread thoughout all of our services.
- We worked alongside 0-19 Health Visiting and School Nursing services to devlop their bid and subsequently launch the Public Health Integrated Nursing Service (PHINS), bringing increased focus on multi-agency working and Early Help
- We have ensured access to appropriate training for all our practitioners to equip staff to fulfil their safeguarding role; and brought our expertise to the delivery of training and development programmes within the LSCP
- LCH safeguarding practitioners contribute towards multi-agency forums to ensure appropriate representation and contribution to the development of safeguarding practice in Leeds. This includes being active members of the LSCP and its subgroups

- Securing the engagement of relevant LCH service managers at MACE meetings where s actions are identified to meet the support needs of children and young people at risk of sexual ro criminal exploitation
- Contributions towards multi-agency process devlopment, policy review and audits including case file audits in preparation for a potential thematic Joint Targeted Area Inspection by Ofsted which may come unannounced.

On-going work that the Childrens Safeguarding Team do to promote safeguarding that we are particularly proud of includes:

- Attendance 0-19 forums updating front line practitioners and learning of their continuous service developments. This strong reciprocal arrangement fosters greater understanding of the services we exist to support and guide infulfilment of their safeguarding duty
- Use of “Lunch and Learn” sessions, addressing topical issues, such as recommendations from Learning Reviews, Safeguarding Shidren Reviews and Domestic Homicide Reviews.
- Standardisation of LCH Safeguarding Supervision model to ensure quality of supervision to support best practice and staff resilience within safeguarding.
- Review of services to ensure reflection of up to date process in relation to current guidance from Working Together 2018

Thinking about our quality assurance processes:

- The CQC Review of health services for Children Looked After and Safeguarding In Leeds (June 2018) highlighted that we are good partners, demonstrate good practice and are contributing positively to keeping children safe.
- There is shared learning across the trust to ensure continued good practice via the Safeguarding Children Operational Group and Safeguarding Committee.
- We have reviewed processes in relation to contacts with the Front Door Safeguarding Hub and how these are managed internally and externally in relation by auditing requests for service made to the Childrens Social Work Service (CSWS). A member of the safeguarding team attends audit meeting monthly.
- We develop annual work plans for implementation and development of the safeguarding agenda across LCH.

The LCH safeguarding children team consider a key challenge during 2019-20 may include ensuring continued commitment and presence within the multi-agency arena from LCH safeguarding practitioners in a time of significant change within the team as we embed our new structure, adapt to changes in the safeguarding multi-agency partnership and respond to the NHS Long Terrm Plan while maintaining our responsivemenss to front line staff.

Specialist Child Protection Medical Services (SCPMS)

Key achievements 2018-19:

- Better engagement in strategy meetings and case conferences where child abuse or neglect is suspected
- Named Doctor and the lead for Child Protection Clinical Governance attended Royal College of Paediatrics and Child Health (RCPCH) safeguarding training
- Senior doctor also attended RCPCH recognised safeguarding training
- Continued to foster strong working relationships with colleagues at the paediatric Sexual Assault Referral Centre including handover of patients
- Strengthened relationships with sexual health and Genito-Urinary medicine doctors
- Involvement with the Risk and Vulnerability Subgroup of Leeds Safeguarding Children Partnership regarding child victims of Female Genital Mutilation.
- Photo-documentation training from LTHT and provision of a SOP for the use of the new, improved cameras.
- Attendance at Multi-agency Safeguarding Operational Group (MASOG) by Named doctor to look at operational processes for community paediatrics, police and social care
- Access to old clinical child protection database has been acquired
- Several team members train on ALSG Child Protection Recognition and Response course
- New named doctor is increasing networking between the Named and Designated doctors for other areas and across Leeds.

Key ambitions 2019-20:

- Continue to improve our interaction around strategy discussions and Child Protection conferences e.g. possibly using skype.
- Continue to provide non-forensic Child Sexual Abuse services for Leeds children in negotiation and partnership with Commissioners and Mountain Healthcare Ltd. (MHL)
- Develop and implement clinical pathways in partnership with MHL for children with Sexually Transmitted Infections including e.g. ano-genital warts
- Continue to engage in regional peer review and Named Doctor regional meetings
- Continue to learn from patient experiences – giving particular attention to the voice of the child by improving child friendly feedback collection processes
- Maintain strong links with the LCH Children Looked After and Safeguarding team
- Undertake psychologist facilitated group supervision for the SCPMS
- Deliver training to social workers and /or police at “lite bite” sessions

Who are we?	What are we proud of?
10 community paediatricians, 2 band 5 nurses, 1 play therapist, 2.8 admin staff and 1 clinical services manager Part of ICAN (Integrated Children with Additional Needs) services; commissioned by Leeds CCG	Providing a daily **senior doctor led** clinic to see children (0-18)referred for all forms of child abuse **Trained and skilled administrative staff** to take referrals from 09:00-17:00 on weekdays **Compassionate, highly skilled nursing staff** to chaperone and support families & medical staff in clinic Clinical work underpinned by **peer review and supervision** to challenge practice & offer support **Dedicated team**, who show great strength and resilience to rise to the many changes this year Continuing to provide **medical training** in child protection **Information sharing** and working together to safeguard children **Monthly governance programme** for continuing professional development and links with the regional peer review programme.

What did we do in 2018-19?

- Saw 356 children between April 2018 – March 2019
- 61% (218) were seen for physical abuse; 18% (64) required sexual abuse examination; and 17% (60) were siblings of index children. Of the sibling assessments 93% were seen for physical abuse and 7% for sexual abuse
- We have designed and printed leaflets for children and young people to explain the nature of our service; these have been well received by parents, Social Care and other agencies
- We aim to provide child protection medical reports to Social Care in 4 working days. Performance has improved significantly in 2018-19 with 75% of reports being returned within 4 days; 92% within 7 days. Some issues arising from doctors not sharing the St. George's base were mitigated use of the EPR
- We held 49 peer review colposcopy meetings in the last year and have attended 2 regional peer review sessions
- Clinical governance sessions have been well attended and covered topics including – the quality of handwritten notes; a refresher on taking photographs; journal article reviews; and planning with psychology colleagues for group supervision in 2019-20
- As we are unable to use standard Friends and Family Test we have developed a specially designed feedback form for implementation in 2019-20

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

(Abridged from the report produced for the Local Safeguarding Children Partnership)

Key achievements 2018-19:

- Undetaking of place of death and home visit performace improved
- Involvement in national bereavement care standards pilot project
- Delivery of a multi-agency study day on: Cot Death and how we can Influence Change

Key ambition 2019-20:

- To demonstrate increased timeliness in completion of 28 day reports
- In conjunction with SUDIC Strategic Reference Group partners organise a West Yorkshire wide SUDIC conference
- Work with the multi-agency partnership to fully implement Working Together 2018 Statutory Guidance

'The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths' **(Chapter 5, Working Together (WT), 2018)**

This report provides an account of activity of the Leeds Community Healthcare NHS Trust (LCH) Sudden Unexpected Death in Childhood (SUDIC) Rapid Response Team during 2018-19.

In 2018, Working Together to Safeguard Children introduced new national guidance was regarding child death review processes; national leadership for the child death review process was transferred from the Department for Education to the Department of Health and Social Care; chapter 5 contains a framework for the two statutory child death review partners (Local Authority and CCG) to make arrangements to review the deaths of children. While the LCH SUDIC Team contributed to local meetings regarding the implementation of the new framework; the immediate response to SUDIC i.e. the Joint Agency Response remains unchanged.

The Leeds Joint Agency Response (JAR) is facilitated by a multi-agency partnership under the aegis of Leeds Local Safeguarding Children Partnership (LSCP). The LCH SUDIC Team is responsible for facilitating the statutory JAR, also known as the SUDIC Process, when the death of a child resident in Leeds has occurred that:

• is or could be due to external causes
• is sudden and there is no immediately apparent cause including unexpected death in infancy/childhood
• occurs in custody, or where the child was detained under the Mental Health Act
• occurs where the initial circumstances raise any suspicions that the death may not have been natural

Following the process set out in the RCPCH Sudden and Unexpected Death in Infancy and Childhood: multi-agency guidelines for care and investigation (2016) the LCH SUDIC team work together with the relevant agencies to respond to the child's death in a thorough, sensitive and supportive manner.

The objectives of this response are to:

• establish, as far as is possible, the cause of the child's death
• identify any modifiable contributory factors
• provide support to the family

• learn lessons in order to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children
• ensure that all statutory obligations are met
(WT July 2018)

Leeds Community Healthcare NHS Trust (LCH) employs the team responsible for the co-ordination of the SUDIC process, supported by the Named Nurses for Safeguarding Children when required. The team provides reports on the circumstances of a child's death to HM Coroner and Leeds LSCP Child Death Overview Panel (CDOP).

SUDIC activity is reported into the LCH CBU Child Death Review Group and LCH Performance Monitoring who further report to the NHS Leeds Clinical Commissioning Group (CCG).

SUDIC Activity

During 2018-19 there were 19 child deaths which met the SUDIC criteria. Six fewer deaths than in 2017-2018. The SUDIC process was completed within the year for 9 of these children; details are set out in Figure 1:

	Date of Death	Age & Gender	Details	Co-sleeping identified SUDIC Under 2yrs	SUDIC Process Complete April 2019	Home/scene visit
1	07/05/2018	22 weeks male	Bronchopneumonia Para-influenza Virus 3			Scene and Home
2	22/04/2018	3 years male	Drowned			Family declined SUDIC contact. Scene visit by police only
3	01/06/2018	2 days male	Sudden Infant Death Syndrome (SIDS)			Scene and Home
4	04/08/2018	15 years 11 months female	Asphyxiation			Home
5	11/08/2018	17 months female	Accidental head injury			Home - Child died abroad
6	13/09/2018	9 weeks male	Cardiomyopathy			Scene and Home
7	25/09/2018	13 years 6 months male	Road traffic collision pedestrian			Scene and Home
8	20/09/2018	17 years 2 months male	Intracranial haemorrhage			Family contacted by letter
9	21/10/2018	42 weeks female	Drowned			Scene
10	08/08/2018	2 years 9months female	Pneumonia			Home -Child died in abroad
11	22/10/2018	14 years 1 month male	Road traffic collision			Scene and Home
12	30/10/2018	45 weeks female	SIDS			Scene with police
13	05/11/2018	2years 5 months female	Pneumonia			Scene and Home
14	02/12/2018	5 weeks male	Near miss SIDS			Home
15	01/12/2018	2 weeks male	Sudden Unexpected Death in Infancy (SUDI)	*		Scene and home
16	01/02/2019	3 weeks female	SUDI			Scene and home
17	03/02/2019	9 weeks male	SUDI			Scene and home
18	11/02/2019	17 years 7 months male	Road traffic collision			Family declined SUDIC contact. Scene visit by Major Collison team
19	28/02/2019	9 weeks male	SUDI			Scene and home

*Co-sleeping = key contributory factor

There were 4 child deaths of babies under the age of 1 year where co-sleeping practices were identified as a key contributory factor. This is 1 fewer than during 2017-18.
During 2018-2019 the SUDIC process was finalised in 12 cases outstanding from 2017-18. Due to the ongoing criminal investigation into the Manchester Arena bombing, the SUDIC process for 1 young person's death from 2017-18 remains outstanding.

SUDIC Home Visits
Home Visits were made in 15 of the 19 cases. This is an approximately 26% increase in the number of visits made in comparison with 2017-18.

In the 4 cases where visits were not made to the family, 2 were due to parents declining the visit. In both of these cases the child had died in a public place. A Scene Visit was carried out by the SUDIC Team for one of these children in close partnership with relevant multi-agency partners; in the other case the police carried out the Scene Visit.

In one case contact with the family was by letter only; a Scene Visit was not appropriate as there was a clear medical cause of death.

A scene visit only was carried out for the remaining child where a home visit was not appropriate due to hospitalisation of the parent.

SUDIC Scene Visits
Scene visits were carried out for 13 of the 19 cases occurring in 2018-19. This is a 16% increase compared to 2017-18. The team aim to visit the scene within 24 hours of the child's death as a priority for babies under the age of one year, though performance is occasionally compromised as the team operates within normal working hours rather than on a 7 day basis.

Initial SUDIC Meetings
This meeting seeks to:

- Understand the circumstances of and, if possible, the reasons for the child's death,
- Consider the immediate needs of all family members, and
- Contribute to the process of identifying any lessons to be learned about safeguarding and promoting future child welfare.

Initial multi-agency meetings were held for 100% of the Leeds childhood unexpected deaths occurring during 2018-19. This is a 44% increase on 2017-18.

28 Day Report to HM Coroner
During 2018-19 reports to HM Coroner have been provided by the SUDIC Consultant for 18 of the deceased children, with 1 report in progress at the time of this report.

Four of the 19 reports met the 28 Day deadline. This is a slight (4%) decrease on the 2017-18 performance. The reasons for the 28 Day Report delays are not entirely clear, however the team has experienced changes in administrative personnel, maternity leave and extended sick leave which have had an impact.

SUDIC Final Case Discussion Meetings
At the time of the SUDIC Activity Report 2017-18, 13 Final Case Discussion meetings were outstanding. Twelve of these were completed during 2018-19. The SUDIC

process for one of the children who died in 2017 remains incomplete as her death is subject to a national incident investigation process.

During the period covered by this report, Final Case Discussion meetings were completed for 5 of the 19 cases which occurred during 2018-19. For 7 of the children it was identified that sufficient information had been obtained at the Initial Meeting and therefore a Final Meeting would not be required. The remaining 7 meetings will be held when the team receive post-mortem reports for each child.

Governance

Child Death Overview Panel (CDOP)

The LCH SUDIC Team takes responsibility for providing SUDIC reports for each child to the Leeds Local Safeguarding Children Partnership (LSCP) CDOP and ensuring that recommendations from the CDOP are fed back to LCH's Child Death Review Group.

Further details of the recommendations can be found in the CDOP Annual Report 2018-19 available on the Leeds LSCP website.

During 2018-19 the LCH SUDIC Team has been actively involved in the Leeds Child Death Overview Panel reform meetings. The meetings are ongoing at the time of this report and full implementation in line with WT 2018 is expected in September 2019.

LCH Child Death Review Group

This meeting was formerly known as the LCH Children's Mortality Governance Group and has been renamed in line with the Child Death Review Statutory and Operational Guidance (2018). The group met 3 times in 2018-19. The SUDIC Team were represented at each of these.

All SUDIC deaths are reported into the group along with expected deaths of children under the care of LCH services. The deaths are reviewed with the aim of ensuring that a critical appraisal of LCH input is carried out and where necessary, action is taken to ensure that lessons are learned. This group reports to the LCH Mortality Review Group which provides assurance to the LCH Trust Board.

SUDIC Strategic Reference Group (SSRG)

The SSRG, a sub-group of the Leeds LSCP chaired by a CCG Children's Commissioner, met 3 times during 2018-19. The LCH SUDIC Team attended each of these meetings and took responsibility for the administration.

The Group is represented by partner agencies in the Joint Agency Response and provides an opportunity to examine and address issues raised in the SUDIC process. Actions are agreed and monitored in the meetings.

During the year, four areas for action were agreed by the group under the broad headings of:

- SUDIC Process Awareness Raising
- Review of Links with Partners
- Process & Performance
- Family Engagement

These also form the basis of the LCH SUDIC Team Work-plan. The SSRG reviewed the Terms of Reference and agreed to meet bi-annually in the future. It has been agreed

that the administration of the meeting will now be undertaken by Leeds LSCP CDOP Team.

Child Death Review Meetings

Chapter 5 of Working Together to Safeguard Children 2018 (WT 2018) outlined changes to the Death Review process. The government produced further, more comprehensive Child Death Review Statutory and Operational Guidance in October 2018 setting out key features of a good Child Death Review process and the statutory requirements that must be followed. The Joint Agency Response (also known as the SUDIC process) described in the WT 2018 remains unchanged.

National Bereavement Care Pathway Benchmarking Meeting

Throughout the 2018-19 the SUDIC Team has been actively involved in a national pilot project to benchmark practice against national bereavement care standards in relation to the SUDI pathway. Leeds Teaching Hospitals Trust is leading the work.

SUDIC Process Awareness Raising

The SUDIC Consultants facilitated an RCPCH CPD accredited study day in November 2018 with the theme of: 'Cot Death and How We Can Influence Change'. Twenty-eight participants from across the Leeds health economy and other agencies from surrounding areas attended; the day evaluated positively and feedback provided is now informing planning of a further study day during 2019-20.

Children Looked After (CLA) and Care Leavers

Key achievements 2018-19:

- Maintenance of high standards of service delivery for 0-17 year olds while working alongside Social Care colleagues developing the Care Leaver Offer and restructure children's residential care in Leeds
- Contribution to the expansion of the Corporate Parenting Board (CPB) and transformation of the Multi-agency Looked After Partnership (MALAP) into the Corporate Parenting Operational Group (CPOG)
- Work with colleagues in commissioning and within LCH to develop new approaches to the delivery of Initial Health Needs Assessments
- Work with colleagues in Social Care to ensure timely notification of children being received into Local Authority care

Key ambitions 2019-20:

- Exploration of technological solutions to improving efficiency, productivity and engagement of young people in the HNA process
- Exploration of alternative Initial Health Needs Assessment service delivery models
- Implementation of a new team structure
- In partnership with commissioners, deliver continuous service improvements

Our client group includes children placed with their parents under a Care Order; placed for adoption or fostering (voluntarily or under a Care Order); Unaccompanied Asylum Seeking Children (UASC), and those living in Residential Children's Homes in Leeds, including secure settings. Our remit extends to Care Leavers who are supported by the Specialists Nurses for CLA and Care Leavers.

To meet the needs of CLA we collaborate with universal and specialist services within LCH, particularly Health Visitors, School Nurses, Community Paediatricians and colleagues in secure settings; with partners across the health economy; commissioners; and with the Children's Social Work Service, the Corporate Parenting Board (CPB) and the Corporate Parenting Operational Group (CPOG).

The delivery of Children Looked After health services is crucially dependent on the commitment of practitioners across LCH children's and specialist services, all of whom recognise and respond to the specific health needs and vulnerabilities of our young people while acknowledging and celebrating their incredible strength and resilience in coping with significantly challenging life events.

Care Leavers are offered support by the Specialist Nursing Team for Children Looked After and Care Leavers on an episodic basis to:

- transition into adult services,
- understand how to register with or tranfers between GP and Dental practices
- access sexual health information and support services
- access emotional and mental well-being support and guidance

The cohort of Leeds Children Looked After has increased through 2018-19, this is reflective of the national trend in Children Looked After numbers. The Leeds CLA cohort (n = 1279) has remained below that of our statistical neighbours; a small subset of the cohort (57 of 1279) is accounted for by Unaccompanied Asylum Seeking Children, most are Leeds children becoming Looked After in Leeds.

The number entering care averaged at approximately 30 per month, this is comparable with previous years; greater numbers are remaining in care, leading to the overall increase in the cohort.

Because more young people are remaining in care until their 18th birthday, there are a subsequent increasing number of young adults (18–25 years) with statutory Care Leaver rights.

The table below indicates the age profile of the CLA and Care Leaver population and statutory health assessment requirement relating to those age groups:

Age:	Number:	Statutory health assessment required:
0-4yrs	286	Bi-annually
5-12yrs	456	Annually
13-17yrs	555	Annually
18-25yrs	549	No statutory requirement

After initial health needs assessment (IHNA) undertaken within the Community Paediatric Service, the addressing of ongoing health needs and assessment review falls largely to Health Visitors, School Nurses and the CLA Specialist Nursing Team, with some reviews also being undertaken alongside Paediatric Neuro Development, Neonatal Abstinence Syndrome or Adoption clinic reviews to avoid duplication of effort and ensure CLA are reviewed by the most appropriate health professional to assess and meet their needs including young people resident in secure settings.

While there is no statutory requirement to assess the health needs of Care Leavers, we have had in place a commissioned health offer to Care Leavers since 2015 which describes the process for accessing support from the nursing team and is publicised to Care Leavers through their CLU'd Up webpage. Currently, 18% (n=98) of Care Leavers have an open referral to the Specialist Nursing team.

At the end of 2018-19 **94.3% of Children Looked After had an up-to-date health needs assessment** in place; this is indicative of the high standard of administrative and clinical commitment which we maintain in LCH year on year in our efforts to ensure the health needs of CLA are understood and addressed.

This achievement is set in the context of a busy year for CLA and Care Leaver services which came under scrutiny by the **CQC** in their **Review of health services for Children Looked After and Safeguarding In Leeds (June 2018)** and Ofsted in their inspection of Local Authority Children's Services (December 2018).

The CQC inspection has been a useful means of gaining focus and traction on the process for involving GPs in initial health needs assessments and the contribution Social Workers can make through timely request of and attendance at IHNAs. Strengthening these areas of practice will bring a greater multi-agency involvement and child focus to process. Progress against the recommendations is reviewed in the CLA and Adoption Commissioning Group, though CCG oversight of the health economy action plan, LCH Safeguarding Team work plan and through the Corporate Parenting Operational Group (CPOG) to the Corproate Parenting Board (CPB)

The Ofsted inspection has highlighted the needs for the Leaving Care Health Summary to be visible within the Social Work electronic record.

Across the multi-agency partnership we are continuing to respond to the recommendations given by the reviewing bodies and these are reflected in our continuous service improvement plans for 2019-20.

The Local Authority review of their Residential Children's Home service has identified the need for trauma informed practice which had led to significant investment from the CCG to enable dedicated psychology support within the service. A service improvement board with Designated Nurse membership will be established in 2019-20 to oversee delivery of the service improvement plan.

Long standing plans for a Care Leaver hub are beginning to move forward with the identification of a potential site. This will offer an opportunity to open dialogue with service commissioners with regard to the health service component of the hub in the light of feedback from Care Leavers who would like to have:

- Additional mental health support for 16-25 year olds and those 25yrs+
- Access to Care Leaver specific mental health and social support groups
- Support for Care Leavers with eating disorders
- A crisis support line for Care Leavers; and
- Access to Care Leaver Nurses

The Corporate Parenting Board (CPB), made up of Elected Members, Care Leavers, LA Officers, Education and Health partners holds services to account for continuing improvement to outcomes for Children Looked After and Care Leavers. During 2018-19 the board was expanded and now has regular attendance from the CCG service commissioner in addition to the Designated Nurse for CLA and Care Leavers.

The Corporate Parenting Operational Group oversees the implementation of service improvements plans identified by the CPB, service users, inspection or reiview body recommendations, audit findings and partner agencies.

The CLA and Adoption Commissioning group acts as the Health and Well-being subgroup of the CPOG. Each subgroup has put in place a continuous improvement plan. In partnership with the CLA and Care Leavers commissioning team the LCH CLA and Care Leaver health team will **work toward delivering on areras of improvement** already identified e.g. through the CQC review (June 2018) as well as those which may need additional commissioning or service specification review in order to implement e.g. introduction of a dedicated Care Leaver Nursing role.

One issue which continues to challenge the CLA multi-agency partnership is the timely request for and completion of Intial Health Needs Assessment (IHNA) within a 20 working day timeframe. Through discussion within CPOG and the Health and Well-being subgroup stronger focus has been brought to identifying and removing process blockages and to examining the potential for new approaches.

As a result, the CLA Administratvie team is now able to request clinic slots outside of the dedicated IHNA clinics when there is a potential for breach of statutory timescales; and our commissioners have requested exploration of the IHNA service delivery model and consideration of alternatives e.g. benchmarking against other areas, nurse led clinics, or use of Advanced Nurse Practitioners to deliver a safe and effective service.

This will be a priority for 2019-20, although statutory guidance requiring a medic undertakes the IHNA will remain a significant risk to implementation of any new service delivery model.

After a significant period of stability, the **Children Looked After and Care Leaver Specialist Nursing Team is set for structura**l change in 2019-20. This has come about mainly through staff retiring and returning on reduced hours during 2018-19 and the planned retirement of another member of staff in 2019-20. As a result, we have taken the opportunity to examine the team structure and build in a better career progression pathway. This will be implemented during 2019-20.

Safeguarding Annual Report Conclusion

2018-19 has been another busy and productive year for the safeguarding team in all areas of our practice; key themes emerging from this report point to the priorities for the team being:

- the setting and maintaining of quality standards;
- responding to CQC recommendations following their Review of health services for Children Looked After and Safeguarding In Leeds (June 2018) ;
- delivering the safeguarding team restructure
- development of EPR templates to support best safeguarding practice and
- the essential development and maintenance of internal and multi-agency relationships and networks to ensure high quality service delivery with safeguarding of vulnerable children and adults remaining at the core of all we do.

2019-20 will see the Safeguarding Team:

- continue to respond to the training and support needs of LCH staff;
- look toward the future and the potential impact of the NHS Long Term Plan;
- embed the service restructure prioritising responsiveness to the needs of the organisation and to the changing landscape of heath service delivery; and
- ensure LCH practice in Children Looked After and Safeguarding is of a high standard and responsive to the needs of the people of Leeds.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (68)

Meeting: Trust Board 4 October 2019	**Category of paper**	
Report title: Infection prevention and control annual report 2018/19	**For approval**	√
Responsible director: Executive Director of Nursing and Allied Health professionals. **Report author:** Liz Grogan, Lead Infection Prevention and Control Specialist	**For assurance**	
Previously considered by: PSEG and Quality Committee	**For information**	

Purpose of the report

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

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

The report covers the period 1st April 2018 to 31 March 2019 and provides information on:

- IPC activities undertaken within the organisation and collaboratively with partners across the healthcare economy.
- Description of the (IPC) arrangements.
- HCAI statistics.
- Forthcoming IPC programme 2019/20.

Main issues for consideration

- Continuation of the collaborative working that IPC have made with partners across the city and wider, inclusive of the Partnership Cooperation Agreement with Leeds City Council.

- The continuing difficulties that the team face in achieving the CQUIN target for the seasonal staff influenza programme, especially with the CQUINs increase by 5% for 2019/20.

- The burden of needle stick injuries throughout LCH and inappropriate use of needle

safety equipment sometimes resulting in harm.

- The continuation of evolving social inequalities throughout the population we serve that impact on the burden of infection and outbreaks that occur throughout the system, for example; measles, MERs and Hepatitis A.
- The difficulties encountered around accuracy of data on ESR, impacting the correctness of staff trained in IPC and data for the seasonal staff flu campaign.

Recommendations

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

Infection Prevention and Control

"Building the Future, restoring the past"

Annual Report 2018-2019 and IPC Programme for 2019/20

Executive Summary

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- HCAI statistics.
- Forthcoming IPC programme 2019/20.

Key Achievements

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

- Continuing compliance with Care Quality Commission (CQC) regulations relating to Infection Prevention and Control.
- Collaborative working across the healthcare economy and working towards a Partnership Cooperation Agreement with Leeds City Council.
- Remained within commissioned targets for CDI and MRSA bacteraemia.
- Development of the Gram Negative E.coli Programme, working towards a national reduction of 50% by 2024.
- Achieving 76.9% uptake in the Seasonal Staff Influenza Campaign.

Key Risks

- Major infection/outbreak – this is a risk for any service. This risk has been assessed within the Trust and removed from its Corporate Risk Register/Assurance Framework as the risk is felt to be managed with the service provided. There were a number of minor outbreaks of infection this year.

- Ensuring that the environment is maintained in good physical repair and condition is a constant challenge. The PLACE (Patient led assessments of the care environment) inspections, cleanliness validation visits and infection control audits support unit managers and Senior Nurse Managers to progress Estates and refurbishment work required. Maintenance of the environment remains a risk due to financial pressures in 2018/19. Recently a central fund has been agreed to support clinical teams who cannot replace condemned furniture on existing ward environment budgets.

- Ensuring that the correct systems and processes are in place to reduce where possible the risk of needle stick injuries to staff throughout LCH. To work with neighbourhoods and teams in identifying causation behind injuries, and where appropriate deliver training on needle safety devices and potentially evaluate equipment in use.

Key Plans for 2019/2020

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

The key plans/changes were

- Commencement of a Partnership Cooperation Agreement with Leeds City Council.

- Identifying new ways of working in line with the NHS Long Term Plan with particular emphasis on digital technologies.

- Co-ordinating the seasonal staff influenza campaign to meet the increased national target of vaccinating 80% of frontline staff and ensuring that staff are fully briefed on the prevention, detection and management of Influenza. There is a Commissioning for Quality and Innovation (CQUIN) payment attached to this target for 2019/20 with full payment for 80% uptake this year, a 5% increase on 2018/2019.

- Collaborate with the Leeds Healthcare economy on the implementation of a work plan to reduce the number of Gram-negative E.coli bacteraemia and aim to reduce by 10% in accordance with Department of Health and NHS Improvement programme.

- Continue to promote knowledge and compliance with hand hygiene practice and other standard infection control precautions through education and audit activity.

- Continue to offer support and guidance to Infection Prevention and Control champions across LCH, providing study days and support.

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

- Risk assessment and planned action in relation to environmental or cleanliness issues.

- Continued education on the standards relating to antimicrobial use and re-audit to monitor compliance with national antimicrobial stewardship guidance.

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

Contents Page:

1. Background

This document provides the annual report on IPC activity within LCH. The primary focus throughout this year has been to raise the profile of infection prevention practice, both within LCH teams and also across the wider community health economy. Central to this strategy has been a subtle changing of perceptions about the importance of infection control. An increasing wealth of evidence relating to the rise of antimicrobial resistance and patient vulnerability has been used to change “hearts and minds” and increase compliance with safe practice.

Infection prevention and control is central to all aspects of health care, from concept and planning to implementation. Therefore, those involved in health or social care must be aware of the role and importance of this. The IPCT is a key resource, providing knowledge and expertise to encourage and enable staff working across the organisation to embrace infection prevention and control. Effective infection prevention and control requires the following elements:

- Surveillance
- Audit
- Education
- Policy development

- Specialist advice
- Commitment from all members of the healthcare community

At the time of the report the Infection Prevention and Control service consisted of the LCH IPCT, the Communicable Diseases Control Team (CDC) and an additional commissioned service to care homes with nursing and GP surgeries.

This annual report captures some of the developments and achievements made during the last year, with progress being mapped against the 2018/19 work plan (see Appendix 1). Performance management information and the IPC programme for 2019/20, which sets out objectives to meet the needs of the organisation to ensure patient and staff safety (Appendix 2), is also included.

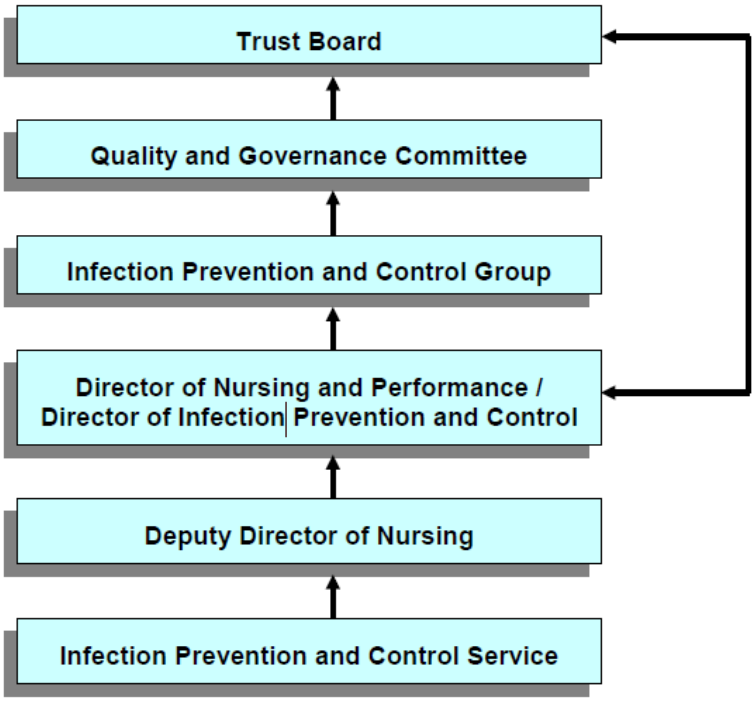
2. Provenance

The information contained within this report has been sourced from the Trust's IPCT and other Infection Control Committee members. It is reflective of actions undertaken throughout 2018/19 and as part of the work of the Committee outlined in the annual programme.

3. Key points for the board to note

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

4. Infection Prevention and Control reporting arrangements



5. Care Quality Commission Review

All elements of the infection prevention and control annual programme are designed to ensure that LCH fully complies with the Code of Practice on the prevention and control of infections and related guidance (DH, 2015). This requirement forms part of the CQC regulation 12 (safe care and treatment) and regulation 15 (premises and equipment).

6. Healthcare Associated Infections (HCAIs) Statistics

6.1. Surveillance of Alert Organisms

Although there are no specific government mandatory targets for individual community care organisations for the incidence of Meticillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile infection (CDI), LCH has worked within locally agreed targets for a number of years. These targets included no more than 2 cases of MRSA bacteraemia and 3 cases of CDI being directly attributed to LCH, where a multiagency review identifies lapses in care that have directly contributed to the infection episode. The Gram Negative Blood Stream Infection (BSI) ambition will change year on year to reflect the yearly 10% reduction ambition. For 2018/19 the E. coli BSI target was 482 community cases.

6.2. Gram negative bacteraemia programme of work

2018/19 saw LCH beginning work to reduce Gram Negative BSI burden in Leeds by 10% each year, leading to a 50% reduction in 2020, as set out by the Department of Health. This target has altered for the 2019/20 financial year and now recommends a 25% decrease in Gram Negative BSI cases by 2021/22 and a 50% decrease by 2023/24.

A Root Cause Analysis (RCA) is conducted for each community acquired E. coli bacteraemia and additional information is added to HCAI Data Capture System (DCS). The results are summarised into both the quarterly HCAI report and a monthly Gram Negative report which is shared with LCH performance team, CCG, and LCH Executive Director of Nursing and Allied Health Professionals.

Other work conducted this year which focuses on reducing the incidence of E. coli BSI includes:

• Commencement of E. coli Collaborative Working Group,
  - Creation of the "I Spy E. coli" branding which is used on all Gram Negative reduction work. This branding is copyrighted to LCH and used only within the wider Leeds Healthcare economy. Shared branding aids the reduction project in its target of being collaborative and seamless.
  - Release of patient and staff posters on E. coli and winter hydration plus patient leaflets on E. coli and urinary tract infections for those who are not catheterised.
- Two awareness days in August and December focusing on PHE identified aspects of awareness and hydration as a method of reducing Gram Negative BSI.
- Benchmarking with other local trusts specifically Kirklees.
- Planning presentations for various conferences in 2019/20 including IPS Yorkshire and National conference, Leeds Collaborative Gram Negative reduction conference, LTHT and LYPFT champions events, NHS Improvement Gram Negative Blood Stream Infections – sharing good practice across North Cumbria and the North East,
- Taking part in cohort one of NHS Improvements UTI collaborative and working to continue this project once the collaborative has finished,
- Working with Leeds City Council colleagues to produce a Winter Wellness TV advert which focuses on E. coli and was played across the Leeds TV channel throughout the winter period,
- Attending Chapel FM radio station to share messages around preventing E. coli infection over the winter period,
- Working with lunch clubs within the local area to reduce E. coli BSI in the older adult population which does not have any health or social care input and are therefore difficult to access from a public health perspective.
- Working with EPR to review and amend the nutrition and hydration section of the Neighbourhood Teams new patient assessment and ensure information gathering is conducive to improving patient hydration,
- Working with Leeds HUB's to implement good practice in identifying whether patients and staff have achieved the recommended daily intake of fluid both whilst in the HUB's setting and in their permanent place of residence (care home or personal home setting) following discharge.

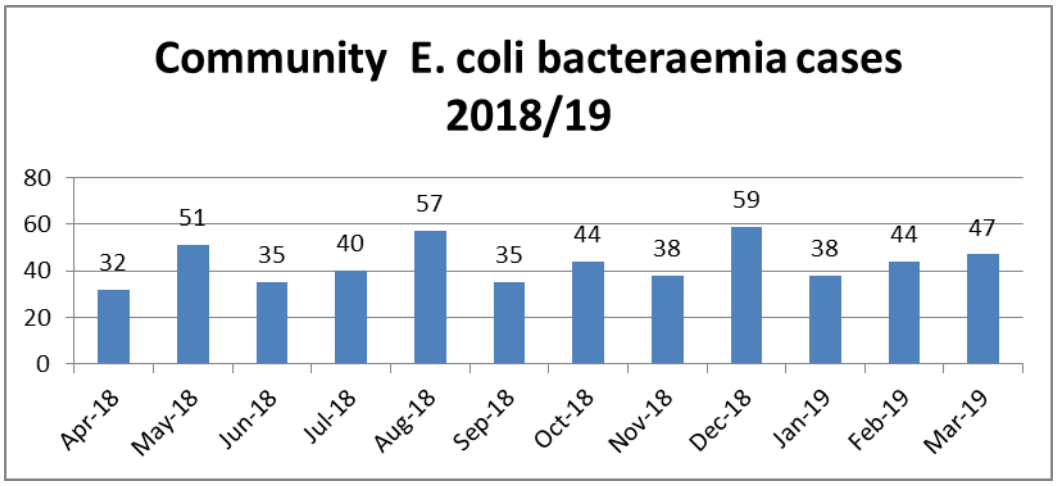


Figure 1.

Community onset E. coli bloodstream infections 2018/19

In 2018/19 a 3% reduction was made to the number of E. coli BSI community cases. This is less that the national 10% reduction ambition, however, due to the nature of the reduction ambition and the requirement for a predominantly public health campaign, the reduction is not surprising as behaviour change can take time to effectively implement.

6.3. Meticillin Resistant Staphylococcus aureus (MRSA)

From April 2018 to March 2019 there have been no cases of MRSA Bloodstream Infection (MRSA BSI) attributed to LCH.

During the reporting period for 2018/19, LCH was notified of 8 MRSA BSI that required joint exploration with stakeholders. LCH was also notified of 4 collaborative cases at Leeds Teaching Hospitals Trust (LTHT).

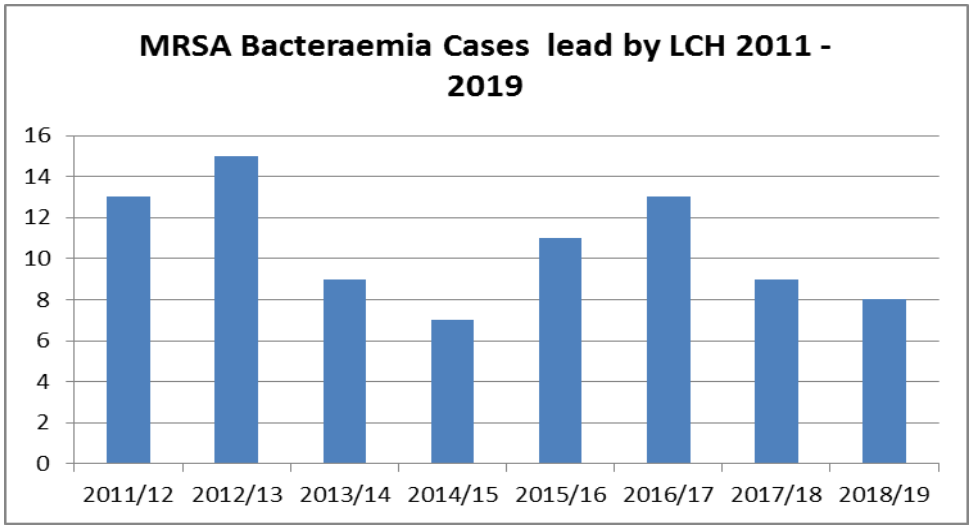


Figure 2. MRSA BSI lead by LCH 2011 – 2019.

All MRSA BSI cases require the Post Infection Review process to be undertaken within 14 working (21 full) days of notification. The principal purpose of the PIR is to deliver zero tolerance on MRSA BSI, to identify how each case of MRSA BSI occurred and to identify actions that will prevent it reoccurring in the future.

GP attendance at PIR meetings has been nurtured and promoted over recent years and all efforts have been made to involve and accommodate GP's within the PIR process. All PIR meetings organised by LCH are now, where appropriate, arranged to be held within GP practices. This increases the likelihood of GP's being able to attend. Where GP's are still unable to attend or it is impractical for the PIR meeting to be held at the surgery, teleconference facilities are made available.

The outcome of the PIR determines clinical learning and relies on strong partnership working with all organisations involved in the patient's care in order to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA BSI. Due to changes in 2018/19 MRSA BSI information no longer requires submission to the HCAI DCS. This also means the process of attributing responsibility is no longer required, as attribution is purely based on the timeframe between acute admission and identification of MRSA BSI. However, the wider Leeds healthcare economy has agreed to continue the attribution process as a means of tracking progress. Using the previous assignment system, during the 2018/19 period 4 cases would have been assigned to third party, 1 case to acute care and 2 cases to wider multiagency. One further case has been identified for 2018/19 Q4, however, due to this being identified late in the financial year (28/03/19) the case is still under investigation and review. It is felt that this case is likely to be assigned to wider multiagency.

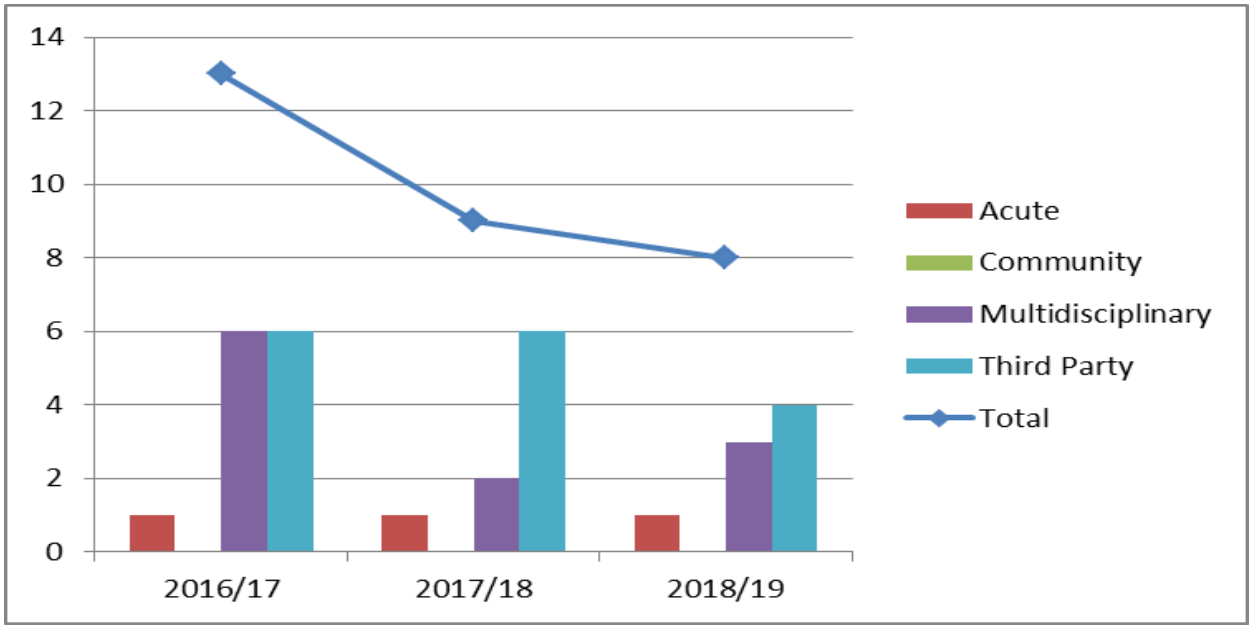


Figure 3. Attribution of cases 2011 – 2019

Within the eight cases investigated by community IPC, 2 were identified as patients who were involved in illicit drug use. Significant numbers of MRSA BSI relating to illicit drug use was noted in previous years, however the two cases identified in 2018/19 had no connections. No MRSA BSI cases from 2018/19 were noted to be care home residents; this is a decrease of 2 cases from the previous year.

Learning from the PIR's throughout 2018/19 have included:

- Ensuring that all cases involving IV drug users are referred to Forward Leeds
- Increasing the quality of communication between trusts and also internally within trusts.
- Ensuring catheter care is effective and appropriate for all who undertake (staff, patients or carers.)

A systematic action plan has been developed and implemented to address the identified deficits throughout the Leeds healthcare economy. The progress of action plans relevant to LCH plan is monitored by the LCH Quality Committee and Senior Management Team (SMT).

6.4. Learning from Post Infection Reviews

All reported cases of MRSA bacteraemia within the wider community health economy are subject to a full (PIR), which aims to identify the root cause of the infection,where possible, and any healthcare contributing factors. Significant work has continued to improve interagency collaboration with reviews where cases have received care from both Primary and Secondary Care providers.
As stated earlier, no cases of MRSA bacteraemia have been assigned to LCH during the report period. Some elements of learning for LCH have, however, been identified.

These include:

- Ensuring all new patients to the Neighbourhood Team are seen by qualified staff at the first visit and “one off” visits are not used as this may lead to future care being missed.

- Ensuring the Neighbourhood Teams electronic records and notes are in-depth and accurate, in order to give a good picture of the patients care.

- Identifying that within the wider community health economy there have been a variety of predisposing risk factors identified in MRSA bacteraemia acquisition. These have primarily related to illicit drug usage, catheterisation, or open wounds/ ulcers.

6.5. Clostridium difficile Infection (CDI)

All community apportioned CDI cases are reviewed by the LCH IPCT. This review process involves the collection and analysis of patient case information and the subsequent identification of potential contributing factors for C diff acquisition.

This information is jointly reviewed by the CCG Medicines Optimisation Team, who directly link to the respective GP practices. A PIR is undertaken in situations where the episode of infection is identified as part of an outbreak, a contributing factor in the death of the patient or when the patient is identified within a LCH in-patient facility. From April 2015 an enhanced process of CDI review is being undertaken. The primary aim of this is to provide insight into the contributing factors for infection in cases where clear causation is not apparent.

A number of concerns had been raised about the accuracy of CDI data provided to LCH from the LTHT Laboratory. On occasions there had been discrepancies between the number of cases reported to LCH for investigation and the number published on the PHE Healthcare Associated Infection Data Capture System (HCAI DCS). The community IPC team now input CDI data to the HCAI DCS where the sample has been taken within the community e.g. by a GP surgery. The review process has also been complicated by delays in the receipt of responses from GP Practices.

6.6 Clostridium difficile community apportioned cases Q1 – 4, 2018/19

The following table outlines the number of community apportioned CDI cases identified and reported to the IPCT during this period

	Quarter 1 2018-19			Quarter 2 2018-19			Quarter 3 2018 - 19			Quarter 4 2018 - 19			Year Total
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Cases attributed to wider community healthcare economy	16	12	11	11	12	16	15	16	15	9	7	10	150
Cases attributed	0	0	0	0	0	0	0	0	0	0	0	0	0

to LCH													

Figure 4. Attribution of C.diff cases per month 2018/19

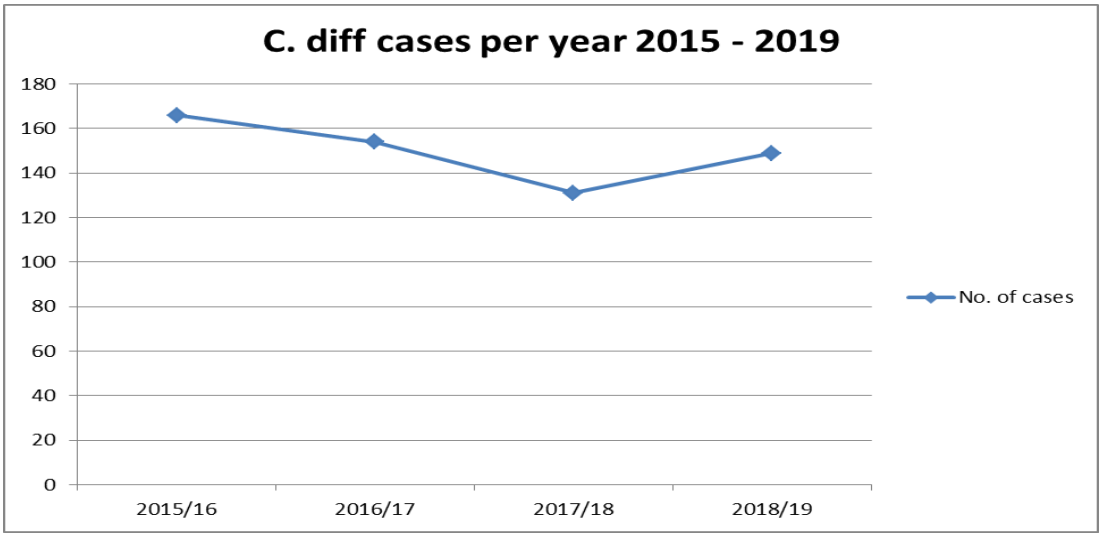


Figure 5. Comparison of C.diff cases per financial year 2015 - 2019

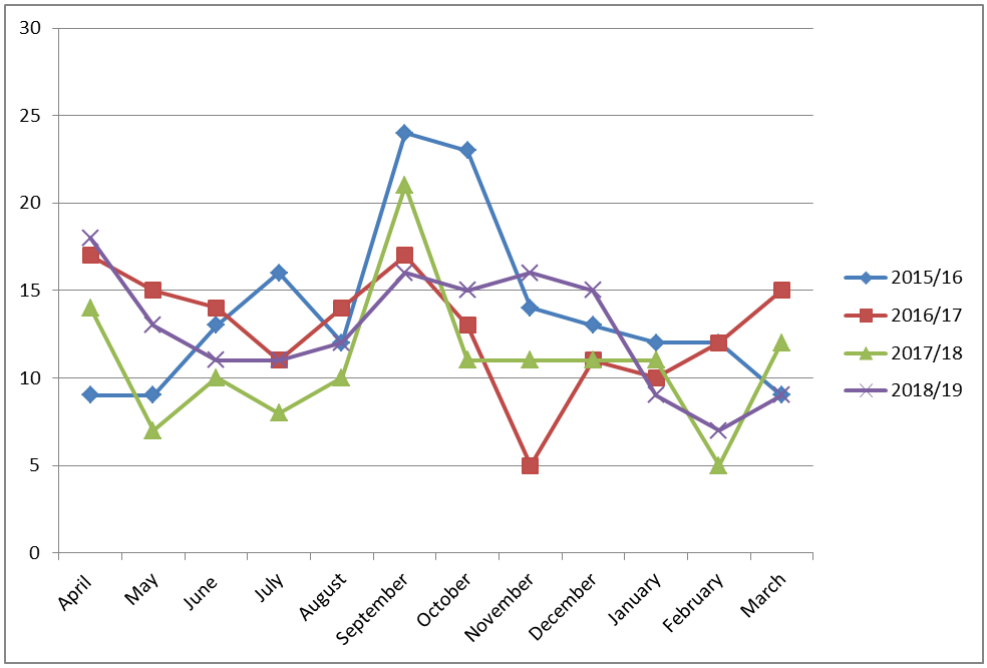


Figure 6. Comparison of CDI cases per month 2015 – 2019

6.7. Clostridium difficile infection (CDI) contributory factors 2018-19

Figure 4 shows there has been an annual increase of 19 cases in comparison to last year in which 131 recorded cases for 2017/2018 and 150 cases for 2018/2019. However for Q4

alone there has been a decrease of 2 cases compared to last year (2018/19 Q4 26 cases reported, 2017/18 Q4 28 cases reported.) Information from the previous four years on the whole shows a downward trajectory however, it is not possible to identify whether the increase identified this year is an anomaly, due to having limited data points to compare and contrast with at present. CDI data is discussed at both the HCAI group and IPCG (Infection Prevention and Control Group) meetings. Concerns regarding this increase have not been expressed within either group.

6.8. CDI going forward 2019/20

Guidance published by NHS Improvement in February 2019 outlined new CDI objectives for 2019/20. This document outlines that although great efforts have been made to reduce the incidence of CDI, the rates of improvement have slowed over recent years. In 2014 the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections advised that the definitions used to attribute CDI cases to an organisation should be updated in line with other recognised international definitions such as Centres for Disease Control and European Centres for Disease Control. NHS Improvement also outlined the need for a system-wide approach for objective delivery and therefore as of April 2019 CCGs will have responsibility for the delivery of reduction of all cases assigned to them.

6.9. IC Net Surveillance

IC Net is the software system currently used by LTHT for the reporting of laboratory specimen results. It is the interface by which MRSA positive and C.*diff* positive samples for patients in the LCH community setting are reported to the IPC team on a daily basis.

Each result is processed by adding a high priority alert/reminder on System One. An IPC information task is sent to any LCH services currently involved with the patient, identified by any services with an open referral. The result is flagged up to the patient's GP by either a task on System One, or a telephone call to those using a different healthcare record system, requesting that the patient is reviewed in light of the result. If the patient resides in a care home or nursing home the facility is contacted to inform of the result and offer appropriate infection control advice.

Current LCH policy recommends that all patients with an MRSA positive sample result are offered decolonisation treatment if not previously given within the last 3 months. GPs are signposted to the MRSA decolonisation guidance, available at Leeds Health Pathways.

In addition to the IC Net daily report, LCH IPC receive a daily report from LTHT listing any patients who have had samples taken during hospital admissions, outpatient appointments and surgical assessments that have returned MRSA positive. These are similarly processed as for the PCT active list.

Particular focus is given to the MRSA positive cases identified with urinary catheters, wounds and/or invasive devices due to the high risk of developing a bloodstream infection. In such cases the GP may be prompted regarding antibiotic prophylaxis prior to catheter change/removal or to review the current antibiotic therapy.

All C.*diff* cases whether 'toxin detected' or 'toxin NOT detected' are reported to the IPCT in the same way as for MRSA – either via the daily PCT Active List or the Community CDI list sent weekly. They are similarly processed with a reminder added on System One. Other services are informed as appropriate and GPs are prompted to review the patient (Proton Pump Inhibitor (PPIs), antibiotic therapy, etc.).

If the patient lives in a care home, the home is contacted to inform them of the result and to reiterate standard infection control precautions.

The above measures are taken as a proactive measure with the aim of reducing the spread of MRSA and C.*diff* within the community and minimising the risk to the affected individuals.

The number of cases notified to the IPCT by LTHT for the 2018-2019 period was: MRSA 1183 (average 99 per month); C.*diff* 225 (average 19 per month); out of area results received was 22 (21 MRSA and 1 C.*diff*).

7. Outbreaks of Communicable Infection

7.1 Norovirus

Throughout the year the LCH Communicable Diseases team have responded to all outbreaks of viral gastroenteritis reported within the Leeds Area.

7.2 Influenza

LCH has again reached flu vaccination targets set out by NHS Flu Fighters. Throughout the flu season sporadic outbreaks have been noted within care home settings and some disruption noted within secondary care. No outbreaks were noted within LCH in-patient areas.

8. Management of Panton Valentine Leukociding (PVL) Cases

PVL is a toxic substance produced by some Staphylococcus aureus strains which has been implicated in severe infection and invasive disease. Throughout the year the IPCT have responded to 8 cases identified within the community economy to provide advice and information to patients and healthcare workers on appropriate management strategies. This represents a significant decrease in numbers in comparison to the 18 cases reported in 2017/18, and 37 reported in 2016/17.

9. Seasonal Staff Influenza Campaign 2017/2018

9.1 The Code of Practice (2012) for the prevention and control of HCAI emphasises the need for NHS organisations to ensure that its frontline health care workers are free of and protected from communicable infections (so far as is reasonably practical). Influenza is a highly contagious illness which can be serious, particularly for older people or those with other health conditions. Health and social care workers care for some of the most vulnerable

people in our communities and 50% of staff may carry flu and may unknowingly pass flu onto others.

Health care staff are also at increased risk of transmission of infections. Therefore it is important that staff help protect themselves (and their families) and the patients that they care for by receiving annual flu vaccinations. Staff vaccination also results in lower rates of influenza-like illness and mortality in healthcare settings and helps to ensure vital business continuity in the health and social care sector (by reducing staff flu related illness).

9.2 Results 2018/19

At the end of January 2019, LCH had vaccinated **76.9%** of its clinical staff. In addition to this figure, by the end of March 2019, a total of **3330** vaccines had been administered by LCH for: LCH staff, LCC staff, and local care home and hospice staff. Numbers of vaccinated staff for each of these three areas is broken down further below:

LCH staff

- 1961 total staff were vaccinated (out of 3317 staff)
- 1632 total clinical staff were vaccinated
- 354 total staff had a vaccine elsewhere
- 313 total clinical staff had had a vaccine elsewhere

9.3 Challenges

Despite successfully achieving the 75% LCH clinical staff target, the 2018/19 campaign came with its challenges. This included an increased six week period of vaccinating which involved additional commitment from the team in continued promotion of the vaccine and in organising and delivering vaccination opportunities. The IPC team performed these extra duties whilst also attending to other IPC work streams and responsibilities. In addition to this, and due to demands of other work streams and responsibilities, at the start of the vaccinating period (1st of October) only two staff members were able to deliver the trust vaccine launch day. Due to this the launch event only resembled a typical vaccination clinic.

Furthermore, during all the vaccinating season, the majority of the IPC team were unable to be as involved as in previous years and the bulk of the work and responsibility fell to only a few of the IPC team members. Considering this and also due the increased period of vaccinating in 2018/19, plans for next year include involvement and responsibility for staff vaccines from other staff in LCH services.

The IPC team had difficulties with the inaccurate date on ESR, as a result of this it was difficult to provide accurate monthly mandatory data (which is used for national publication and is also linked to CQUIN monitoring). Data required includes the total number of clinical staff employed, the numbers of clinical staff vaccinated and the number of clinical staff who have declined their vaccine.

This will help to ensure the sustainability and success of future campaigns. For example front of house staff will be requested to be more involved and committed in alerting staff at

their premises (on the days when the clinics will be at their premises). Service managers will also be asked to work with the IPC team in being aware of and monitoring which of their staff have not been vaccinated (and should also provide encouragement to their staff to receive the vaccine).

10. Learning for Patient Safety

10.1. Systems

The IPCT continue to work with managers and clinical staff to support learning for patient safety. Systems are in place to ensure incidents are recognised, recorded, analysed and learning shared across services.

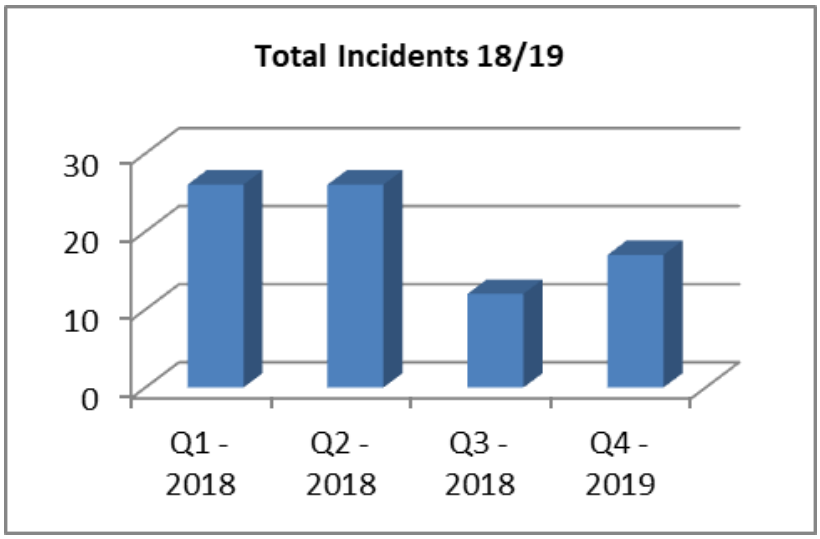
10.2. Incidents

Incidents are categorised into four areas:

- Environment
- Treatment/procedure
- Sharps
- Other Infection control related incidents

There was a total of 81 infection control related incidents reported from April 2018 to end March 2019. These were reported from a number of LCH service including Neighbourhood Teams, Children's services, Podiatry, Dental, Sexual Health and Custody services.

A breakdown of these injuries show that the highest reported infection control incidents continue to be sharps related:



- Sharps incidents 39
- Sharps with harm – 34

–

- Treatment/Procedure – 6
- Environmental issues – 2

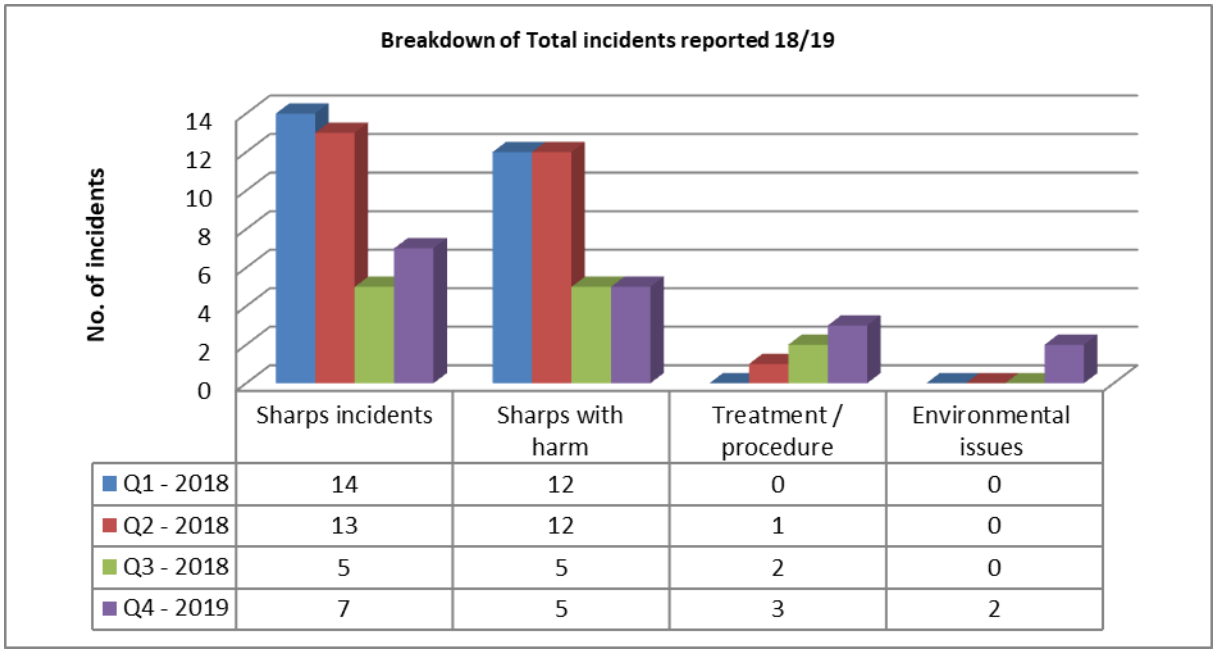


Figure 7. Total incidents reported

Figure 8: Breakdown of total incidents

10.3. Sharps

Wherever a medical sharp device is used there will always be risk of sharps injury associated with these devices. The IPCT strive to reduce this risk as far as possible by following LCH risk management strategies and ensuring that all teams are provided with adequate education, safer sharps equipment, adhere to standard infection control precautions and follow relevant LCH policy.

There was a total of 39 sharps related incidents, 37 of which resulted in harm.

10.4. Breakdown of reported sharps incidents with harm

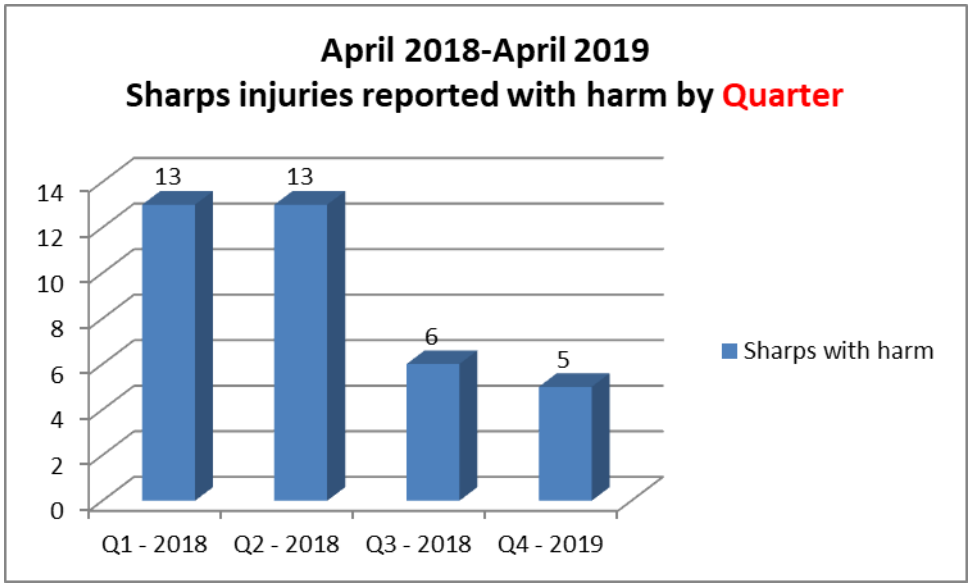


Figure 9.

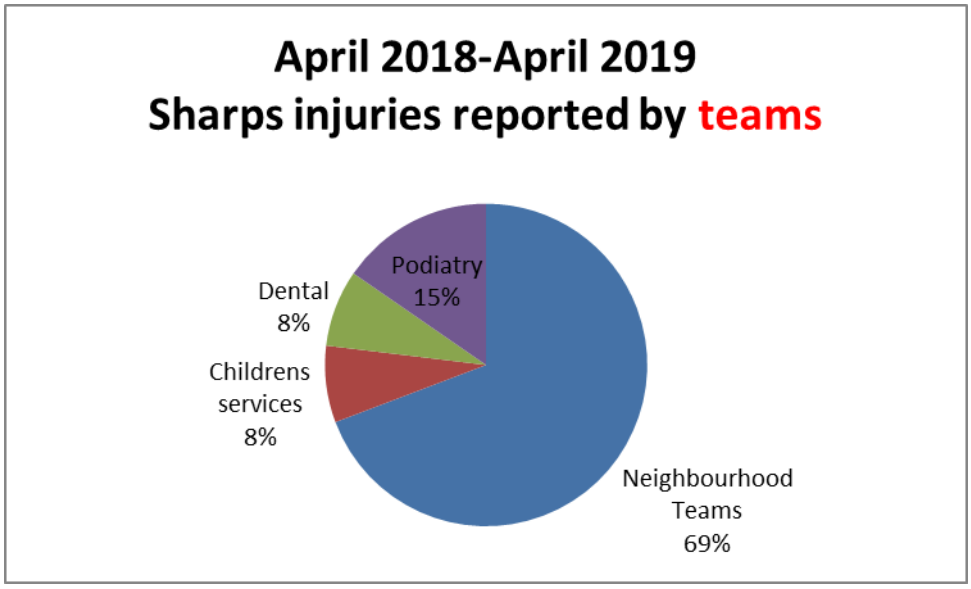


Figure 10.

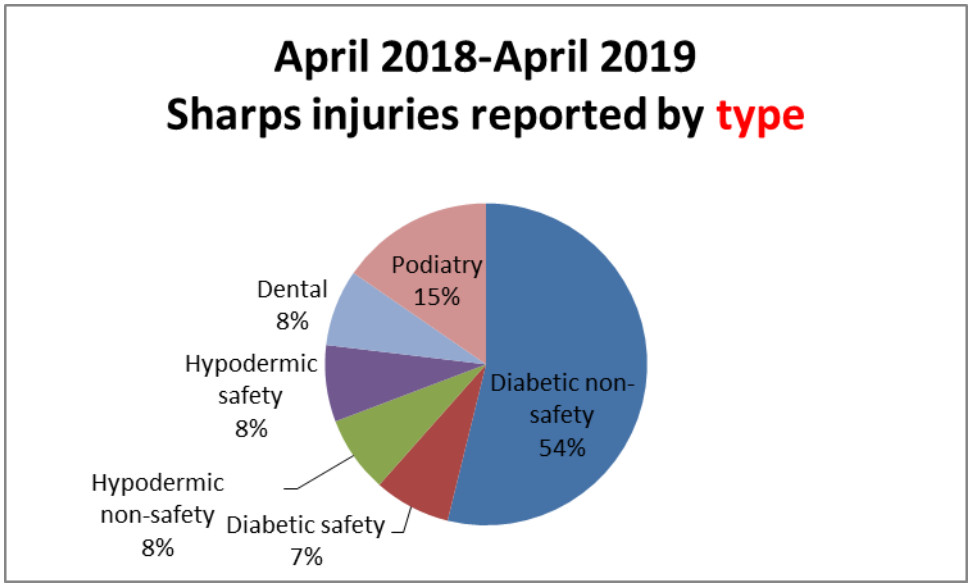


Figure 11.

As shown in the graphs, the majority of sharps injuries were reported by the Neighbourhood Teams (69%), involving a diabetic non-safety device (54%) such as patients own blood glucose lancet and non-safety insulin pen needles.

This continues to be the biggest area of risk in terms of sharps injuries sustained in the community.

Each injury that is reported is followed by an individual specialist review and any learning identified is disseminated locally and wider if appropriate.

A comprehensive work stream has been established to address this burden and includes:

- Multiagency working with CCGs to review the availability of safety equipment. The Leeds CCGs have developed a “commissioning statement” which indicated that they will not prescribe safety needles or syringes for administration of insulin by LCH staff. An organisational decision has been made by LCH to provide an appropriate safety device to all staff engaged in the use of insulin delivery pens during patient care. Further work is required with the CCGs and informal carers administering injections.
- The production and distribution of posters and leaflets to staff, outlining safe practice requirements.
- Joint working with the Diabetes Team to increase awareness of safety system usage within care teams.
- Enhanced awareness raising at IPC Mandatory Training sessions.
- Effective post injury review and investigation with the dissemination of learning throughout the organisation.
- Audit of equipment use within Neighbourhood Teams.

- During mandatory IPC training and induction, sharps safety is highlighted focussing on how to prevent a sharps injury and what to do in the event of a sharps injury.

10.5. Exposure to infection

There have been no particular themes or trends that have been identified and appropriate actions have been implemented following each investigation. Typical examples of incidents within this category are exposure of staff to body fluids from burst abscesses, bleeding following injection etc.

All incidents reported via the DATIX system will continue to be monitored on a daily basis. Quarterly reports and action plans will be fed into the IPCG.

11. Decontamination

LCH has a robust decontamination process for the management of reusable surgical equipment used in dentistry, podiatry and offender health. The organisation continues to utilise a central reprocessing system from and external provider with “state of the art” facilities. The IPCT continues to monitor decontamination standards with regular meetings and “Duty of Care” visits to the facility.

Within the report period there have been no reported untoward incidents relating to the provision of sterile medical devices from this source.

12. Estates/ Facilities

Throughout the year, the IPCT have continued to work closely with the Estates Department to assure and maintain the safety of clinical environments where LCH care activities are taking place. A fundamental element of this assurance process has involved the periodic auditing of facilities to monitor the condition of the environment and fixtures such as hand wash basins, toilets, cupboards etc. and the structured feedback of identified deficits to the estates team to ensure remedial action is completed.

A number of healthcare facilities have been subject to refurbishment programmes to ensure they continue to comply with current best practice and infection control standards. During 2018 a Six Facet survey was undertaken of all the LCH premises to review environmental standards, compliance with environmental regulations and legislation, effective utilisation of space, etc. As a result of this project significant investment has been made to many of the care environments and alterations made to many treatment rooms. The predominant focus of this work has been Pudsey and Meanwood Health Centres.

The IPCT have continued to work as part of the LCH Water Safety Group, overseeing current operational controls that protect patients and staff from water related infections. Throughout the year emphasis has been placed on the continued implementation and improved recording of water outlet flushing regimens, important for the prevention of water related infections such as Legionella and Pseudomonas. Comprehensive Water Risk Assessments are in place for each of the LCH premises and these provide the underpinning framework for the water safety control measures in place for the areas. In situations where water quality

issues have been identified, appropriate actions have been taken to ensure the maintenance of patient and staff safety.

13. Clinical Governance

13.1. Governance Structure

Governance is assured through the Infection Prevention and Control Group (IPCG) and its reporting mechanisms via the organisational governance structure. Throughout the year further work has been done to ensure a robust communication pathway is available via the Patient Safety and Experience Group and Quality Committee. The monthly Director of Nursing Briefing also reviews infection prevention and control issues/status.

13.2. IPC Policies

The IPCT are responsible for a suite of policies and have continued to develop and review clinical policy documents and best practice clinical guidelines to support front-line staff. A number of “key note” policies have been updated throughout the year and the team continue to “horizon scan” to ensure that practice in concurrent with current evidence and best practice.

The IPC policies and guidelines are directly related to patient, staff and visitor safety and to the consistency of quality of care a patient receives. They ensure compliance with the standards outlined by the Health and Social Care Act (2008), National Health Service Litigation Authority (NHSLA) and Health and Safety at Work Act. A number of “key note” policies have been updated during the report period including the Management of MRSA in the community setting.

13.3. Audit

Audit is a requirement of the Health and Social Care Act 2008, Code of practice for registered providers on the prevention and control of health care associated infections and related guidance. The code states that registered providers must audit compliance to key policies and procedures for infection prevention.

13.4. Process

Due to a lack of suitable products being available the IPCT has yet to acquire an effective tablet-based tool that will allow paper free auditing and reporting, however work is ongoing with this goal. On the completion of audits, feedback is provided to the relevant team leader(s) via the action plan.

Areas or systems of good practice are highlighted as well as areas / issues of concern that required addressing. Time specific, ameliorative recommendations are included for the highlighted areas of concern. Recommended actions are agreed with the staff identified as being responsible and the progress of any improvements is monitored by subsequent follow up visits.

Simultaneously, the action plan is registered on the organisational data base and sent to relevant departments, for example facilities which include external cleaning agencies.

13.5. Audit Results

The IPC team perform annual audits of its areas and premises used by LCH clinical staff for clinical purposes. Data gathered from the LCH auditing activity is used to applaud good practice, identify concerns and themes which is used to improve LCH environments, services and staff performance. These improvements will reduce the risk of transmission of healthcare associated infections to patients, staff and visitors.

From April 2018 to March 2019 the IPC team audited 57 premises which were:

- 24 health centres/clinics used by LCH
- 33 areas where clinical activities take place outside of LCH health centres/clinics :

    - Wharfdale Hospital MSK unit
    - Sunfield Medical Centre MSK room
    - Thornton Medical centre
    - St Marys Hospital Community Rehabilitation Unit
    - Rutland Lodge – Continence Urology and Colorectal service suites
    - Merrion Centre Leeds Integrated Sexual Health
    - Hannah House
    - Little Woodhouse Hall
    - St Georges Centre for Musculoskeletal (MSK) and Children's Out patients
    - Leeds Assisted Living Centre
    - Wetherby Young offenders institute (HM prison)
    - 17 Police Custody Suites for East, North, South and West Yorkshire
    - 4 Special inclusion learning centre (SILC) schools
    - North West Recovery Hub

However Reginald Centre and Park Edge have not been audited this year (and will be audited earlier this year) for due to changes to the annual audit programme.

13.5.1 Findings

Findings of the 57 audits varies between premises. Below are examples of compliant, moderately compliant and minimally compliant findings:

Compliant areas – Minimal risk

- Clinical staff bare below the elbows (short sleeves, no rings or wrist jewellery and no false nails/nail polish)
- Hand hygiene facilities such as paper towels, liquid soap and alcohol gel widely available in clinical areas via replenished wall dispensers
- Window blinds clean
- Wide spread use of trust recommended combined trust detergent and disinfectant wipes
- Toilets are clean

Moderately complaint areas – Medium risk

- 4 health centres (as discussed above) delivered from tired and worn environments with issues of chipped paint work, lifting wall paper, damaged plaster and damaged radiators
- Throughout varying premises many hand hygiene sinks are not Department of Health Building Note compliant**.** The IPC team has recommended that these sinks are upgraded to compliant sinks when the sinks are next upgraded
- Evidence of staff eating and drinking in clinical areas and hand hygiene sinks being used to wash staff crockery
- Sharps bins not labelled
- Dust to high surfaces and behind desk top PC's and printers to several premises.
- Areas cluttered (with not needed items). On review many areas had been decluttered and not needed items had been removed (i.e. old out of use ultrasound machine and old wall clock which was not on the wall)
- Build-up of several locked sharps bin to a clinic room

Minimally compliant areas – High risk

- Portable fans not cleaned and clinical staff not aware it is there responsibility to clean fans used in their clinical areas. Clinical teams are alerted to their responsibilities to clean the fans in the action plans.
- Toys not on regular cleaning schedule and one clinical team not aware of their responsibility to clean the toys that they use. Soft non-wipable toys were also seen in several premises. Following identification of these problems, the IPC nurse liaised with the discussed clinical team lead to ensure the staff were aware of their role to clean their toys. The nurse also forwarded a copy of the toy cleaning policy and first choice product list (to assist staff with ordering trust wipes for cleaning the toys) to the clinical lead. Adding to this the IPC recommended in the action plans that all soft toys should be disposed of.
- Out of date box of syringes found. Following the audit the team disposed of the syringes and the team's clinical lead has advised the staff to regularly check expiratory dates (which includes before using sterile equipment) and will also raise the issues at the next team meeting.
- Blood spots/splashes on walls and floors. On IPC nurse investigation this problem was due to phlebotomy staff practice (who were from a different provider). The IPC nurse raised this concern with the providers IPC team and phlebotomy team lead).
- Cleaner's cupboards dirty, untidy and cluttered (to rented premises). This issue has been raised with the LCH team cleaning lead (who has liaise with the landlord) and a follow up visit will be done by the IPC nurse to review progress.
- In the Leeds Equipment Service it was noticeable that the activity levels within the unit have significantly increased since the last audit and that the general standards of environmental cleanliness have reduced, with dust accumulations being noted on many of the horizontal surfaces and stored equipment. The team are attempting to negate the risks associated with dust contamination by applying plastic wrapping to complex items of equipment. Although this has been a long standing issue, the level of dust contamination has increased since the audit undertaken in 2017. As stated in previous audits, the building, by virtue of its industrial nature has inherent design difficulties that make dust control almost impossible. The IPC nurse recommended that a review of the cleaning input and resource provided to the facility is required and

specific design controls are required when considering the lay out of the new, proposed facility. Central to this would be the provision of impervious, cleanable shelving and a storage area that would include covered shelving.

13.6. Dental Water Lines (DWL) Audit

A programme of systematic testing of dental waterlines has continued with 6 monthly reports on water quality results being submitted to the IPCG. On the identification of elevated bacterial levels within lines, specific remedial action is implemented to assure patient safety.

The surveillance and monitoring process identified high bacterial counts within the equipment at Yeadon Dental Suite. Rapid intervention and modification of the disinfection regime prevented any risk to patient safety and enabled resolution of the problem.

13.7. Hand Hygiene Compliance Audits

The process provides an element of assurance that clinical staff members have an appropriate level of competence in relation to hand hygiene and the basic principles of IPC. A process of monthly hand hygiene compliance monitoring has been established at the Community Rehabilitation Unit (CNRU) and Little Woodhouse Hall. Work is ongoing to establish a formalised process for Hannah House. Within the wider community economy peer assessment observations have been ongoing within care delivery teams. Compliance information generated as a result of The Essential Steps observational process is submitted by teams to the Quality Challenge + programme.

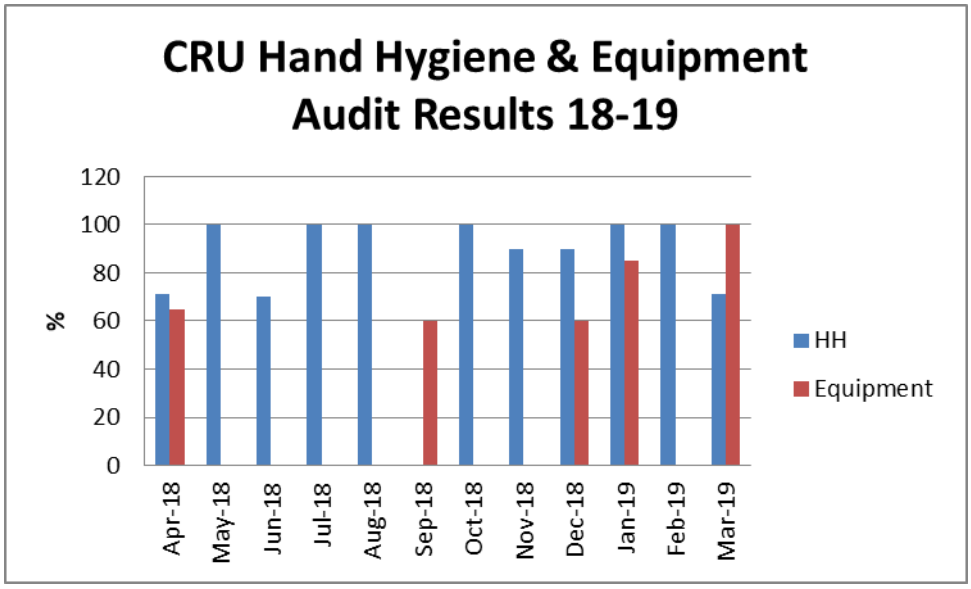


Figure 12: Hand Hygiene and Equipment Compliance CNRU 2018/2019

14. Quality

14.1. Quality Challenge plus

In order to provide robust quality assurance pathways, IPC features on the organisational Quality Challenge + Framework. This involves all care providing teams giving assurance that

they are compliant with important infection prevention criteria such as; having appropriate hand hygiene materials available at all times. That IPC features on job descriptions, is reviewed during appraisal and performance review and that staff have peer led assessments of individual hand hygiene compliance. As stated previously data collection and review has been difficult and measures to improve the process will be integrated into the activity during the 2017-18 year.

15. User Engagement

15.1. Patient Public Involvement (Safe Clean Care and PLACE projects)

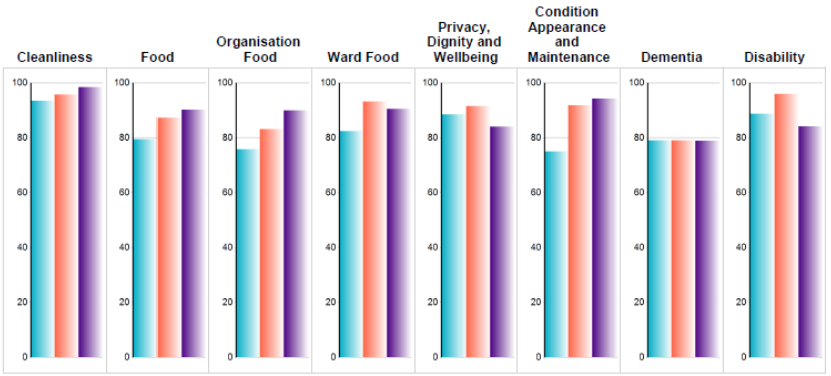
The LCH Infection Prevention Team continues to coordinate the PLACE inspection programme within LCH in-patient areas. The PLACE programme is undertaken annually within LCH and follows the assessment framework published by the Department of Health. During April 2018 a group of Patient Members and other stakeholders visited Little Woodhouse Hall, Hannah House and The Community Neurological Rehabilitation Unit (St Mary's Hospital).

The primary focus of the assessment activity is to review the condition and cleanliness of the care environment as well as elements relating to privacy dignity and wellbeing as well as food quality, disability and dementia care.

Results 2018

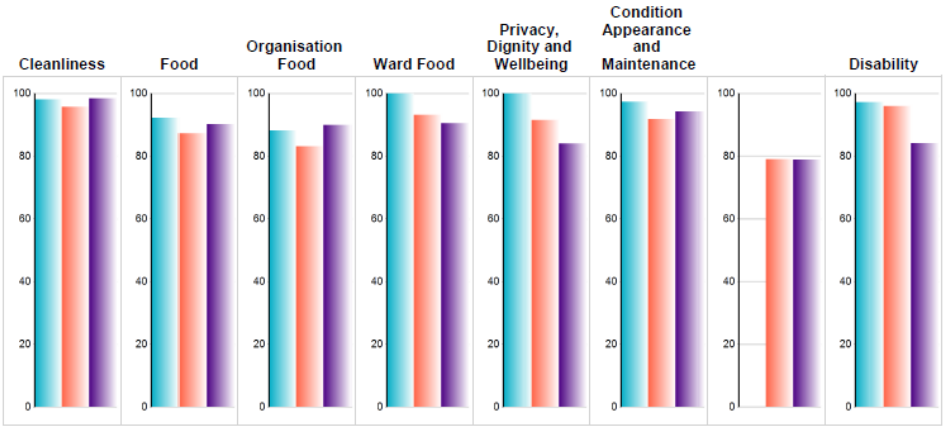
The following graphs provide an overview of the results achieved in each of the three areas appraised and also give a comparison with the national average figures for each of the standards.

PLACE Results 2018 CNRU St. Marys Hospital



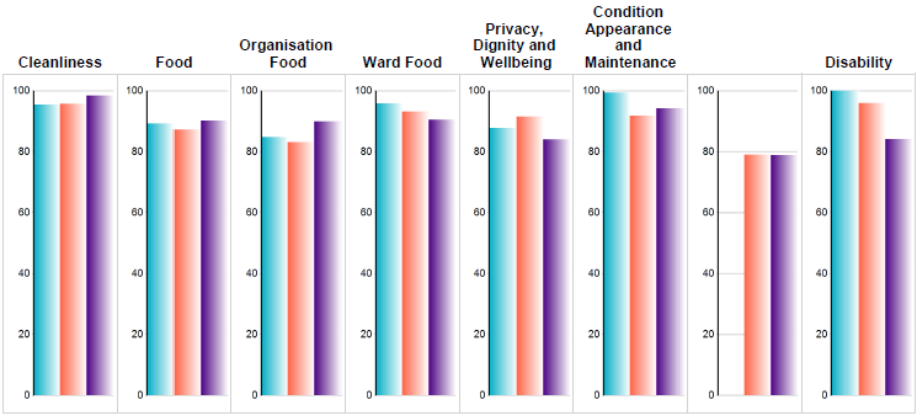
Achieved Score (Actual)	286.0000	209.4578	89.9704	119.4874	56.6666	126.0000	82.8571	80.2100
Available Score (Actual)	306.0000	263.5291	118.5880	144.9411	64.0000	168.0000	104.8571	90.3697
Site Score	93.46%	79.48%	75.87%	82.44%	88.54%	75.00%	79.02%	88.76%
Organisation Average	95.69%	87.30%	83.20%	93.21%	91.51%	91.89%	79.02%	96.00%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%

PLACE Results 2018 Hannah House



Achieved Score (Actual)	263.0000	142.7729	89.4284	53.3445	52.0000	150.0000	53.0756
Available Score (Actual)	268.0000	154.8065	101.4620	53.3445	52.0000	154.0000	54.5882
Site Score	98.13%	92.23%	88.14%	100.00%	100.00%	97.40%	97.23%
Organisation Average	95.69%	87.30%	83.20%	93.21%	91.51%	91.89%	96.00%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	84.19%

PLACE Results 2018 Little Woodhouse Hall



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance		Disability
Achieved Score (Actual)	321.0000	159.5717	90.8057	68.7660	68.5000	187.0000		59.0458
Available Score (Actual)	336.0000	178.8256	107.1008	71.7248	78.0000	188.0000		59.0458
Site Score	95.54%	89.23%	84.79%	95.87%	87.82%	99.47%		100.00%
Organisation Average	95.69%	87.30%	83.20%	93.21%	91.51%	91.89%		96.00%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%		84.19%

The results for the “Privacy, Dignity and Wellbeing” assessment criterion demonstrated an organisational compliance which was more than 7% above the national average. This criterion is central to the PLACE process as it appraises the general standards of the environment that directly relates to patients physical and psychological care and also infection prevention and control. Hannah House achieved the highest rating within the LCH assessed buildings

The standard of cleanliness in all areas was noted to be marginally below the national average scores. Action plans have been developed for areas to address the issues identified. The highest compliance rating was achieved by Hannah House with a score of 98.13%. Following the review, further audits of the areas have been undertaken and have demonstrated significant improvements.

The assessment of the condition, appearance and maintenance of the care environment identified issues at CNRU. The results for both Hannah House and Little Woodhouse Hall were well above the national average. The deficits identified at CNRU have been integrated into the organisational action plans that have been submitted to the respective Land Lord.

The quality of food (Ward Food) standard was well above national average for Little Woodhouse Hall and Hannah House, with deficits noted in the quality of food at CNRU. In relation to the dementia care standard, only CNRU was assessed. The results are around the national average and demonstrate a need to review the environment.

The PLACE review process 2018 has highlighted specific environmental issues within the areas reviewed. Comprehensive action plans have been developed for all areas and progress against the identified deficits is being monitored to ensure quality improvements are achieved as a result of the programme.

15.2 Information Technology

The IPCT continues to review its activity in relation to available Information Technology systems.

The Flu campaign continued to see the team using Social Media in a more advanced nature, linking professionally using Twitter and Facebook. The team also used electronic consent forms to allow ease of completion and reduce admin time when collating patient information for flu database.

The team are looking to use an electronic auditing system for the use of environment and hand hygiene, this will allow the service to improve efficiency around the audit process and reduce the timings around audit write up and action planning.

15.3 Patient and Public Information

A dedicated infection prevention and control information resource page for patients and public is maintained on the Leeds Community Healthcare NHS Trust website. This site provides easily accessible IPC resources and tools suitable for use by the general public or healthcare professionals. Staff can also access these resources via the IPC pages on the LCH intranet system ELSIE.

15.4 Collaborative Working

The IPCT have continued to work hard to improve engagement and collaborative working with other agencies/ stakeholders in the Leeds health economy. Throughout the year, the LCH Team have actively contributed to the city wide promotion of infection prevention, working on such initiatives as pandemic Influenza planning, antibiotic resistance, winter planning and the gram negative E.coli conference.

This will be further strengthened through the Partnership Cooperation Agreement that the IPC Lead has been working on through 2018/19 to commence in April 2019, which is an enormous achievement for the service.

The team have worked collaboratively with other stakeholders as a part of the Sepsis Citywide Forum which was established by the IPC Lead, working on priorities across the city in line with NICE Guidance, and a work plan which was written to support roll out of NEWS2 and improving education and training around the awareness of Sepsis.

Throughout the year the IPCT have worked with LTHT on cases of MRSA and C difficile infection where joint involvement has been noted. This joint review process has enabled a more integrated approach to identifying causes and solutions to infection related issues.

The IPCT have actively engaged with the Local Authority Social Care provider Teams and deliver bespoke IPC training to the care providers. Work has been done within a number of schools and children's centres the team provided a number of IPC awareness sessions.

15.5 Student Learning Opportunities

For several years, the IPCT has been providing placements for nursing student and Allied Health Professional Students where applicable. The IPCT works closely with the practice learning facilitators to ensure that placements are stimulating and meaningful; therefore student placements with the IPCT are limited to two weeks – owing to the lack of patient contact and opportunities for skills to be signed off. A wide range of exposure to IPC is

provided, including visits to the acute and mental health trusts, offender health and specialist teams within LCH (CIVAS, TB, palliative discharge facilitators etc.).

Students are provided with a comprehensive workbook, microbiology work sheets and case studies to complete prior to placement commencement. The student booklet is currently in the process of being updated. Once completed, this booklet will be appropriate for both undergraduate and apprenticeship students. Students are allocated a primary and secondary mentor with whom to work and will also receive support from the wider IPCT members.

Verbal, written and student portal feedback is good and the student placement audit was completed this year with no major actions identified.

16. IPC Training

16.1. Programme

The IPC mandatory training programme has undergone further modification through the year.

16.2. Attendance

The proportion of staff that have attended IPC training as set out in the statutory and mandatory training grid had remained at around 84% (source ESR) throughout the report period. This figure is below the 90% organisational threshold and so the IPCT have implemented a host of local measures to increase uptake. These have included:

- Innovative thinking around the use of Skype with custody suite staff
- Providing bespoke training within staff bases, including sessions out of hours for night and twilight staff
- Reviewing individual team/neighbourhood performance and providing targeted sessions to areas of low compliance
- Reviewing data quality issues with the Workforce Information Team
- Increasing the availability of generic training sessions

The issue remains on the organisational Risk Register and the issue is identified on the IPC programme for 2019-20, with an expectation that the training target will be achieved by March 2020.

17. Communicable Disease Control (CDC)

17.1. The CDC Team

The CDC Team consists of 1.2 WTE nurses and is based with Leeds City Councils (LCC) Environmental Health Food and Health Team. Their purpose is to investigate, act and report on all individual cases and larger outbreaks of notifiable gastric diseases within the population of Leeds. They investigate confirmed and suspected food poisonings and also manage outbreaks of viral gastroenteritis within any establishment including care homes, child care settings, schools, day centres, etc. They work closely with partner agencies including Leeds City Council and Public Health England (PHE) and have continued to work

with PHE and West Yorkshire local authorities to review and standardise key principles of managing Gastro intestinal illnesses across West Yorkshire.

Outbreak management details (Wider Leeds community health Economy) 1/4/18 to 31/3/19.

Total outbreaks 119.

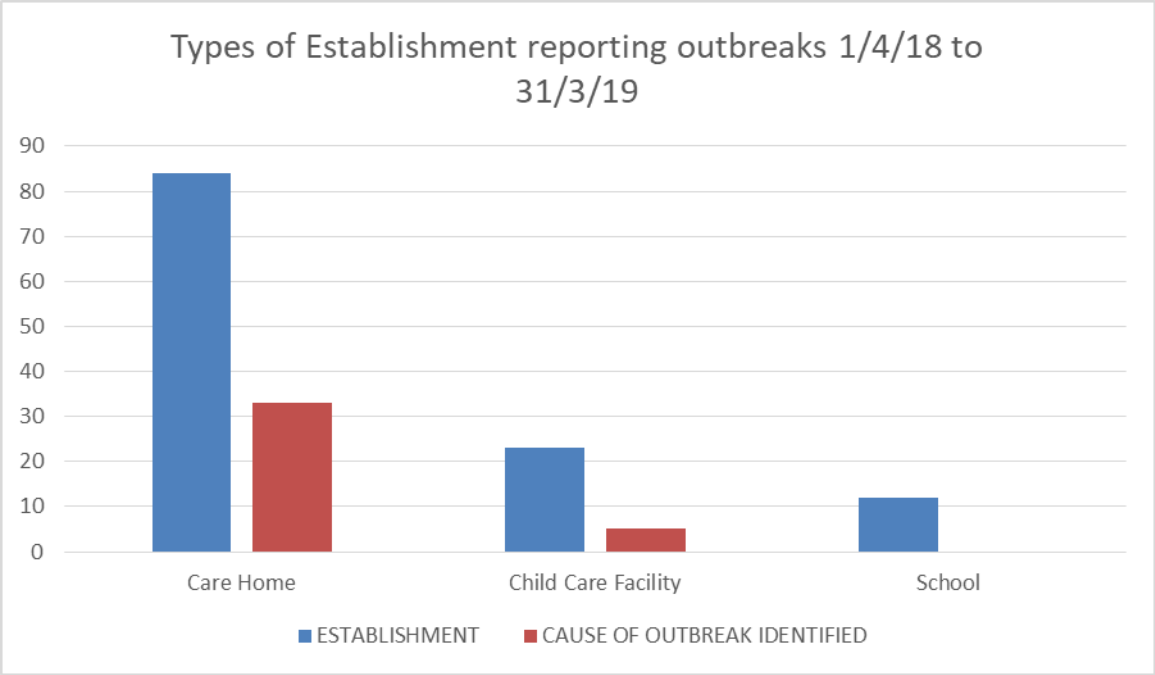


Figure 13. Type of Establishment reporting outbreaks

The chart provides and overview of the types of facilities that have reported outbreaks of gastro intestinal illness during the reported period. Each of the identified outbreaks have been visited, advised and managed by the CDC nursing team. The graph shows that a variety of settings have reported incidents and the majority of causative organisms have been identified as predominantly Norovirus.

In the last 12 months the CDC nursing team have been working closely with the staff in the Food and Health team at Leeds City Council to develop and improve the service.

As a result of a visit and communication with staff in the microbiology department at Leeds General Infirmary, the method of receiving “positive” laboratory results was streamlined. A daily telephone call to obtain laboratory results, which was time consuming and potentially open to inaccuracies, was replaced by secure, password protected emails. After an initial pilot of the system, sending postal copies of the emailed results was also discontinued to avoid duplication, paper/filing and postage. Any urgent results for same day action are telephoned to the CDC nurse by12 midday to ensure response targets are met. This system is now working effectively for the microbiology staff and the CDC team.

A more formalised approach to best practice in the management of outbreaks of gastrointestinal illness in Care Homes has been developed to reinforce decision making regarding any implemented restrictions within the premises. The assessment tool, developed in partnership with LCHT, LTHT and LCC, assists in ratifying actions which enable business

continuity where possible whilst there is an ongoing situation at the premises. This is proving to work well in the Care Home economy, resulting in a shorter duration of the outbreak in most situations, and is reassessed at each point of contact to ensure patient safety remains paramount.

The CDC nursing team continue to work in close partnership with PHE regarding the ongoing review of management of specific enteric illnesses, particularly Shiga toxin producing E coli (STEC). There has been recent training provided by PHE on the actions and management of cases for staff across Yorkshire and the Humber to ensure best practice and continuity of management of cases throughout the region. Review and training is provisionally planned to continue for the management of additional enteric illnesses.

The management of complaints of suspected food poisonings from members of the public has also been redeveloped within LCC Food and Health Team/CDC. This has historically been a large volume of work for several disciplines within the team with very little additional response from the complainant. From 23rd April the redeveloped response will now be initiated by business support, with a daily review of all reports of illness by the CDC nurse to ensure any potential outbreaks of illness associated with a food premises are identified and managed in a timely manner.

The team are currently working towards a paperlite/paperless service and to facilitate this andare working with Leeds City Council's IT department to ensure all necessary GDPR requirements have been addressed and implemented. A risk assessment has been undertaken by senior staff in the Food and Health Team and are currently awaiting further contact from IT staff regarding storage of confidential information. Access rights to the majority of necessary computer programmes have been obtained with 1 area outstanding. It is envisaged that access to this programme will be obtained within the next month.

Planned ongoing training continues with staff in the Food and Health Team at Leeds City Council to ensure business continuity if required by the service.

Organisms identified through notification of infectious disease reporting 1/4/18/ to 31/3/19

ORGANISM	NUMBER OF CASES
Campylobacter	952
Cholera	1
Cryptosporidia	61
Cyclosppora	5
E.Coli 0157	18
Entamoeba Histolytica	1
Giardia	123
Listeria	2
Salmonella	129
Shigella (including Sonnei, Boydii,Flexneri and Disenteriae)	51
Typhoid/Paratyphoid	11
Yersinia	5
Vibrio	2

TOTAL POSITIVES	1361

Reported cases of suspected food poisoning 1/4/18 to 31/3/19

248 individual reports of illness after eating from establishments in Leeds which were all responded to and advised accordingly.

17.2 Ectoparasitic Management

The IPCT provide a specialist service for the management of head lice (Headstart) infestations within the community. The service offers advice and support in cases of persistent head lice infestation. The main sources of referrals come through school staff, with additional referrals via school nurses, health visitors and social workers.

During the 2017/2018 period the service has seen a further reduction in referrals with a total of 15 cases referred this year. These were assessed and appropriately managed by the team with 15 referrals being accepted. Three referrals were declined as inappropriate – feedback and advice was offered in these cases.

Access to free Hedrin via the Pharmacy First Minor Ailments Scheme continues to be a positive step in reducing referrals to the service by removing the financial barrier to obtaining treatment, while also directing parents for first-line advice to their local pharmacist rather than attending their GP Practice.

The service continues to encounter some complex and challenging cases where children have presented with severe head lice infestation in addition to other issues, which have occasionally led to safeguarding concerns. These families are often hard to engage and repeatedly fail to check their children's hair and/or apply a pharmacy-approved head lice product in accordance with the instructions. These cases can be hard to resolve. It can be very difficult to get all family members together and frequently adult members of the family are reluctant to have their hair checked.

Often difficulties with head lice management have arisen due to family breakdown, parental illness or disability. Support and advice has been provided in these circumstances to help the parent acquire the necessary knowledge and skills to take on the responsibility of managing their child/children's head lice.

Headstart visits continue to take place predominantly in the school environment wherever possible. This facilitates better engagement with parents/guardians and closer collaborative working with the school staff, particularly the learning mentors/child protection leads, who are the main source of referrals into the service. Moreover, seeing referred cases in the school environment has eliminated the problem of unattended appointments and minimised the potential risks associated with lone working. Visits are conducted in the home only in special cases when we are specifically requested to do so (as in the example of the migrant family given above), or when this is the only remaining option available.

18 CCG Commissioned Services

Much progress has been made to engage advise and provide quality assurance for the commissioned services within the Leeds healthcare economy. Specific work streams have been implemented to improve IPC compliance in these areas.

18.1. Care Homes

The IPC nurse visits care homes with nursing (CHWN) to perform periodic IPC audit visits. Currently there are 39 CHWN in the Leeds locality. The purpose of auditing is to appraise the activities of IPC in CHWN against national standards. From this non-compliant areas are identified and advice and an action plan is given to support care homes work towards compliancy.

Each CHWN should receive a primary audit visit minimally every 3 years. Care home visits are followed up again in 3 months to review progress and further advice is given as needed. The audits are scored in line with the Department of Health scoring system which provides a clear indication of compliance for each audit criterion and of the overall audit score:

Compliance score	Compliance rating	Risk rating
85% or above	Compliant	Minimal Risk
76-84%	Partial Compliance	Medium Risk
75% or less	Minimal Compliance	High Risk

18.2 Results for the year 2018/2019

- 14 care homes received a primary audit (which includes one hub which has nursing staff based at the hub)
- 10 care homes received follow a follow up visit

Areas of non-compliance and concern:

- All the care homes had the availability of an Offensive/Hygiene waste stream but several care homes did not have the availability of a Hazardous/Infectious waste stream. The audit nurse developed a poster which outlines 3 common waste stream used in care homes which was shared widely across all the care home economy. On follow up the majority of the care homes had a Hazardous/Infectious waste stream.
- Several care homes had not completed a sharps risk assessment. However the majority of the care homes had converted to using safety sharps
- No re-usable clinical equipment cleaning schedules were available. On follow up the majority of car homes had developed schedules.
- No funding provided by care home owner for staff immunisations. This is an ongoing issue for care homes.

18.3 IPC in the Recovery Hub

Due to a high number of diarrhoea and vomiting outbreaks in one of the 3 recovery hubs, the IPC nurse did several visits to this care home. Visits included inspecting premises and practice and providing an action plan of improvement recommendations. Since then the hub has received a full IPC audit where several areas requiring work was identified. However on review visit improvement had been made as recommended. Nevertheless some areas requiring improvement had not been actioned and the audit nurse plans to review the care home in 3 months. During the initial visits it was noted that the hub staff only had IPC training on a 3 yearly basis.

It was recommended by the IPC nurse that the staff increase training (which was implemented in all 3 hubs) annually. To help with the increased training requirement, the IPC nurse provided one complementary IPC training event in each of the Hubs. The IPC nurse also liaised with the contracted cleaning team to give cleaning advice and was asked to review the cleaning team IPC training presentation. From reviewing the presentation the IPC nurse gave further advice such as on the deep cleaning procedure which was incorporated into the training presentation. The lead of the cleaning team also increased IPC training for the cleaners of the hub to be annual. For winter 2018/19 the care home reported only one outbreak of diarrhoea and vomiting which was short lived and deemed as unlikely to be an infectious outbreak of symptoms.

18.4 UTI Collaborative

The IPC nurse continues to attend the Gram Negative Collabarative Group meetings as a representative for care homes. The IPC nurse and project lead nurse for the Gram negative reduction ambition attended 4 national events by NHS Improvement. The aim of the events was to assist teams to undertaking a quality improvement project (using quality improvement methodology) to reduce urinary tract infections (UTI) and improve patient experience. The Leeds project group consisted of members of the acute trust, CCG Pharmacist, LCH Continence Urology and Colorectal Nurse Specialist, LCH IPC team, and two local pilot care homes.

The Leeds project aim was to improve urinary tract infection diagnosis and residents hydration in the 2 pilot care homes (and would also involve meetings with the local GP's regarding UTI diagnosis and prescribing). Combined with the national events, the local project team met fortnightly and reviewed progress of the project using PDSA cycles and statistical process control tools. The IPC nurse attended the care home on 11 occasions which included providing 4 training sessions on hydration and 2 hydration events.

The CCG pharmacist also visited the care home to collect base line data and did GP visits to raise awareness on correct diagnosis. However obtaining baseline data was not achieved for the project (which was largely due to not having a long enough time to collect the data during the short project duration) Both care homes were also did not have a large quota of UTI's to reduce and had already been given support by a dedicated care home nurse (was employed via the local GP surgeries. Adding this after the project closed the Leeds project group felt 5 months was a short duration to help 2 external organisations make improvements. Nevertheless feedback from the care home of the project was good.

Both care homes said from the project that the staff had an improved understanding of the importance of improving residents hydration. One care home had plans to start structured

drinks rounds, had started providing fluid rich snacks and the other care home had inserted a large soft drinks dispenser in the day room. The care home noted that several residents (including those with dementia) began helping themselves to drinks from the dispenser (when usually they would only receive served drinks from the staff) and would help themselves to drinks after seeing other residents do so. The project has made a good foundation for the development of a city wide care home hydration projects in which the IPC nurse and project lead nurse have been meeting to develop. This will involve developing a dedicated web page or resources for care homes.

18.5 Support provided for residential care homes

The local authority contract officers include aspects of IPC during their general auditing programme of residential care homes. However the IPC team has also provided support to this sector by:

- Telephone/email/face to face advice
- Access to the dedicated care home web page
- Sharing of relevant updates and resources such as the biannual newsletter and best practice posters
- Inclusion of 4 monthly residential care home champions updates
- Supportive visits to care homes where outbreaks of communicable disease have been identified, or where untoward infection episodes have been identified
- Premises inspections with action plans and follow up visits after request from care home managers or from stake holders.

18.6 Residential care home support visits 2018/19

During 2018/19 the IPC nurse visited 7 residential care homes and also did 3 follow up visits. Visits to these premises occurred due to concerns raised by stakeholders such as Leeds City Council Contracts managers, CCG quality managers, CQC Inspectors and the IPC team and included issues such as:

- Environmental cleaning issues and general IPC issues
- A care home reporting a potential Clostridium difficile outbreak (which on outcome was not a Clostridium difficile outbreak)
- An incident of 2 recent E. coli blood stream infections (which matched the same strain of E. coli)
- An MRSA blood stream infection (related to catheter care)

18.7 Link to health and social care agencies and commissioning teams

Further to the all auditing activity and support provided above, the IPC nurse acts as a link for care homes to the wider health and social care agencies, services and commissioning teams. Consequently this provides a pathway for escalations of concerns and sharing of good practice.

18.2 GP Commissioned Audit Programme

Throughout 2018/19 the IPC team completed 42 GP audits. The aim of the audit process is to establish the level of compliance of commissioned GP practices in Leeds against national infection prevention and control standards; providing a baseline position for improvement.

Areas of non-compliance and concern:

- Sinks in clinical rooms being inappropriately used for disposal of water or cleaning of instruments.
- Not all practices are using sharp safety devices
- Portable fans not cleaned and clinical staff not aware it is there responsibility to clean fans used in their clinical areas.
- Toys not on regular cleaning schedule. Soft non-wipable toys were also seen in several premises.
- Out of date box of syringes found. Following the audit the team disposed of the syringes and the team's clinical lead has advised the staff to regularly check expiratory dates (which includes before using sterile equipment) and will also raise the issues at the next team meeting.
- Cleaner's cupboards dirty, untidy and cluttered.
- Sharps bins not labelled, assembled correctly, used inappropriately.

Overall there continues to be a significant improvement around the compliance of the seven elements appraised, and generally many of the practices visited have an overall compliance with infection prevention.

In order to continue maintaining a safe standard of care it is important that annual audits are completed by the Infection Control Lead at each practice. Audit tools and resources can be found on the LCH website, which has been shared with all practices.

During 2018/19 the IPC team set up a quarterly IPC Lead Forum Group – which is a session opened up to all practices and is available on a first come first based and free. The forum brings together a small number of nurses (20 on average) to discuss key topics. Throughout the year three sessions were held, in different locations: Leigh View, Kirkstall Lane and St Martins Practice. Some of the topics covered were: sepsis, E.coli, legionella, auditing and winter precautions. An Eventbrite booking is available to staff, and evaluations show that small groups are beneficial as this enhances learning, and that they find the sessions really valuable and supportive.

19 Infection Control Champion Programme

The IPCT continues to provide support and training to Infection Control Champions. They act under the supervision of the IPCT as a resource and role model for colleagues. They are a key contact for the IPCT, cascading new information and facilitating change as required. The IPCT provide quarterly training for all champions covering a range of different topics including; Sepsis, E.coli Gram Negative Work, Winter Preparedness and Legionella.

20 Personal Development of IPCT

In October 2018 a permanent IPC Lead was appointed to the service, the individual was an existing member of the team, and this has now provided a sense of stability to the service, as there has been some changes in role over the last 12 months.

A band 6 in the team has been successful in being appointed as a secondment opportunity filling the role as a band 7 to complete a commissioned piece of work on the Gram negative E.coli programme, following the success of the first year this post has been extended for a further 12 months.

National study days or conferences are attended as appropriate for professional development, and all members of the IPCT are members of the Infection Prevention Society (IPS). The Senior IPC Nurse is the chair of the Yorkshire Branch of the IPS. There is regular communication with other members of the Infection Prevention Society IV Forum and Research and Development Forum for networking and sharing of ideas and expertise.

21 Conclusion

Throughout the year, The IPC Team have continued to raise the profile of Infection Prevention and Control and to ensure that safe IPC practice is a fundamental element of all care delivery activities. The team have worked hard to foster relationships with internal and external partners, developing collaborative working arrangements to form the foundation of a strong partnership with a multi-faceted approach to the prevention and management of communicable disease.

To ensure continued quality improvements and to support the organisations zero tolerance to HCAIs, further work has been indentified throughout this report which will form the basis of the IPC programme and priorities for 2018-19 as set out in the 2017-18 Infection Prevention and Control Programme.

23 Recommendations to the Board

The Board of Directors is asked to note the contents of this report and approve its publication.

Approved by:

Compiled by: Liz Grogan Lead IPC Nurse Specialist

With reports compiled by:
Joanne Reynard Senior IPC Nurse Specialist
Dave Hall Senior IPC Nurse Specialist
Louise Popple IPC Nurse Specialist
Jeanette Wood IPC Nurse Specialist
Danielle Dobson IPC Nurse Specialist
Dawn Scholes IPC Nurse
Janice Collier CDC Nurse
Kirsty Taylor Surveillance Officer IPC

Appendix 1

Infection Prevention and Control Programme 2018-19

In addition to existing IPC activities this programme describes activities that meet the needs of the organisation to ensure patient safety.

This year's annual programme is mapped to the Health and Social Care Act 2008, Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (2015). Compliance with the Code of Practice is enforceable by the Care Quality Commission and a declaration of compliance with the Code by the Trust, is a statutory requirement for registration under the Health & Social Care Act 2008. The Code comprises of ten compliance criteria against which the Trust will be assessed by the CQC. In addition Infection Prevention and Control cleanliness standards are monitored under regulation 12 and 15 of the Care Quality Commission Regulations.

There are also relevant NICE standards that are referenced in the plan. The NICE quality standard QS113 on Healthcare Associated Infections (2016) and QS61, the overarching quality standard which reflects other NICE guidance are also referenced. In addition the programme reflects recommendations from other relevant NICE standards such as NICE PH36 (2011) Healthcare associated infections: prevention and control and NICE PH43 (2012) Testing for Hepatitis B and C in drug services and NICE NG60 (2016) HIV testing: increasing uptake among people who may have undiagnosed HIV (Joint NICE and Public Health England guideline).

In addition NHS Improvement (2017) has published its ambition to halve healthcare associated Gram-negative bloodstream infection (BSI) rates across the NHS by 2021, which will involve all parts of the healthcare community working together on improved surveillance of E.coli*, Klebsiella* and *Pseudomonas* blood stream infections and prevention of these infections.

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Policies								
Update existing LCH policies due for expiry 2018-19 • Healthcare Waste • Aseptic Technique • Outbreak Policy • MRSA Policy	LG/LP	March 19						*IPC Policies updated and ratified through the CCPG.*
Training								
Ensure compliance levels for IPC Mandatory training reaches 90% target	JR	Interim results to IPCG Quarterly						*Due to difficulties with ESR in the inaccuracy with data 90% of staff have not been trained and it is around 84% compliance*
Facilitate a one day IPC conference	LG	May 19						*A one day E.coli conference was held in May, and*

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
								we plan for a Sepsis Citywide conference in September 2019.
Collaborative working to support AMR Agenda in GP economy	LG	Ongoing						*IPC continue to collaboratively engage with the AMS group, and awareness raising days were held.*
Develop and implement IPC Training for GP and Practice based Teams	Team	December 18						*GP training slides were updated to reflect new information.*
Develop champion based training for GP practice staff.	LG	December 18						*A GP IPC Practice Nurse forum was successfully established, meeting quarterly and rotating around the city with a capped attendance of 20.*
Review and refresh IPC mandatory training programme look too develop innovative ways to reduce travel	LG							*Powerpoint slides updated though out the year as required.*
Perform IPC training for social care staff at Enterprise House, discuss evaluations and maintain the contract	Team / JR							*This was successfully completed and continues to evaluate well.*
IPC Performance and Quality Assurance								
Work collaboratively with CCG partners to facilitate surveillance and investigation process of Gram negative bacteraemia episodes in line with DH Mandatory requirements. Report monthly and input on DCS.	LP							*The IPC team continue to work collaboratively with partners across the city in response to national aim to reduce GNBSI's.*
Standardise IPC assessment and assurance framework in Custody Suite areas and initiate self-assessment tool.	JR	Sept 18						
Assist clinical teams through the completion of IPC elements of Quality Challenge Plus and integrate into IPC Assurance Framework	DH	March 19						*This has been completed.*
Undertake structured audit	LG and	March 19						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
activity within GP practices as part of commissioned service	Team							
Undertake and Coordinate PLACE reviews of : • Little Woodhouse Hall • Hannah House • CNRC	DH	April 18						
Produce an Annual Report and release it publically	Lead	June 2019						
Modify and refresh LCH Internal Audit Tool	JW/ LG	August 18						
Review and refresh Risk assessment process	DH	August 18						
Identify ongoing concerns and audit 50 cases that were telephoned from LTHFT to CDC for accuracy. Explore what can be done to mitigate the risk as an IT solution is not forth coming.	CDC Nurse	September 18						
The partnership agreement is in development by LCC and will be shared to LCH by July 18. This will need senior review by the board and DIPC.	DIPC	March 19						
IC net will cease to be used by April 19. LTHT are transferring to PPM plus. IPC team need to understand the impact this will have on their processes and ensure their needs are addressed as part of the development led by LTHT.	Lead	March 19						
To review with EH and LCH the role of EH and CDC nurse role	Lead							
To review and continue ongoing contracting arrangements for the Care Home staff IPC training.	Lead/JW							
User Engagement								
Coordinate staff influenza vaccine campaign 2018-19 achieving CQUINN target of 75% frontline uptake	JW	March 19						
Foster engagement with								

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
cohort of membership with PLACE induction training session, to look to engage at developing connections with Health Watch with the PLACE process.	DH	March 19						
Undertake Hand Hygiene, Sepsis and AMR awareness Campaigns within LCH	Team	March 19						
Further develop FFP3 Mask Fit Testing programme for LCH in response to potential Pandemic Flu risks. To ensure database is effectively in place to record LCH staff in line with HSE guidance.	DH	Dec 18						
Work with LCH colleagues to develop a sepsis forum and look at develop engagement at all levels within the organisation	LG	March 19						
Service Improvement								
Facilitate IPC Team Building Event	Team	March 19						
Work with CCG partners to review IP performance and improve the wider community CDI review process	LC/DH LTHT/LYPFT	Nov 17						
Work with CCG partners and other stakeholders to review the MRSA decolonisation protocols	LG	September 18						

PEYS = Predicted end of year target
Joanne Reynard and IPC Team
IPC Team
20th June 18
Updated May 2018 Liz Grogan

Infection Prevention and Control Annual Plan 2019/2020
Liz Grogan Lead Infection Prevention Nurse Specialist

Reference	Objective in line with the H&SC Act 2008	Lead	Status (RAG) Quarter 1	Status (RAG) Quarter2	Status (RAG) Quarter 3	Status (RAG) Quarter 4
	Policies					
1	Update existing LCH policies due for expiry 2018-19	Louise Popple				
	Training					
2	Ensure compliance levels for IPC Mandatory training reaches 90% target	Liz Grogan				
3	Facilitate a one day IPC conference	Liz Grogam / Team				
4	Collaborative working to support AMR Agenda in GP economy	Liz Grogan / Team				
5	Develop and implement IPC Training for GP and Practice based Teams	Joanne Reynard				
6	Develop champion based training for GP practice staff	Joanne Reynard				
7	Review and refresh IPC mandatory training programme look too develop innovative ways to reduce travel	Liz Grogan				
8	Perform IPC training for social care staff at Enterprise House, discuss evaluations and maintain the contract	Team				
	IPC Performance and Quality Assurance					

9	Work collaboratively with CCG partners to facilitate surveillance and investigation process of Gram negative bacteraemia episodes in line with DH Mandatory requirements.Report monthly and input on DCS.	Liz Grogan / Louise Popple				
10	Standardise IPC assessment and assurance framework in Custody Suite areas and initiate self-assessment tool.	Danielle Dobson				
11	Assist clinical teams through the completion of IPC elements of Quality Challenge Plus and integrate into IPC Assurance Framework					
12	Undertake structured audit activity within GP practices as part of commissioned service	Team				
13	Undertake and Coordinate PLACE reviews of : Littlewood House Hall, Hannah House and CNRC	Dave Hall / Kirsty Taylor				
14	Produce an Annual Report and release it publically	Liz Grogan / Team				
15	Modify and refresh LCH Internal Audit Tool	Jeanette Wood				
16	Review and refresh Risk assessment process	Liz Grogan / Dave Hall				
17	Migration from Icnet to PPM+.	Liz Grogan				
18	Maintain partnership agreement with LCC	Liz Grogan				
19	On going development of EH and LCH the role of EH and CDC nurse role	Liz Grogan				

20	To review and continue ongoing contracting arrangements for the Care Home staff IPC training.	Liz Grogan				
	User engagement					
21	Coordinate staff influenza vaccine campaign 2018-19 achieving CQUINN target of 75% frontline uptake	Kirsty Taylor / Liz Grogan				
22	Foster engagement with cohort of membership with PLACE induction training session, to look to engage at developing connections with Health Watch with the PLACE process.	Dave Hall / Kirsty Taylor				
23	Undertake Hand Hygiene, Sepsis and AMR awareness Campaigns within LCH	Team				
24	Further develop FFP3 Mask Fit Testing programme for LCH in response to potential Pandemic Flu risks.	Dave Hall				
	Service Improvement					
25	Facilitate IPC Team Building Event	Liz Grogan				
26	Work with CCG partners to review IP performance and improve the wider community CDI review process	Liz Grogan				
27	Work with CCG partners and other stakeholders to review the MRSA decolonisation protocols	Liz Grogan				

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (69)

Version 4:23 July 2019

Topic	Frequency	Lead officer	24 May 2019	2 August 2019	4 October 2019	6 December 2019	7 February 2020	27 March 2020	27 May 2020
Preliminary business									
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X	X
Patient story	every meeting	EDN	X	X	X	X	X	X	X
Quality and delivery									
Chief Executive's report	every meeting	CE	X	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X	X
Perfomance Brief: annual report	Annual	EDFR	X						X
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X		X
Care Quality Commission inspection reports	as required	EMD							
Quality account	annual	EDN	X						X
Mortality report	annual	EMD					X		
Staff survey	annual	DW						X	
Safe staffing report	2 x year	EDN		X			X		
Seasonal resilience	annual	EDO			X CE's report				
Serious incidents report	4 x year	EDN	X	X		X	X		X
Patient experience: complaints and incidents report	2 x year (six monthly Dec annual August)	EDN	X Annual report			X Six monthly report			
Freedom to speak up report	2 x year	CE		X Annual report		X			
Guardian for safe working hours report	4 x year	EMD	X Annual report	X		X	X		X Annual report
Strategy and planning									
Organisational priorities position paper	3 x year	EDFR	x 2018-19 End of year report		X			X 2020-21	x 2019-20 End of year report
Service strategy	as required	EDFR			X Engagement strategy Estates strategy				
Quality strategy	annual	EDN					X		
Workforce Strategy	every meeting from May 2019	DW	X Leadership and skills	X Resourcing	X Wellbeing	X Diversity and inclusion	X Integration and Partnership	X Proactive Analytics	X
Research and development strategy	annual	EMD		X Verbal update	Deferred to December	X			
Governance									
Medical Director's report: doctors' revalidation	annual	EMD		X					X b/f prev August
Nurse and AHP revalidation	annual	EDN		X					
Well-led framework	as required	CS	X Self assess update	X CEs report		X Action plan			X Self assess update
Annual report	annual	EDFR	X						X
Annual accounts	annual	EDFR	X						X
Letter of representation (ISA 260)	annual	EDFR	X						X
Audit opinion	annual	EDFR	X						X
Audit Committee annual report (part of corporate governance report)	annual	CS	X						X
Standing orders/standing financial instructions review (part of corporate governance report)	annual	CS	X						X
Annual governance statement (part of corporate governance report)	annual	CS	X						X
Going concern statement (part of corporate governance report)	annual	EDFR						X	
NHS provider licence compliance	annual	CS	X						X
Committee terms of reference review	annual	CS	X						X
Board and sub-committee effectiveness	annual	CS	X						X
Register of sealings	annual	CS	X						X
Declarations of interest/fit and proper persons test (part of corporate governance report)	annual	CS						X	
Corporate governance update	as required	CS							
Reports									
Equality and diversity report	annual	DW				X			
Safeguarding annual report	annual	EDN			X				
Health and safety report - analysis of staff incidents and resultant actions	2 x year	EDFR				X			X
Infection prevention control annual report	annual	EDN			X				
Additional items									
West Yorkshire Mental Health Services Collaborative	as required	CE		X					
Leeds Health and Care Academy - Partner Board briefing	as required	CE							
Leeds Providers Integrated Care Collaborative - Committees in Common	as required	CE							
Leeds Community Healthcare/Leeds General Practice Confederation - Committees in Common	as required	CE							
CAMHS Tier 4 - Building	as required	EDFR							
Healthwatch review of patient engagement activity	as required	EDN							
HSCN Migration	as required	EDFR							
Proposed new lease for 4th floor Stockdale House	as required								
LIFT Under Lease Plus Agreements (ULPAs) from Community Health Partnerships (CHP)	as required	EDFR							
West Yorkshire and Harrogate Health and Care Partnership (Formerly STP)	as required	CE							

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

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AGENDA ITEM 2019-20 (70a)

Quality Committee
Monday 22 July 2019
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Neil Franklin	Trust Chair (Committee Chair)
	Helen Thomson	Non-Executive Director
	Thea Stein	Chief Executive
	Stephanie Lawrence	Executive Director of Nursing and Allied Health Professionals (AHPs)
In Attendance	Sam Prince	Executive Director of Operations
	Diane Allison	Company Secretary
	Maureen Drake	Assistant Director of AHPs, Patient Experience and Engagement
	Vanessa Hunt	Assistant General Manager for Children and Families (deputising for Helen Rowland)
	Suzanne Slater	Clinical Governance Manager
	Carolyn Nelson	Head of Medicines Management
	Rachel Lee	Quality Lead, Adult Business Unit (deputising for Caroline McNamara)
	Helen Knight	Clinical Head of Service for Neurology and SLT (deputising for Elaine Goodwin)
	Hannah Beal	CAMHS Clinical Lead
	Rachel Lee	Quality Lead, Adult Business Unit
	Caroline Schonrock	Business Planning Manager (Item 33e)
Observing	Julia Walker-Brown	Quality Manager, NHS Leeds Clinical Commissioning Group
	Helen Blenkinsop	Clinical Audit and Effectiveness Manager
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies	Professor Ian Lewis	Committee Chair
	Ruth Burnett	Executive Medical Director
	Caroline McNamara	Clinical Lead, Adult Services
	Helen Rowland	Clinical Lead for Children's Services
	Elaine Goodwin	Clinical Lead for Specialist Services

Item no	Discussion item	Actions
Welcome and introductions		
2019-20 (30a)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed everyone. The group introduced themselves. Apologies were received from the Committee Chair, Executive Medical Director, Clinical Lead for Adult Business Unit, Clinical Lead for Children's Services and Clinical Lead for Specialist Services.	
2019-20 (30b)	**Declarations of Interest** Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Committee members. The Committee Chair asked if there were any additional interests. There were no additional declarations of interest received.	

2019-20 (30c)	**Minutes of meeting held on 24 June 2019** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2019-20 (30d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. 2019-20 (5b) Coroner's report and transitions collaborative The action was tabled on the agenda and was agreed as complete. 2019-20 (13) Service spotlight review and committee effectiveness The action was tabled on the agenda and was agreed as complete. 2019-20 (26) (i) Performance brief and domain reports The action was tabled on the agenda and was agreed as complete. 2019-20 (26) (iii) Performance brief and domain reports The Company Secretary updated the Committee and explained that the run charts are included in the reports to show trends only. The action was agreed as closed.	
Service Spotlight		
2019/20 (31a)	**Service spotlight review** The Executive Director of Nursing and AHPs presented the paper and asked the Committee to approve the proposals, suggesting that the revised programme is trialled, beginning with the End of Life service in September 2019. The Chief Executive stated that the patient and family voice is important and should be included together with the evidence that the Trust is providing good clinical care. It was suggested that each presentation begins with a patient story. The Trust Chair expressed concerns that services would choose what they want to be included in the presentations and that it needed to be based on openness, and not be judgemental. The Assistant Director of AHPs, Patient Experience and Engagement stated that the proposal was to gather what is known across business units to form a briefing which will go out in the committee papers creating a quality spotlight conversation rather than a spotlight presentation. It was noted that any issues presented to the Committee would have been dealt with at an executive level prior to this. There was a discussion about the topic list and it was agreed that in order to provide assurance, the process for choosing the topics should be systematic. It was also agreed that the Committee would require a forward programme of topics. **Action:** Executive Director of Nursing and AHPs to discuss with Non-Executive Director (HT) and devise the proposed programme for the next six months. Programme to be presented to the Committee in September 2019. The Committee approved the paper with agreement that further work would be completed on oversight of the programme.	**Executive Director of Nursing and AHPs**

2019/20 (31b)	**Specialist Business Unit workshop format** The item was deferred.	
Key issues		
2019-20 (32a)	**Serious Incident update report (patient AY)** The Executive Director of Nursing and AHPs provided an update on the action plan which had been developed following the investigation into the suicide of a patient who had previously accessed the CAMHS service. 14 recommendations had been made, with involvement from family members of the deceased. The Committee was advised that 12 actions had been completed so far. The final two actions were due to be completed by 31 July 2019. The serious incident investigation process has also initiated further quality improvement around transition from child to adult mental health services. The Committee will receive a further update on progress with the action plan in September 2019. **Action:** Executive Director of Nursing and AHPs to provide the Committee with a further update on progress with the action plan in September 2019.	**Executive Director of Nursing and AHPs**
2019-20 (32b)	**Pressure ulcers investigation update** The Committee was presented with the findings of a review into the category 3 pressure ulcers reported in quarter one of 2019/20. It was noted that the Trust's tolerance for the year is to have no more than seven incidents, and there was a risk that this would not be achieved. The Committee noted that the data provided was inconsistent with other papers submitted to the Committee. Assurance was given that the information contained in the Performance Brief would be accurate in time for the Board meeting and an update on the true position of pressure ulcers would be provided to members and attendees by the close of business. The Committee discussed the factors identified as having contributed to the development of pressure ulcers. It was recognised that it was not due to staffs' lack of knowledge about the prevention of pressure ulcers, but more about how the knowledge was being applied – there was a lack of risk assessments and care planning, as well as not using EPR appropriately and some poor communication. An overarching issue was a lack of capacity within neighbourhood teams and it was recognised that teams needed to work differently. The Committee heard that lots of learning had taken place and that the Trust was in a better position, in terms of numbers of 'avoidable' pressure ulcers, than in some previous years. There was however a concern that, given the quarter one data, the situation may have begun to deteriorate. The Committee agreed that scrutiny of pressure ulcers should be delegated to one group (PSEGG) within the organisation, as currently monitoring was taking place in three separate groups. An action plan for the reduction in pressure ulcers is to be presented at the September 2019 Committee meeting. **Action:** Executive Director of Nursing and AHPs to present the action plan for the reduction in pressure ulcers at the Committee meeting in September 2019. The Committee agreed that progress would be reviewed in January 2020, including benchmarking on performance. **Action:** Executive Director of Nursing and AHPs to provide an update on the progress of achieving the Trust's reduction target in avoidable category 3 pressure ulcers in January 2020.	**Executive Director of Nursing and AHPs** **Executive Director of Nursing and AHPs**

2019-20 (32c)	**Matters to escalate from subgroups** Refer to item 35.	
Quality governance and safety		
2019-20 (33a)	**Performance brief and domain reports** The Committee acknowledged that the updated version of the Performance brief would be presented to the Board. *Safe & Caring* The improvement to 97.37% of community patients who responded who would recommend the service to family and friends was noted. Of inpatients, 100% or respondents would recommend. Changes to the Friends and Family Test (FFT) will be formally announced in September 2019. *Responsive* It was noted that although the IAPT targets remain challenging, the new contract would provide a more comprehensive service, addressing the current waiting list challenges. In the meantime, the Committee heard that the service continued to work with commissioners on a waiting list initiative. *Effective* The Trust Chair referred to clinical outcome measures and asked if there was a timescale for improvement. The Committee heard that the Project Manager would be joining the Trust in August 2019. Once the project team was in post, it was expected that the figures would significantly improve and would be within target by March 2020. A Non-Executive Director (HT) asked about the number of overdue incidents and was advised that these were mainly Adult Business Unit incidents and that the Quality Lead for ABU had a firm grip on this, therefore there was confidence that the situation would improve. The Assistant Director of AHPs, Patient Experience and Engagement referred to the appendices which proposed a different way of presenting the narrative for the Safe and Caring domains and asked for comments from the Committee. There was concern that the highlight reports needed to answer the "so what" question. It was felt that the narrative should be included at the beginning of the performance brief. It was agreed that the report would be revised and included in the Performance Brief for September 2019. **Action:** Assistant Director of AHPs, Patient Experience and Engagement and Clinical Governance Manager to revise the Safe and Caring highlight reports and add to the Performance Brief for September 2019.	**Assistant Director of AHPs, Patient Experience and Engagement / Clinical Governance Manager**
2019-20 (33b)	**Clinical governance report** The Executive Director of Nursing and AHPs highlighted the following: *Duty of Candour* A review of the Duty of Candour process is currently taking place with the findings to be discussed at the July PSEGG meeting. An update will be presented to the Committee in September 2019. *National updates* The Committee heard that the new Serious Incident Framework is due for release in July 2019. The CCG have been approached by NHS England to take part in the pilot study of implementing the framework. The Clinical Governance team will look at how the Trust can support the pilot study and Trust services with the revised framework.	

	Clinical Lead report updates The Clinical Lead reports for each business unit were restructured to be in line with the CQC well-led framework key line of enquiry. The Committee was provided with a review of each business unit under the headings: Leadership, Vision and Strategy, Culture, Governance, Risks and Performance, Information Processes, Stakeholder Engagement, Learning and Improvement. The ABU highlighted the increased challenge for their leadership team to maintain business as usual whilst enabling the developing volume of work streams relating to integration. SBU and CBU both raised concerns about the reliability of workforce information (ESR).	
2019-20 (33c)	**Risk register** The Company Secretary highlighted that there were five new risks, one risk with an increased score and two risks with a decreased score. It was noted that no risks have been closed since the previous report. The Company Secretary drew the Committee's attention to the following risks: • Risk 973: No access to immediate life support refresher training for staff at Little Woodhouse Hall • Risk 978: Provision of post Selective Dorsal Rhizotomy (SDR) physiotherapy in the Community • Risk 980: Capacity within Trust's Operational Recruitment service • Risk 981: Application of constant supervision at WYOI **Outcome:** The Committee noted the risks and the recent revisions made to the risk register.	
2019-20 (33d)	**Draft Quality improvement (QI) strategy** The Executive Director of Operations presented the strategy and highlighted the current objectives: • We can all Make Stuff Better – Develop and embed continuous quality improvement which engages staff and service users to undertake small or large scale change. • Enabling and supporting all staff to Make Stuff Better – Provide tools, training and resources to staff and other teams that help them improve their area of work. • Recognising good stuff happens and sharing our learning – Enable all staff and service users to access QI tools, QI team members and shared learning and improvement stories. **Outcome:** The Committee recommended approval of the strategy to the Board.	
2019-20 (33e)	**Organisational and Quality Account Priority report** The Committee was advised that good progress was being made with the Organisational and Quality Account Priorities. One priority was not forecasting being on track to be completed by year-end; this was Priority 12, concerning the development of an innovative and viable model for the new CAMHS Tier 4 Service within the previously agreed time-frame as it was not anticipated that NHSE/I would be in a position to approve the full business case by the end of quarter three.	
2019-20 (33f)	**Quality challenge** The Clinical Audit and Effectiveness Manager presented an end of year report on the Quality Challenge+ programme 2018/19. The Committee heard that a	

	number of planned visits had been cancelled during the year. Some of these had been successfully rearranged. It was noted that the Quality Challenge+ programme had been reviewed and the learning utilised to ensure that improvements were made to the programme for 2019/20. The Committee was advised that there was now more staff signed up to conduct the quality walks than in the previous year, and that a reasonable number of walks had taken place in quarter one 2019/20. The Committee was also advised that feedback from staff was that, despite initial anxieties about the programme, generally, staff found it a helpful process which enabled them to improve and it was becoming less onerous as the pro-forma had been revised and simplified. In response to a query about NEDs participating in quality walks, the Committee heard that a number of NEDs had already completed these and it was agreed that this should be encouraged and built into the programme. **Action:** Clinical Governance Manager to share the quarterly programme of Quality Challenge with NEDs and invite them to take part in the programme. **Outcome:** The Committee approved the recommendations with a view to monitoring.	**Clinical Governance Manager**
2019-20 (33g)	**Guardian for safe working hours** The Head of Medicines Management presented the report which provided a quarter one update. The Committee learned that work had been conducted since the last report to ensure an accurate database was held centrally of doctors and dentists on training placements within the Trust. No issues had been identified in the last quarter via exception reporting or the junior doctors' forum and work was continuing to facilitate improved engagement with trainees across all specialties. The Committee was assured that trainee doctors and dentists were working safely and in a manner compliant with the 2016 Junior Doctors' contract. **Outcome:** The Committee approved the report and submission to the Board.	
2019-20 (33h)	**Board members service visits** The Committee noted the report.	
2019-20 (33i)	**Medical Director's annual report** The Head of Medicines Management presented the Medical Director's annual report and highlighted the main issues for consideration. Additional information in support of the submission was tabled at the meeting. It was noted that both papers would be combined for the August Board report and in addition, there would be a list of planned actions for 2019/20 for the Board to consider. **Outcome:** The Committee recommended that the Board approved the statement of compliance.	
Clinical effectiveness		
2019-20 (34a)	**Clinical audit (retrospective review)** The Committee received a progress report on the (rolling) Clinical Audit Programme 2018/19. The report provided details of clinical audits undertaken	

	and reasons for any audits that were cancelled. The report provided thematic information about learning and improvements made. Examples of this were improved working methods, tighter control of documentation, and increased training. The Committee was keen for clinical audit to follow the established Quality Improvement methodology and was advised the Clinical Effectiveness Group (CEG) was to examine the learning from clinical audit and to incorporate Quality Improvement.	
2019-20 (34b)	**Patient group directions (PGDs)** The Committee was asked to ratify three PGDs. It was confirmed that the PGDs had been through the correct processes and were recommended for ratification. **Outcome:** The Committee ratified the three approved PGDs.	
2019-20 (34c)	**Research and development strategy implementation plan – verbal update** The Head of Medicines Management gave an update on the implementation plan. It was noted that work on patient engagement and involvement had been linked with the Patient Engagement team to ensure that research is part of their work with patient engagement. The Committee also heard that Professor Rory O'Connor, University of Leeds has agreed to be the academic link to higher education connections. It was noted that the plan was progressing, with the next iteration due to be presented to the Committee in September 2019. The Committee noted the update.	
2019-20 (34d)	**Internal audit reports: Risk Management** The Company Secretary advised the Committee that the Risk Management internal audit had been completed and had received reasonable assurance. The Committee was asked to note in particular, recommendation one, which applied to the Trust's governance processes and included an action for committees and other groups to ensure that the risk management process was utilised when risks were identified in meetings.	
Sub group minutes		
2019-20 (35a)	**Patient Safety and Experience Group** The Committee noted the minutes.	
2019-20 (35b)	**Safeguarding Children's and Adults Group** The Committee noted the minutes and the following items for escalation: • A request for the Trust to consider the IT support required for voiceover presentations to assist with training and the costs involved. The Executive Director of Operations stated that it would be beneficial to escalate the issue to the Senior Management Team (SMT) in the first instance. The Committee concurred. • To note the revision of performance data reviewed at Safeguarding Committee meetings to be more relevant to safeguarding concerns live within the organisation. • Department of Health notice - Deprivation of Liberty Safeguards (DoLS)	

	replacement bill approved by Parliament with Liberty Protection Safeguards due to come into force in on 1 October 2020.	
2019-20 (35c)	**Mental Health Act governance group 15/03/19 and 21/06/19** The Committee noted the minutes.	
Quality Committee work plan		
2019-20 (36a)	**Items from work plan not on agenda:** • Clinical Effectiveness Group: 26/06/2019 – No minutes to be received as this was a workshop • Mortality Surveillance Group: 11/06/2019 Meeting cancelled to bring reporting schedule in line. Next meeting will be on 13 August 2019.	
2019-20 (36b)	**Work plan** The Company Secretary asked the Committee to note that there would be a number of annual reports to be presented at the next meeting in September 2019.	
2019-20 (37)	**Matters for the Board and other committees including assurance levels** It was agreed that the Committee Chair would provide an update to the Board at the next meeting on the following: *Recommended for Board approval:* • Draft Quality Improvement Strategy • Medical Director's annual report (revalidation) *Assurance levels:* • Pressure ulcers investigation update: **Limited** • Specifics in Performance brief and domain reports and Clinical governance report : **Reasonable** • Organisational and Quality Account priority report Q1: **Reasonable** • Quality challenge 2018/19 report: **Reasonable** • Guardian for safe working hours: **Reasonable** • Clinical audit (retrospective review): **Reasonable**	
2019-20 (38)	**Reflections on meeting** The Committee Chair thanked the group for attending and commented that he was pleased with the contributions from the deputies for the Clinical Leads.	
2019-20 (39)	**Any other business** There was no further business.	
	Dates and times of future meetings (09:30 – 12:30) 23 September 2019 21 October 2019 25 November 2019	

Leeds Community Healthcare NHS Trust

Agenda Item 2019/20 (70c)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 24 July 2019 (9.00 am to 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director
	Richard Gladman	Non-Executive Director (RG)
	Helen Thomson	Non-Executive Director (HT)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Laura Smith	Director of Workforce
	Diane Allison	Company Secretary
	Donna Ryan	Head of Service CAMHS (in attendance for item 27 only)
	Andrew Llewellyn	System Administrator (in attendance for item 27 only)
	Penny Netherwood	Consultant Clinical Psychologist (for item 27 only)
	Sara Clarke	Service Manager (in attendance for item 27 only)
	Helen Rowland	Clinical Lead; Children's and Families Services (for item 27)
	Cherrine Hawkins	Deputy Director of Finance (in attendance for item 30b only)
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2019/20 **(26)**	**Welcome and introductions** The Committee Chair welcomed the new Non-Executive Director, Helen Thomson (HT) to the meeting. Following discussion at the June 2019 meeting, the Chief Executive provided an update on the work which was underway with GP Confederation regarding primary care network (PCN) recruitment and contracts. The workforce offer to PCN staff was starting with community pharmacy. The Director of Workforce (LS) said that there were quite a lot of workforce and employment complexities to agree. The Committee noted that about seven PCN staff had expressed an interest. The Chief Executive said that there would be a point when the Trust would have to make a decision about the risk appetite based on the terms of the service level agreement. A development session between the Trust, GP Confederation and general practitioners was to be held on 30 July 2019 for developing an outline expectation; looking at the under arching structure. The Chief Executive said that her aim was to achieve the ability to create a new clinical model that would provide better outcomes. A letter was expected from Leeds Clinical Commissioning Group (CCG) setting out explicit ways of working closely together. The Committee Chair thanked the Chief Executive for her helpful update	

	regarding the employment offer and the ongoing work with the Confederation. **a) Apologies**: None recorded. **b) Declarations of Interest** Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Committee members. No additional potential conflict of interest regarding the meeting's agenda were raised. **c) Minutes of last meeting** The public and private minutes of the meeting dated 26 June 2019 were noted for accuracy and approved by the Committee. **d) Matters arising from the minutes and review of action log** The Committee reviewed the action log and no comments were noted.	
2019/20 **(27)**	**Service support session** (presentation) **Child & Adolescent Mental Health Service (CAMHS) waiting times update** The Committee Chair welcomed representatives from the CAMHS service to present details of the service's performance and progress against waiting times targets. The presentation covered demand for CAMHS, the current position in MindMate single point of access triage service (SPA), crisis team development and increase in urgent and emergency referrals, community CAMHS including neurodevelopmental waits and successes, challenges and possible resolutions. The Committee was advised that currently the turnaround rate for referrals was four weeks, (the target is two weeks). There was a recovery plan in place to remedy this and the team was committed to driving down waiting times. A service review was underway and the Commissioner was providing financial support. Data provided showed that autism referrals had almost doubled between 2017/18 and 2018/19. CAMHS emergency referrals had increased significantly in 2018/19, compared to the previous year, however, commendably, the 4 hour response rates continued to be met. The Committee heard about the focus on, having a more 'home-grown' workforce, including developing bands 3/4 staff for more senior roles. The Committee discussed the challenges the service was experiencing in relation to this, and offered support. The Committee Chair said he understood the complexity of the different and improved ways of delivering the business and ways of streamlining to better effect. Throughout the presentation he took a degree of assurance of the next steps, some of those looked deliverable and some would make a clear difference in terms of getting to a position of contractual compliance. He also recognised the overriding sense of care for quality for young children and the importance of that. A Non-Executive Director (RG) noted that the Trust was comparatively doing well nationally and asked if there was anything that the service could learn from other similar organisations, working in different ways that could be usable by	

	the Trust. The Head of CAMHS Service said that she was in regular contact with Manchester and Sheffield CAMHS Services who use similar models. The difference for the Trust was the development of the crisis team, when running to full capacity should make a significant improvement to internal and external waits. The Committee recognised the pressure on CAMHS staff could have an effect on their morale and their sense of wellbeing. The Chief Executive said that she was aware that significant work was underway to bring people together as a team. She was expecting the workload pressure being one of the challenges and staff needed to be supported. The Committee Chair concluded the discussion to say that the Committee recognised the progress made in a number of different aspects of working and with different ways of aligning processes and judgements about the risks and issues around the CAMHS business. **Action:** The Committee asked for a further update at a future meeting. The Executive Director of Operations was invited to set the timing for that with the service. **Outcome:** The Committee noted the pressure the service was under, particularly in the support and training and development side. Other models operated in other organisations were being considered.	**SP**
2019/20 **(28)**	**Business development** **Operational plan priorities** (quarterly update) The Committee received an overview of the progress at the end of the first quarter towards achieving the Trust priorities set out in the 2019/20 operational plan and a forecast for the year-end. Of the fifteen priorities, at the end of quarter one, three priorities were not currently on track, though only one priority was forecast not to be achieved at year-end. This was Priority 12: develop an innovative and viable model for the new CAMHS Tier 4 service to the agreed time-frame. The Committee was advised that the business case was unlikely to be approved by the end of quarter three and the strength of the business case would affect the approval time. The Committee approved the proposal to replace the current success measurement with a single measure: that NHS Employers and NHS Improvement approve the full business case before the 31 March 2020. The Committee heard that the final business case would be received by the Business Committee before submission; approval time was between three to six months, dependent on planning permission (which was expected in September 2019). **Action:** The operational plan to come back to the Committee in three months' time (October 2019). **Outcome:** The Committee noted the assessment of progress at the end of quarter one and the forecast for the year-end. The Committee approved the request to replace the success measure for priority 12 as outlined in the report.	**BM**

2019/20 **(29)**	**Project management** **a) Productivity group update** A first meeting of the revised productivity group had been scheduled for 6 August 2019. The Committee will receive a written paper at its next meeting in September 2019. The Executive Director of Finance & Resources said that he had secured access to the 'model hospital' being promoted nationally for community services. **Action:** The Committee was to receive an update at its next meeting in September 2019 on the progress of the productivity group. **Outcome:** In the absence of a group, the Committee continued to receive examples of activities and ways of working to make pieces of the business more productive. **b) Projects report update** (change board) The Committee was provided with an update on the Trust's key projects, including a flash report indicating key milestones achieved since the last update, and where there had been, or expected to be delays. The Executive Director of Operations said that the Integrated Service for Children with Additional Needs (ICAN) transformation programme had now mobilised. The first of the four planning workshops had taken place on 22 July 2019 which focused on entry criteria and triage processes, which brought together clinicians and managers and change experts to look at what is 'to be' ideas for ICAN. There were no issues identified for escalation to Business Committee. The Committee Chair queried the delays indicated in 'red' on the change board flash report. The Executive Director of Operations said that the main issue was around the administration review getting behind on original timeframe. A business case was due at the senior management team (SMT) meeting in August 2019 to put work in motion. Whilst the milestones for the estates project had been delayed, the Committee was advised that once the strategy was agreed and approved, this would ensure that project gathered momentum. A draft estates strategy was due in September 2019. A Non-Executive Director (RG) said that he understood that NHS Improvement had set a deadline that all NHS Trusts must implement an e-rostering system by end of March 2021 and asked about the e-rostering policy being in place to set the ground rules. **Action:** The Director of Workforce (LS) to check about the e-rostering policy with the e-rostering Project Manager. **Outcome:** The Business Committee received the report. No issues had been escalated for consideration by the Committee. **c) CAMHS T4 update** The engagement event on 16 July 2019 with the local community had gone well. The Executive Director of Finance & Resources said that he met with the Chair of Health and Wellbeing Board and there was a great deal of positivity for	**BM** **LS**

	the service enhancement offer. No other comments were noted. **d) Estate strategy** (progress update) The Executive Director of Finance & Resources said that following the consideration of the initial draft estate strategy at the last Committee meeting in July 2019, this version now reflected on the comments that the Committee Chair subsequently provided following his meeting with the estate project team. A high level conclusion from the meeting was that the strategy did not promote the aim of the vision and positivity around the core strategy. The implementation plan chapter had been removed. The Chief Executive said that the City Council had declared a climate emergency and any climate issues regarding estates should be considered. **Action:** A revised estate strategy to be received by the Committee in September 2019 before final submission to the Trust Board. **Outcome:** The Committee noted the update, taking into account a number of issues that had been shared and a desire to become more efficient to deliver high quality care in a modern environment. **e) Business development strategy update** The Committee was advised of two very recent successful bids: Leeds Mental Wellbeing Service (LMWS) and the Community Chronic Pain Service. The LMWS was going live on 1 November 2019. The Committee also received updates on recently mobilised services and discussed current trends regarding tendering. The position for the Trust was very positive. The Executive Director of Operations reported that there was a slight delay to the mobilisations of Humberside Liaison and Diversion and Specialist Weight Management Tier 3 services. This was due to a number of people progressing through transfer of undertakings - protection of employment (TUPE). 0-19 Public Health Integrated Nursing Service (PHINS) had met all the first quarter key performance indicators. Extensive work was being undertaken with Local Care Partnership, PCNs and with Population Health Management pilots as part of integration work with primary care. An update by the Chief Executive had been provided earlier in the meeting. The new Community Dental Service had gone live on 1 October 2018. The Trust was continuing with work to reduce the estate footprint to realise efficiencies that will fund new elements of the new service. The Executive Director of Operations said that the Community Dental Service had been through the Scrutiny Board and five focus groups had been established. The service was looking at maximising use of limited estate rather than providing limited services over a large estate. **Outcome:** The Business Committee noted the positive progress against the business development strategy priorities. **f) Workforce strategy: progress and delivery** (Resourcing) The Committee was provided with an update on the delivery of the Workforce	**BM**

	Strategy, focussing on the resourcing priority, which was one of the six workforce strategy priorities. The key messages were that retention rates had consistently improved and remained well within target over the last couple of months. The recruitment team had been nominated for a Nursing Times Award for Best Recruitment Experience. The e-rostering project successfully completed its pilot phase and had entered into implementation phase. However, the current challenges were regarding operational recruitment, due to high staff turnover and absence levels in the recruitment team, which led to a requirement for a recovery plan being put in place. The overall rating for the resourcing priority had been rated as amber at quarter one. There was a commitment that the situation would be stable by the end of quarter two and revert back to green. **Outcome:** The Committee noted the progress made with resourcing in the last six months and the operational recruitment challenges which are currently subject to a recovery plan.	
2019/20 **(30)**	**Performance management** **a) Performance brief and domain reports + waiting list report** The Committee reviewed the June 2019 performance data. The Committee discussed staff incidents and recognised a need to improve flow of information and assurance regarding staff health and wellbeing from 'floor to Board'. The Committee asked for themes of long term absence, which was absence over 21 days, to be brought to a future Committee meeting. Overall, the well-led section of the performance brief provided the Committee with reasonable assurance. The Executive Director of Finance & Resources said that the first three domains (safe, caring and effective) were reviewed by the Quality Committee meeting on 22 July 2019. A deeper review of avoidable pressure ulcers was ongoing within the adult business unit to identify root cause. The Committee Chair commented on the reporting of 44 staff incidents in the month. The Executive Director of Finance & Resources said that more focus was needed. He added that detailed discussions take place at sub-groups but do not flow through to the Trust Board. He said an annual report to the Audit Committee provides an opportunity for Board members to receive assurance about the security management arrangements in the Trust including staff safety support. There should be a more regular way of flagging up incidents against staff, through the performance pack. **Action:** The Executive Director of Finance & Resources offered to review the reporting of staff incidents, how to minimise and mitigate through the Health and Safety group and to see if there was a connection with staff sickness levels. **Outcome:** The Committee note present levels of performance for the month of June 2019. **Responsive** The Executive Director of Operations reported that the IAPT targets remained challenging. The Trust (with its partners) had been awarded the new contract	**BM**

	to provide Mental Wellbeing Services from 1 November 2019. The Committee was keen to learn whether the new model would deliver the targets. It heard that the service had tasked itself to improve these prior to the commencement of the new service. The new contract will provide a more comprehensive service and will address the current waiting list challenges. In the meantime the service continues to work with Commissioners on a waiting list initiative. **Well Led** The Director of Workforce (LS) said that the staff turnover remained low, standing at 13.1%. The Committee queried the 'Executive Team' turnover rates in the performance brief and was provided with brief details of the individuals concerned. The Committee agreed that 'Executive Team' needed clearer defining. Sickness absence remained below target and well within tolerance. The appraisal compliance rates had improved again this month; particularly in the corporate directorate. It was noted that statutory & mandatory training rates had dropped slightly, standing at 93.8% from last month's 94.4%. A Non-Executive Director (RG) asked whether there was any cause for concern regarding staff leaving within first twelve months of employment. The Director of Workforce (LS) advised the Committee that there were a number of people who are promoted within first twelve months but not leaving. The Chief Executive said that she was concerned with people leaving the organisation but not with those moving to another part of the organisation, and asked if this could be clearly identified. The Committee Chair noted that the ICAN waiting issue still remained a concern. Whilst the Trust comfortably meets the targets, performance was on a downward trajectory. Action continues and the Committee will be kept informed regularly. The Executive Director of Operations said that the main area of concern was with the ICAN service. Extensive work within the ICAN transformation project was underway. Commissioners were aware and have provided additional funding for a waiting list initiative to reduce the backlog before the new pathway was put in place. **b) Quarterly finance report** (presentation) The Committee welcomed the Deputy Director of Finance to the meeting to assist with presenting the finance item to the Committee. The Committee received two presentations from the Executive Director of Finance and Resources. The first presentation introduced the in depth consideration of the Trust's finances in quarter one covering income and expenditure. Whilst this year's CIPs were broadly being delivered, the Committee agreed that there needed to be renewed and sustained focus on productivity. The Committee noted that the Children's business unit financial position was causing most concern with their overspending primarily due to the costs of medical locums. A plan for reducing dependency on locums was in place, the financial impact of which was built into the business unit's year end forecast. The children's business unit believe that once the medical position is filled they would be in the same position as the other business unit and in balance with budget. The Committee discussed whether the financial position, noting particularly the assumptions the Executive Director of Finance and Resources was making, presented a risk to service delivery or quality. The discussion concluded that	**LS**

	any risk was not caused by the financial position but the availability of staff. The Executive Director of Finance and Resources proposed how the anticipated public health-pay award funding and the contribution from the successful Leeds Mental Wellbeing Service tender would be applied to budgets. The Committee supported the proposal which was also included in the finance section of the performance brief. The Executive Director of Finance and Resources explained the work done across the West Yorkshire and Harrogate Integrated Care Services to meet a 21% shortfall in capital funding. He said the Trust had agreed, subject to Board approval, a 15% in year reduction with a commensurate increase in 2020/21. He said that the deferment of capital spending did not unduly concern him; all expected high priority needs could be met. The second presentation introduced the principles of the 'Utilisation of Resources: assessment framework"', which the Care Quality Commission (CQC) used to assess acute trusts. The Executive Director of Finance and Resources explained that many of the metrics used for the assessment in acute trusts did not apply in community services. Where the assessment key lines of enquiry did apply he provided a personal and high level assessment of how the Trust may be rated. The Committee thought that the framework did provide scope for more in depth discussions and it was agreed that this would be done with members outside of the meeting after the SMT meeting had considered it further. The Executive Director of Finance and Resources informed the Committee that his judgement was that the Trust would meet its control total. Further to the conversation earlier about the increased level of recruitment, the Executive Director of Finance & Resources said that there was a reduced level of vacancies compared to last year factored into this, and that he was concerned about how that increased level of recruitment was translating into the financial position. The second part of the presentation covered the evidence to demonstrate CQC key lines of enquiry. The Committee Chair suggested meeting outside the meeting to review the questions in more detail. In the meantime the Executive Director of Finance & Resources said he would circulate the criteria and the requirements set out to the Committee members and the executive team. It was agreed that a monthly update on the financial position would be provided over the next few months. The Committee Chair said he would review the criteria to focus on a particular point during the quarterly finance reporting. **Action:** The Executive Director of Finance & Resources to circulate the criteria and the requirements set out to the Committee members and the executive team. **Outcome:** The Committee received a quarterly finance update. **c) Quarterly workforce report** The Committee was advised that during quarter one, the continuation of a sustained reduction in the number of formal HR cases had become statistically significant with the "normal" number of formal cases now >50% lower than it was previously, with managers feeling empowered to use the principles of 'people before process'.	**BM**

The appraisal rate had shown slow but steady improvement during quarter one. The Director of Workforce (LS) said that this remained an area of focus, as performance remained short of the 95% appraisal compliance target. The Committee Chair was concerned about whether there was a way to make judgement on how effective the appraisals were completed. He asked whether there was a fair feedback to staff on performance, development and motivating staff for another twelve months.

There had been a 20% increase in the number of vacancies advertised during the past two quarters. The Director of Workforce (LS) said other than resourcing priority already discussed the Trust was on track for all the priorities in the workforce strategy at end of quarter one. The Trust had been shortlisted for a Nursing Times award for its innovative approach to recruiting newly qualified nurses.

The NHS Interim People Plan had been published in June 2019 and many of its themes were aligned to the Trust's Workforce Strategy. The substantive People Plan was due before the end of this calendar year; and the associated national workforce engagement programme. The NHS Interim People Plan was being discussed at the next Trust Board meeting on 2 August 2019.

Outcome:
The Committee received a quarterly report providing the Committee with an update on the progress made on the delivery of the priorities.

d) Workforce Disability Equality Standard (WDES) action plan
The WDES was considered by SMT in June 2019 and at the Trust Board Development workshop on 2 July 2019. The Committee was asked to review and agree governance arrangements for the performance management of the WDES action plan.

The Director of Workforce (LS) said that she was seeking approval of the Committee in respond to comments made at the Trust Board workshop whether it was sensible for WDES action plan to mirror closely to WRES action plan. Nationally WDES and WRES mirror each other and the expectations were very similar. The Director of Workforce (LS) said that the first network group was due to meet in August 2019. Another change to note in the action plan was around reverse mentoring scheme.

The Director of Workforce (LS) said that the governance for WRES was being monitored through the Business Committee incorporated in the workforce quarterly report. She said if the Committee agreed, she could do the same for WDES. The Committee Chair agreed that it would make sense to keep it as one document rather than creating another one.

The Committee Chair expressed a clear reservation that the WDES approach was almost identical to the WRES program. The issues were different – and the differences should be respected. The disability group should be encouraged to develop their own approach.

The Trust WDES action plan was being presented for approval to the Trust Board meeting on 2 August 2019. The Committee Chair said that any further comments by the Committee members would be welcomed before Friday 26 July 2019.

Outcome:
The Committee confirmed the governance arrangements for the performance

	management of the WDES action plan. **e) Operational and non-clinical risks register** The Committee considered changes to the non-clinical risks on the risk register as follows: • No extreme risks (scoring 15 or more). • Three new risks • No risks had an increased score • No risks had a decreased score • One risk had been closed since the previous report **Action:** The Company Secretary said that following a recent meeting about the board assurance framework with the Committee Chair's, any suggested changes to the risks assigned to the Business Committee were to be further considered at the September 2019 meeting. **Action:** The Executive Director of Operations proposed changes to the description of risk 979: Resourcing for the 0 - 19 services, which would be reviewed outside the meeting by the Director of Workforce. **Outcome:** The Committee noted the recent revisions made to the risk register **f) Internal audit report: Review of Risk Management** This paper covered the completed audit from the 2019/20 plan and the audit opinion related to risk management. The Committee noted the audit concluded a reasonable assurance opinion before submission to the Audit Committee. The Company Secretary said that the Committee should, in particular, note recommendation one, which applies to the Trust's governance processes. It challenged some of the ways the Committee deals with risk management process. There were areas where risks should be considered even if the risk was not on the risk register. It was to ensure there was a process of assessing the risk and determining the action, and or deciding whether a follow up was required. The Committee Chair said that at the end of each meeting he would be happy to review the agenda to satisfy risk levels. **Outcome:** The Committee noted the completed audit and recommended it to the Audit Committee.	**DA** **LS** **BC**
2019/20 **(31)**	**Minutes to note** **Contract Management Board minutes (26.02.19)** The Committee received the Contract Management Board minutes of meeting dated 26 February 2019.	
2019/20 **(32)**	**Business Committee work plan** The work plan was reviewed by the Committee members and no changes were requested.	

	Outcome: The Committee agreed the work plan.	
2019/20 **(33)**	**Matters for the Board and other Committees** • CAMHS service support session • Operational plan • Business Development strategy • Productivity group update • Projects report • Workforce strategy • Performance brief and domain reports • Finance report • Quarterly workforce report	
2019/20 **(34)**	**Any other business** None discussed.	

NHS
Leeds Community Healthcare
NHS Trust

Agenda item 2019-20 (70c)

Audit Committee

Room 1, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
Wednesday 22 May 2019
8.30am–10.00am

Present:	Jane Madeley (JM)	Chair
	Professor Ian Lewis (IL)	Non-Executive Director
	Richard Gladman (RG)	Non-Executive Director
In Attendance	Bryan Machin	Executive Director of Finance and Resources
	Cherrine Hawkins	Deputy Director of Finance and Resources
	Diane Allison	Company Secretary
	Matthew Moore	External Audit Manager (KPMG)
	Clare Partridge	External Audit Partner(KPMG)
	Tim Norris	Internal Audit Manager (TIAA Limited)
	Thea Stein	Chief Executive
Apologies:	Peter Harrison	Head of Internal Audit (TIAA Limited)
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
	Presentation from the Chief Executive The Chair welcomed members and attendees, particularly the Chief Executive who was attending to give her perspective on the Trust's activities and finances for the previous financial year. In introducing her presentation, the Chief Executive focused on the strategic goals set at the beginning of 2018/19 and reflected on the key achievements: **Recruit and retain high quality staff** • Recruitment continues to improve including for hard to recruit groups and retention rates were well above the national average • A happy and engaged workforce is directly linked to the provision of good patient outcomes and the Trust is committed to supporting the health and wellbeing of its staff teams. During the year a significant amount of work had been done to enhance the support to staff including creating the best environment possible to support mental wellbeing and supporting the development of leaders to make sure every individual experiences good or excellent leadership. • The NHS National Staff Survey Results for 2018 were positive. 46 of the 66 questions had positive changes from 2017. • Progress on creating an organisation that supports diversity and inclusion. In March 2019 the Trust held a 'Race for Equality event' aimed at increasing leaders and managers understanding of the Workforce Race Equality Standard and to increase awareness of the issues facing BAME colleagues.	

	Provide high quality services • Services have continued to grow and develop with the Trust delivering more care to more people in the community. From April 2018 to March 2019 the Trust delivered 1.5 million episodes of care to people across Leeds – with the aim of providing high quality patient care. • The Trust assessed the quality of care by using the same questions as the Care Quality Commission (CQC) uses in its inspections: by making judgements about whether services are Safe, Caring, Responsive, Effective and Well-Led. • Quality improvement programmes undertaken during the year helped to improve both patient outcomes and staff experience. **Work with health and social care partners to deliver joined up care close to home** • Work continues with partners across the city by bringing together collective expertise to provide the best possible care for all the citizens of Leeds. **Services are fit for purpose and close to home** • There were excellent examples of how the Trust was working to achieve this across all three service areas; Children and Families, Adult and Specialist. • Adult services developments for 2018/19 included Self-Management/Self Care with a focus on 'working with' rather than 'doing to' people. In the context of sustainability the Chief Executive said that Trust had met all its financial duties in 2018/19 and business and commercial developments would be actively managed during 2019/20. The Chair of the Committee thanked the Chief Executive for her presentation and asked the members for their comments or questions. Both internal and external auditors indicated that the Chief Executive's presentation and the contents of the annual report showed a consistent picture with their own findings and observations of the Trust. ***The Chief Executive left the meeting.***	
2019-20 (16a)	**Apologies** Apologies were received from Peter Harrison, Head of Internal Audit TIAA Limited.	
2019-20 **(16b)**	**Declarations of interest** There were no declarations of interest in any items on the Agenda.	
2019-20 (16c)	**Minutes of the previous meeting 26 April 2019** The minutes of the meeting held on 26 April 2019 were reviewed and agreed as an accurate record subject to the following amendment: *2019-20 item (1a): Apologies were received and accepted from Matthew Moore, External Audit Manager.* The Committee members had met informally to review the draft annual report and accounts in detail on Friday 10 May 2019; no minutes had been taken of this meeting.	
2019-20 (16c)	**Actions' log** The Chair asked for verbal updates on two completed (blue) actions: • *Health Centres - Establishment* Reviews: The Executive Director of Finance and Resources reported that the Health and Safety Group had met on 21	

	May 2019 and discussed what building management arrangements could be put in place to notify other occupants of significant risks which were identified in shared buildings. • *Internal audit strategy and annual plan 2019/20:* the Internal Audit Manager confirmed that he had reviewed and re-scheduled the audits across quarter 2 and 3. The completion of actions from previous meetings was noted. There were no other matters arising from the minutes.	
2019-20 17(a)	**Internal audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and advised that since the Committee's last formal meeting on 26 April 2019, the one remaining audit for 2018-19 for the Well-Led Framework had been completed and the final report issued. The audit indicated a reasonable assurance opinion and the Committee discussed the executive summary and management action plan for the one important recommendation contained in the report which related to the Trust ensuring there will be a process of continuous review of the Well-Led Framework. The Chair of the Committee asked for a copy of the full report to be circulated to members of the Committee. **Action:** The Internal Audit Manager to circulate a full copy of the report to members of the Committee. The Chair of the Committee suggested that the Trust Board should receive an update on the Well-Led Framework every six months. **Action:** The Company Secretary to review the Board Workplan and consider the frequency of reports on the Well-Led Framework. **Outcome:** The Committee noted the contents of the summary internal controls assurance report, including the conclusion of the internal audit plan for 2018-19.	**Internal Audit Manager** **Company Secretary**
2019-20 (18a)	**ISA 260 external audit opinion** The External Audit Partner reported that all the audit work would be completed in time for the report to be presented to the Trust Board on 24 May 2019. She introduced the year-end report for 2018/19 and said that they expected to issue an unqualified audit opinion on the accounts following the Board adopting them and an unqualified Value for Money Conclusion. The report contained no management recommendations for 2018/19. The External Audit Partner reported that there were no unadjusted audit differences and confirmed that the annual governance statement and the annual report had been reviewed and some observations would be made during the review of the annual report under Item 18b on this agenda. The External Audit Manager expanded on a number of areas in the end of year report: • the unchanged value of material land and buildings included in the financial statements represented a reasonable valuation and was deemed a cautious approach since generally property values had increased during the year • the level of prudence within key judgements in the financial statements and the strength of the statement of financial position given the additional	

	expectations on NHS Trusts in 2018/19 • the findings from the significant risk based value for money work which concluded that the Trust had made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2019. The External Auditors thanked the Trust's finance team for their co-operation to complete and progress the audit work within the allocated timeframe. The Chair of the Committee said that she had been pleased to receive the satisfactory report and that this evidenced robust financial management during the course of the year.	
2019-20 (18b)	**Annual report 2018/19** The Executive Director of Finance and Resources introduced the draft annual report for 2018/19, and advised that the report presented at the meeting reflected the actions taken in response to the comments made by the Committee's members at the informal meeting held on 10 May 2019. The Chair of the Committee invited the auditors to comment on the annual report. The External Audit Partner made the following observations: • information relating to time off for trade union facility time had not been included in the version of the report presented to the Committee. She pointed out that this would need to be done before the Annual Report was signed off by the Trust Board on 24 May 2019. • queried whether the individuals referenced in the report had given their consent for the Trust to use their personal information. The Chair asked for these points to be resolved before the report was presented to the Board on 24 May 2019. Both the external auditors and internal auditors indicated that the contents of the annual report showed a consistent picture with their own findings and observations of the Trust. The Chair of the Committee thanked officers for their work in drafting the annual report**.** **Outcome:** The Committee: • noted the draft annual report, including the annual governance statement • received assurance from external auditors that the draft annual report was compliant with guidance as set out in the manual for accounts • recommended the draft annual report for adoption by the Board at its meeting on 24 May 2019, subject to satisfactory conclusion of the points raised by the External Audit Partner.	
2019-20 (18c)	**Annual accounts 2018/19** The Executive Director of Finance and Resources introduced the annual accounts for 2018/19. He explained that the annual accounts would be made available to the public as part of the Trust's annual report; the content of the report and the accounts being prescribed by the Department of Health. He added that the accounts were to be presented to the Board and subsequently submitted to NHS Improvement on 29 May 2019. The Executive Director of Finance and Resources also reported that the external	

	auditors had undertaken a detailed examination of the annual accounts and reviewed the mandatory disclosures in the annual report; their findings being contained in the ISA 260 audit memorandum to KPMG's audit of the 2018/19 financial statements. The report from KPMG had contained no significant issues. The Executive Director of Finance and Resources referred to the informal meeting of the Committee on Friday 10 May 2019 which had provided members with the opportunity for detailed consideration of all the elements within the accounts. The Chair of the Committee agreed that the informal meeting had proved very helpful and thanked the Executive Director of Finance and Resources and his team for their work in producing the accounts and supporting analysis. The Executive Director of Finance and Resources introduced the required statements and certificates for signature and inclusion in the annual report and accounts to be approved at the Board meeting on 24 May 2019. **Financial statements 2017/18: letter of representation** The Executive Director of Finance and Resources referred to the draft formal letter of representation made by the Trust to the external auditors. **Outcome:** The Committee received the annual accounts and (subject to the completion of the outstanding matters annotated on the ISA 260) recommended the adoption of the accounts by the Board at its meeting 24 May 2019 and the signing of the letter of representation.	
2019-20 (19a)	**Audit Committee annual report** The Company Secretary introduced the report which had been revised following review by the Committee on 26 April 2019. **Outcome:** The Committee approved the annual report prior to submission to the Trust Board on 24 May 2019.	
2019-20 (20)	**Committee's Workplan** There were no matters removed or changes made to the workplan – but noted action under 17a Well-Led Framework.	
2019-20 (21)	**Matters for the Board and other committees** The Chair noted the following items to be referred to Board colleagues: • the annual report and accounts would appear as substantive items on the Board agenda for the meeting on Friday 24 May 2019 • external auditors confirmation that in terms of value for money, the Trust had made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2019. • No recommendations had been made in respect of Management actions.	
2019-20 (21)	**Any other business** The Committee agreed that the next meeting should be re-scheduled to Thursday 1 August 2019 at 9.00am-11.30am.	
	Date and time of next meeting Thursday 1 August 2019 9.00 am – 11.30 am Boardroom Stockdale House Leeds LS6 1PF Stockdale House Leeds LS6 1PF	