Leeds Community Healthcare NHS Trust
Public Board Meeting
Agenda
Friday 5 February 2016
9.00am – 12 noon
Venue: Trust Headquarters, 1st Floor, Stockdale House, Victoria Road, Leeds. LS6 1PF
Please note: agenda timings are approximate.

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		PRELIMINARY BUSINESS		
9.00	2015-16 (94)	Welcome, introductions and apologies	Neil Franklin	N
9.00	2015-16 (95)	Declarations of interest	Neil Franklin	N
9.05	2015-16 (96)	Questions from members of the public	Neil Franklin	N
9.10	2015-16 (97)	Minutes of previous meetings and matters arising: a. Minutes of the meeting held on 4 December 2015 b. Action tracking log c. Committee's assurance reports: i. Audit Committee: 11 December 2015 ii. Quality Committee: 25 January 2016 iii. Business Committee: 27 January 2016	 Neil Franklin Neil Franklin Jane Madeley Tony Dearden Brodie Clark	 Y Y Y Y Y
		QUALITY AND DELIVERY		
9.30	2015-16 (98)	Chief Executive's report	Thea Stein	Y
9.40	2015-16 (99)	Outline financial planning assumptions 2016/17	Bryan Machin	Y
9.50	2015-16 (100)	Integrated performance report	Bryan Machin	Y
10.10	2015-16 (101)	Programme management board report	Sam Prince	Y
10.20	2015-16 (102)	Safer staffing report	Marcia Perry	Y
		STRATEGY		
10.30	2015-16 (103)	Quality strategy	Marcia Perry	Y
10.45	2015-16 (104)	Safeguarding strategy	Marcia Perry	Y
11.00	2015-16 (105)	Organisational development strategy: six monthly update	Sue Ellis	Y
		GOVERNANCE		
11.15	2015-16 (106)	Review of Board effectiveness	Neil Franklin	Y
11.25	2015-16 (107)	Board assurance framework	Thea Stein	Y
11.35	2015-16 (108)	Corporate risk register	Thea Stein	Y
11.45	2015-16 (109)	NHS Trust Development Authority: Board compliance statements and Monitor's licence conditions	Emma Fraser	Y
11.50	2015-16 (110)	Board workplan	Thea Stein	Y
		REPORTS		
11.55	2015-16 (111)	Approved minutes of Board committees: a. Audit Committee: 23 October 2015 b. Quality Committee: 23 November 2015 c. Business Committee: 25 November 2015 d. Leeds Safeguarding Children Board minutes:19 November 2015 e. Leeds Safeguarding Adults Board minutes: 14 October 2015 f. Leeds City Council Health and Wellbeing Board minutes: 30 September 2015	Neil Franklin	Y
12.00	2015-16 (112)	Close of the public section of the Board	Neil Franklin	N

Date of next public meeting
Thursday 31 March 2016, 9.00am – 12 noon. Trust Headquarters, Stockdale House, Leeds

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust
Trust Board Public meeting

AGENDA ITEM 2015/16 (97a)

Boardroom, Stockdale House, Victoria Road, Leeds

Friday 4 December 2015, 9.00am – 12 noon

Present:	Robert Lloyd	Deputy Chair and Non-Executive Director
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Professor Ieuan Ellis	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Sue Ellis	Director of Workforce
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Marcia Perry	Executive Director of Nursing
	Emma Fraser	Director of Strategy and Planning
	Paul Morrin	Director of Integration
Apologies:	Neil Franklin	Trust Chair
	Dr Amanda Thomas	Executive Medical Director
In attendance:		
	Vanessa Manning	Company Secretary
Minute taker:	Tricia Hannon	Interim Assistant Board Secretary
Observers:	Beth Elias	CLaSS Service Manager
	Em Brown	Membership and Involvement Manager
	Chloe Thompson	Membership and Involvement Officer
	James Wood	Communications Officer, Communications Team
	Chris Toothill	Pharmacist, Medicines Management
	Peter Gardonyi	Peter Gardonyi Associates
Members of the public:	None present	

Item	Discussion points	Action
2015-16 (74)	**Welcome and introductions** The Deputy Chair welcomed Trust Board members and opened the meeting. A welcome was also extended to the Leeds Community Healthcare NHS Trust members of staff attending in an observing capacity. The Deputy Chair advised that he was deputising in the absence of the Trust's Chair, Neil Franklin, who was unable to attend due to illness. **Apologies** Apologies were noted from Neil Franklin, Chair and Dr Amanda Thomas, Executive Medical Director.	
2015-16 (75)	**Declarations of interest** Declarations of interest not received.	

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2015-16 (76)	**Questions from the members of the public** There were no members of the public present. The Deputy Chair said that several questions had been received from Councillor Dobson prior to the meeting in relation to the patient and public engagement on service relocation proposal agenda item. He advised that questions on the proposals would be addressed under that agenda item later in the meeting.	
2015-16 (77)	**Patient story** The patient story item was introduced by the Executive Director of Nursing. She introduced a local resident and carer and thanked him for taking the time to attend the meeting. She provided an outline of the carer's story in that his late father had suffered a pressure ulcer whilst in the Trust's care. She said it was important that patient stories were brought to the Trust in order that the Trust learnt from patient experience. She reiterated the importance of work around pressure ulcers, the Trust had some new approaches in place. The carer presented his patient story concerning his late father's experiences of suffering a pressure ulcer, the health care he received and the outcome. His father's first occurrence of a pressure ulcer was in 2008, which he believed was not categorised correctly and appropriate treatment had not been received. His father had had a pressure ulcer for the remainder of his life until he died. The carer said the health care treatment his father received had not been good which resulted from several factors including: lack of communication and engagement with his family, appropriate pain relief and control not prescribed, inspection of the wound not made due to reliance on other health care professionals and a lack of follow up appointments. Towards the end of his life he had experienced an infection, weight loss and mental health problems. The carer provided an update on the investigation that had taken place following his father's death. The carer praised Leeds Community Healthcare NHS Trust and particularly the intervention and assistance received from Nikki Stubbs, from the wound prevention and management service; and Caroline McNamara, Clinical Lead, Adult Services. The carer ended his story on a positive note by saying he keeps in contact with Nikki Stubbs and Caroline McNamara. He had been asked to speak directly to clinicians and to have future working involvement with the Trust. The Deputy Chair thanked the carer for bringing his story and this very important issue to the Trust's attention. He passed on his condolences to the carer and his family for their bereavement. The Chief Executive added her thanks and said that pressure ulcers were viewed very seriously by the Trust.	
2015-16 (78) **(78a)**	**Minutes of the previous meeting held on 2 October 2015, matters arising and action log.** The minutes were reviewed for accuracy and approved an as accurate record.	

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(78b)	**Action log** The Deputy Chair said there were no overdue (red rated status) actions on the action log as of 4 December 2015. Two amber actions were included on the log, one of which was due for completion in December 2015. ***Action 2015-16 (38) Nursing and midwifery revalidation*** The Executive Director of Nursing provided an update on the action concerning nursing and midwifery revalidation. An update on processes and progress will be included in future Chief Executive's reports. Revalidation processes are effective from 1 April 2016. A series of workshops had been planned for 2016 with the item being promoted through the Trust's webpages. A Non-Executive Director (TD) queried if there would be challenges for future appraisal training requirements. The Executive Director of Nursing felt that the three year process for revalidation was not onerous. **Action:** An update on nursing and midwifery revalidation to be included in future Chief Executive's Board reports from 5 February 2016. ***Action 2015-16(65) safeguarding annual report 2014/15*** **Action:** The Executive Director of Operations confirmed a brief summary of PREVENT responsibilities would be circulated to the Board members.	**Executive Director of Nursing** **Executive Director of Operations**
(78c)	**Assurance reports from sub-committees** **Item 78c(i) – Charitable Funds Committee held on 20 November 2015** The Committee Chair/Non-Executive Director (BC) provided an update to the report. He reported that several small funds were to be consolidated into one fund. Concerning Hannah House, there is to be more flexibility of funding for larger sums. Processes are being put in place for the recruitment of a fund-raising manager. The Committee Chair/Non-Executive Director (BC) further added his thanks to both the Director of Strategy and Planning and the Membership and Involvement Manager for their marketing work on charitable funds which was going well. **Item 78c(ii) – Nominations and Remuneration Committee held 20 November 2015** The Director of Workforce said there was nothing of specific note except for changes to mandatory and statutory training policies every 12 months. **Item 78c(iii) – Quality Committee held 23 November 2015** The report was presented by the Committee Chair/Non-Executive Director (TD) who highlighted the main items within the report. *Medical child protection report* Following the Royal College of Paediatrics and Child Health review of specialist child protection medical services at Leeds Community Healthcare NHS Trust, a positive report had been received with several recommendations made including timescales. Further work is progressing focussing on outcomes of clinical effectiveness and learning from serious incidents.	

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	Risk register A Non-Executive Director (JM) asked the Committee Chair/Non-Executive Director (TD) about the Quality Committee providing limited assurance on the risk register report. It was confirmed by both the Executive Director of Nursing and the Non-Executive Director (TD) that this was due to the risks related to statutory and mandatory training. **Item 78c(iv) – Business Committee held 25 November 2015** The report was presented by the Committee Chair/Non-Executive Director (BC) who highlighted the main items within the report. He advised of several areas of concern. *Neighbourhoods' performance review* The Business Committee had received an in-depth report on the Beeston, Wetherby and Morley neighbourhoods. The Committee remain concerned over the delivery against action plans in neighbourhood teams. *Workforce issues* Sickness absence had risen to 6.01% against the target of 4.6%. Sickness absence management actions were reviewed through the Trust's staff health and wellbeing group. *Programme management office (PMO)* The range and number of projects the PMO oversee was being reviewed. A Non-Executive Director (JM) enquired about the electronic patient records programme, as one of the projects being overseen by the PMO, and asked for an update. The Executive Director of Operations replied that the project is progressing well, she also confirmed the next six monthly report is due to the Board at its 5 February 2016 meeting. **Action:** The six monthly report to be taken to the 5 February 2016 Trust Board meeting. **Outcome:** The Board noted the committees' reports and the matters highlighted.	**Executive Director of Operations**
2015-16 (79)	**Chief Executive's report** The Chief Executive presented her report and also provided a verbal update on specific issues of note. Following notification received from NHS England that the Trust had been unsuccessful in securing the prisons' adult estate bid for providing healthcare in prisons, the Trust's priorities were now to support the staff affected by the change; meetings with staff were taking place. The Chief Executive said a letter had been received from Jim Mackey, Chief Executive, NHS Improvement around winter preparation. She advised that 400 more patients had been admitted to hospital in the previous week compared to the same time last year. Work was currently taking place around avoiding unnecessary admissions to hospital and re-admissions. The Chief Executive advised on the good work and progress made by the recruitment team on staff recruitment. Staff retention remains a concern and work is being overseen by the Business Committee.	

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	A Non-Executive Director (IE) made reference to the item on the Department of Health's spending review 2015 in the Chief Executive's report and the possible restraints on future expenditure on recruitment, and how to make Leeds a good place to work, live and study. The Chief Executive said the Trust's participation in the recent RCN's career fair had been a positive initiative. The Executive Director of Operations provided an update to the Chief Executive's report on the South Leeds Independence Centre (SLIC). The centre had opened beds for 40 patients including ten residential beds. There were 34 patients in the unit with some further changes being made to the referrals for the residential beds. The Executive Director of Finance and Resources directed a question to the Executive Director of Operations concerning acute hospitals' pressures. He asked what the Trust could do to assist with this problem. The Executive Director of Operations replied that the Trust does not have control over identification of patients in a hospital setting, suitable for discharge and care at home. The Deputy Chair asked about the associated risks being only at the start of winter. The Executive Director of Operations replied that discharge arrangements are discussed in hospital settings once ward staff had identified patients ready for discharge. A Non-Executive Director (JM) asked about the monitoring of GP referrals into acute hospitals. The Executive Director of Operations explained that the local System's Resilience Group met every two weeks to review trends in in-patient admissions, discharges and the pressure on the social care sector. The Deputy Chair proposed that, in order for the Board to receive winter planning assurances, the Chief Executive and the Executive Director of Operations continue to monitor winter resilience and that sub-committees are kept updated. A Non-Executive Director (TD) commented on the operational detail but that he had concerns over strategic issues and the level of hospital admissions capacity. **Action:** The Chief Executive to keep the Board updated on winter planning resilience and any issues arising. A Non-Executive Director (TD) referred to the CQC re-inspection for the organisation and the requirement to prepare for a re-inspection during Spring 2016; bearing in mind the continuing system and financial pressures. A Non-Executive Director (TD) referred to the 26 October 2015 Quality Committee where the Goddard review had been an item discussed. The Executive Director of Nursing explained that Justice Goddard had led a national enquiry regarding safeguarding children. Two actions arose from the inquiry: no children's or adults patients records are to be destroyed – this is effective immediately; this will have an impact on patient record storage and recommended guidance on future paper storage is awaited. Secondly, safeguarding policy review is taking place to ensure compliance with guidance. A Non-Executive Director (BC) highlighted the recruitment and retention item in the Chief Executive's report and reported positive feedback on induction processes. He also enquired about the Vanguard item and asked about Vanguard funding for new initiatives and services. The Chief Executive replied that the first and second stage Vanguard bids had passed and focus was now on emergency and urgent care, funding was now available in Leeds to support emergency and urgent care.	**Chief Executive**

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	Outcome: The Board noted the report and the matters highlighted.	
2015-16 (80)	**Mid-year review of annual plan 2015/16** The Director of Strategy and Planning presented the report. The Board had approved the Trust's priorities for 2015/16 at its meeting in March 2015 as part of approving the Trust's operational plan. The December 2015 update provided the Board with a mid-year review of these priorities. A high level summary of performance was provided which included detailed assessment of performance against objectives and successes. Much of the content had already been reviewed by the Board and the sub-committees. The Chief Executive highlighted the summary of progress against the 2015/16 priorities, areas at risk, the sound progress already made and the outstanding actions to be addressed, the main features of which were: • *High quality services.* A significant amount of work had been undertaken to further improve quality processes and practice following the CQC inspection. A better understanding and improvement in waiting times across services (not just the services with nationally reportable waiting times) had been achieved. Patient safety remained a focus; the number of falls had reduced in SLIC but more work is planned to reduce the incidence of pressure ulcers. The pressure ulcers' priority was recorded as 'off track' and was the only area where achievement was not expected. • *Work in partnership.* The Trust was working hard to ensure community services are at the heart of future planning for new models of care in the city. Progress has not been as timely as was originally anticipated at the beginning of the year. Work is now progressing in each CCG to test different approaches to integrated models of care. The Trust has been focussed on patient engagement, through initiatives such as health coaching. • *Workforce.* Recruitment and retention of staff remains an overriding priority; significant recruitment effort had resulted in 155 new starters. Analysis of the reasons people leave the Trust has been undertaken as part of the retention work stream. Progress is being made on staff engagement. The *50 voices* group is well established enabling a close dialogue with staff and ensuring input to help shape future initiatives. • *Viable & Sustainable.* The in-year stretch target meant an increase in the target surplus from £1.5m to £2.2m. The Trust had also seen an increase in agency staff costs, over and above planned levels. The Trust had taken action to ensure it delivers its surplus by putting in place restrictions on discretionary spend and agency staff expenditure. There had been some slippage on the cost improvement programme; mitigated by non-recurrent savings. The Trust continues to maintain a strong cash position. A Non-Executive Director (BC) commented that it was good report and helpful to receive the detail. He also welcomed the planning timetable for 2016/17. A Non-Executive Director (TD) commented on the number of items "off track" and that focus is continued be given to these items. **Outcome:** The Board noted and received the mid-year review, priorities for the remainder of the year and the approach to planning in 2016/17.	

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2015-16 (81)	**Integrated performance report (IPR)** The report was presented by the Executive Director of Finance and Resources. He reported the main quality concerns were around pressure ulcers, patient falls and medication incidents; and key performance concerns related to staff sickness absence, appraisals, staff turnover and statutory and mandatory training. The Deputy Chair said the integrated performance report was comprehensive and had received substantial scrutiny in the sub-committees. <u>Measure – Responsive</u> A Non-Executive Director (TD) referred to the child and adolescent mental health services (CAMHS) issues around waiting times and said there had been some further recent improvements but the organisation was still not at the point of providing satisfactory assurances. **Action:** An accurate forecast for CAMHS waiting times for the year end position to be reported back to the 5 February 2016 Board meeting. A Non-Executive Director (JM) queried the CAMHS waiting times of 12 weeks or less and the benchmark for referrals. The Executive Director of Operations replied that all referrals were appropriately triaged, with less urgent or less complex cases generally experiencing longer waiting times. <u>Measure – Well-led</u> An update was provided by the Director of Workforce on staff turnover. She indicated that whilst the Trust benchmarked satisfactorily when compared to other community trusts, the Trust was working to address turnover of over 15%. <u>Measure – Caring</u> A Non-Executive Director (JM) referred to the below target figure for complaints closed within the agreed timeframe. A Non-Executive Director (TD) said these related to complex complaints involving multiple agencies which often took longer to resolve. <u>Measure – Financial position</u> The Executive Director of Finance and Resources drew the Board's attention to the non-pay expenditure item and the successful reduction in discretionary expenditure which was a result of staff proactively making savings. He also reported on the reduction in agency staff costs. He said one of the biggest current risks was the potential costs associated with the occupancy of LIFT buildings. **Outcome:** The Board noted the Trust's performance against all its performance objectives.	**Executive Director of Finance and Resources**
2015-16 (82)	**Agency staff controls** The Director of Workforce presented the report and provided a summary of the main items. The report provided an update on the Trust's local approach and actions to restructure bank and agency staffing demand and supply arrangements; and to reduce spending on temporary staffing in 2015/16. The NHS Trust Development Authority had introduced further new rules from 23 November 2015 around the use of bank and agency staff and the Trust has had to adapt its approach in order to maintain compliance with these rules.	

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	The Director of Workforce advised that the Trust had made some progress in the reduction of agency and bank staffing usage, but still not to the required levels. The Board was appraised of the year end forecast and monitoring methodology. The Director of Workforce drew the Board's attention to the hourly rate price caps effective from November 2015 and to the potential clinical risks but she reinforced that patient care remained the priority. The imposed caps could result in agency staff seeking work elsewhere or moving to other employment. She further drew attention to the budgetary position as outlined in the report. The 4% overall limit applies to nursing agency expenditure, with a total of no more than 4% to be spent on agency staff. All nursing and nursing support staff are to be sourced from framework agencies only. A Non-Executive Director (IE) referred to the report and the planned agency spend for 2015-16 set at £7.3m and the challenge of meeting this target in light of winter pressures. **Outcome:** The Board received and noted the report in respect of progress made to date, the plan for implementing agency controls' compliance with national guidance and the approach for close monitoring towards the year end.	
2015-16 (83)	**Quality improvement plan** The Deputy Chair put to the Trust Board that this agenda item and item 84 (complaints and incidents report) be approved following confirmation and assurance that these items had been discussed fully at the Quality Committee. Confirmation was received by both the Executive Director of Nursing and Committee Chair/Non-Executive Director (TD). It was further confirmed by the Chief Executive that the items within the reports had been discussed in detail at the Quality Committee. A Non-Executive Director (JM) enquired about the results from the staff survey. The Chief Executive provided an update that the survey had concluded at the end of November 2015 and the results and an analysis will be made available in due course. There had been a significant improvement in the number of responses received compared to last year. The Chief Executive to report back on the survey at the respective February 2016 and March 2016 Board meetings. **Action:** The Chief Executive to include an update on the staff survey outcome in her report for the 5 February 2016 Board meeting with a further full report to the 31 March 2016 Board meeting. **Outcome:** The Board received the report.	**Chief Executive**
2015-16 (84)	**Complaints and incidents report** Following Board agreement with the scrutiny undertaken by sub-committees under the previous agenda item 83, this item was received but not discussed in detail. **Outcome:** The Board received the report.	
2015-16 (85)	**Patient and public engagement on service location proposals** The Deputy Chair introduced this item which was presented by the Director of Strategy and Planning.	

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The Deputy Chair brought the Board's attention to two particular issues that he wished to see addressed. The first being a number of questions and comments received from Councillor Dobson on 2 December 2015 (circulated to all Board members) which outlined concerns about the Garforth Clinic building and service provision in Garforth. The second related to comments gathered during the engagement process about how public feedback would be utilised.

The Director of Strategy and Planning said there was a substantial amount of detail within the draft report and she intended to concentrate on the main aspects. The report would be finalised in the light of Board discussions and approval of proposals.

The Director of Strategy and Planning provided a summary of the background to the service change proposals. She explained that the proposals had been developed following reviews of the Trust's community health services and aimed to provide a planned, more equitable provision of services across the city. The principle being followed was that more clinic appointments would become available as a result of the changes and this would represent greater value for money for each pound of health care expenditure. This would maximise face to face time with patients over and above service availability in every location. The Director of Strategy and Planning reminded the Board that currently services were not available on an equitable basis; the current pattern of provision having evolved over time.

The proposals were outlined to the Board as being:

- **Garforth clinic:** adult dietetics, cardiac, children's speech and language therapy, musculo-skeletal service, podiatry, weight management and improving access to psychological therapies (IAPT) to cease providing appointments in Garforth clinic and closure of the building.
- **Podiatry:** propose to reduce where clinics are provided, from 25 locations to 19 locations across Leeds.
- **Children's newborn hearing service:** propose to move the clinics in health centres to hospital sites (this part of the consultation was still ongoing; re-provision on hospital sites remained the preferred outcome).
- **Continence, urology and colorectal service:** propose to reduce where clinics are provided, from 14 to 10 locations across the city.
- **Cardiac rehabilitation:** propose to reduce where clinics are provided, from six leisure centres to four.
- **Adult nutrition and dietetics:** propose to reduce where clinics are provided, from 30 locations to 15 locations across Leeds.
- **Children's speech and language therapy:** propose to reduce where clinics are provided, from 23 locations to 12 locations across Leeds, plus a change to referrals, waiting lists and episodes of care in the way the service is provided
- **Improving access to psychological therapies:** propose to reduce where clinics are provided, from 54 locations to 22 locations across Leeds.

The proposed changes had been the subject of a 12 week patient and public engagement period. The consultation period commenced on 13 August 2015 and ended on 5 November 2015. Feedback was proactively sought from patients, carers and staff from the services which would be potentially affected.

The patient and public engagement process had been publicised through health centres, posters, the Trust's website, social media and within local communities. Appropriate support had been in place for both patients and staff potentially affected by the proposals.

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There had been dialogue throughout the process with Garforth councillors, the Council's Scrutiny Board's development group, the Chair of the Health and Wellbeing Board and Healthwatch. The Trust's lead commissioners had been involved and were in support of the proposals. The engagement had been an open process and feedback had been relayed on a continuous basis throughout the 12 week period.

The Director of Strategy and Planning said that a number of themes and trends had been identified during the engagement period. These included: the difficulties elderly people and families with young children faced when accessing services; people not being aware of the choices open to them when accessing care; the social aspect and interaction with other health or social activities; considerations over travelling time and public transport; parking and ease of access to services and how to find and access clinics (improved signage and postcodes); the current location and distribution of services across the city; future planning for population growth and new housing developments and confidence in how engagement feedback would be used.

Reflecting on the feedback, the Director of Strategy and Planning said that plans would be put in place to support people affected by the changes. Referring to the proposal to close Garforth Clinic in particular, she said that plans would include: support for older people with public transport; ensuring access to clinics that best suited health and social needs and work with the voluntary sector in the area to ensure that no one was disadvantaged.

It was noted that, if new housing was developed in Garforth in the future, it would be the duty of the clinical commissioning groups to commission appropriate care for the new population and that the Trust would be keen to play a full part in any new commissioning. The Chief Executive confirmed that, in her view, the current building would not be fit for this purpose. She welcomed the fact that councillors had highlighted this issue during the involvement process and was ensured therefore that it would be raised in future planning.

The Director of Strategy and Planning stated that the Trust would continue to provide services to the people of Garforth after the proposed closure of the clinic. She added that some Garforth patients already chose to access services elsewhere in the city. Providing assurances about service provision had led to further consideration of alternative options for the provision of adult dietetics, musculo-skeletal and podiatry services in the Garforth area.

As a result of the feedback received, modifications had been made to the proposals, these included: retention of nutrition and dietetics in the Rothwell/Oulton area to be operated from Rothwell Health Centre and the retention of psychological therapies (IAPT) from Compton Centre, Harehills.

In closing her presentation, the Director of Strategy and Planning explained that a package of further engagement, information-sharing, promotion of choice and personal support to affected people would be put in place.

The Deputy Chair asked about timescales for implementation of the proposals. The Director of Strategy and Planning replied that, subject to Board approval, services would move or cease in line with plan. Along with the majority of proposals, the proposed closure date for Garforth Clinic was 31 January 2016.

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	The financial and productivity benefits were highlighted by the Chief Executive. She indicated that the new plans would realise approximately 800 appointments each year. In addition there would be savings resulting from the closure of Garforth clinic (£44,000 per annum running costs) and an opportunity provided by not needing to fund £900,000 required to bring Garforth clinic building to an appropriate standard. A Non-Executive Director (TD) said that the report was a comprehensive description of the proposals. He asked whether stakeholders, such as the clinical commissioning groups (CCGs), had been involved in the engagement process. This was confirmed by the Director of Strategy and Planning who said the CCGs had been involved from the commencement and that they were supportive of the proposals. The Chief Executive said conversations had also taken place with the Chair of the Scrutiny Board and the Chair of the Health and Wellbeing Board, in which they had been supportive of the organisation's proposals. A Non-Executive Director (JM) agreed that the paper was a good and helpful report and demonstrated a detailed and analytical process. She asked about the criteria used to determine which proposals would be modified as a result of feedback. The Director of Strategy and Planning said that the organisation had listened carefully to concerns and modifications to proposals had occurred when concerns were not able to be mitigated sufficiently. Non-executive directors expressed the view that the way in which concerns raised had led or not led to modifications was not sufficiently clear in the report and asked that this be clearly outlined in the final public report. The Director Strategy and Planning and Chief Executive agreed that this would be a useful addition. The Deputy Chair welcomed this approach and added that the modified proposals seemed to coalesce around four criteria: clinical quality; patient experience, access and choice; financial sustainability and staff deployment. In relation to the matter of clinical quality, the Executive Director of Operations suggested that the quality impact assessments undertaken as part of the service reviews and which identified quality measures could be added to the final version of the report. A Non-Executive Director (IE) endorsed the view that the engagement had been a thorough process and asked about the proposed implementation timescale of 1 February 2016 and the amount of work, particularly in relation to the communication of changes, to be carried out. The Chief Executive said that work to implement the proposals, once approved by the Board, would be begun without delay; she was confident in the Trust's capacity to effect the changes. A Non-Executive Director (JM) asked if the Trust owned the Garforth Clinic building; this was confirmed by the Executive Director of Finance and Resources. The Director of Strategy and Planning further added that conversations had taken place about the future possible uses of the building with the possibility of the Garforth community using the building for community purposes or for use by voluntary groups. The Executive Director of Finance and Resources added, however, that the Garforth clinic building should be disposed of in a timely manner. He also confirmed that there was no provision for community assets transfer for NHS properties. The Board recognised that there was a tension between the duty incumbent on the Trust to achieve best value for money from the sale of the property and the Board's desire to explore options for the Garforth community to gain a community benefit from the building as long this did not lead to further costs or risk to the Trust.	

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	The Chief Executive proposed that an estates recommendation exploring all these options and clarifying a way forward be drafted which would be progressed through the 24 January 2016 Business Committee, then onward reporting to the 5 February 2016 Board meeting. This was agreed. **Action:** An estates recommendation to be drafted for the release of Garforth clinic which is to be progressed to the Business Committee on 24 January 2016, for onward reporting to the Board meeting on 5 February 2016. A Non-Executive Director (BC) commented that he felt that the engagement process had been good and had been valuable in drawing out secondary considerations such as social and community factors. He added that reconciling the Trust's estates requirements with the needs of the service was a coherent approach to service planning. A Non-Executive Director (JM) asked how quickly, following approval of the recommendations, the changes could take place. The timescales for implementation of the service change proposals and closure of Garforth clinic were discussed. It was noted that mobilisation would commence immediately with the closure of the Garforth clinic taking effect by 1 February 2016. In reply to the Deputy Chair, the Chief Executive confirmed that the risk implications involved in closing Garforth clinic and the other service changes had been thought through carefully along with mitigating actions. In particular, communication and liaison with patients. The Chief Executive confirmed that if the recommendations were agreed by the Board, conversations would take place with immediate effect with local GPs and relevant groups. The Deputy Chair asked the Board if they felt adequate consideration had been given to the questions and comments raised by Councillor Dobson; it was noted that Councillor Dobson's questions had been valuable in shaping mitigations and this was confirmed by Board members. It was agreed that the Director of Strategy and Planning would reply directly to Councillor Dobson's questions and provide a separate response. The Chief Executive added that a draft minute of the discussion would also be made available to councillors in the areas affected by the changes and to the Scrutiny Board. **Action:** The Director of Strategy and Planning to provide a written response to Councillor Dobson's questions and comments. The Chief Executive proposed that the final report should include: clarity as to the grounds for modifications to the original proposals; the matter of the future of Garforth clinic building and related assurances to the local community. The Deputy Chair requested that the third party endorsements be included in the final version of the report on service change proposals, subject to appropriate approval being received to include the correspondence. **Action:** The final version on the service change proposals to include the changes as agreed and approved at the Board meeting; and to also include appended letters of support as received from the Leeds Clinical Commissioning Groups and Healthwatch (subject to receiving authorisation to publish the correspondence).	**Executive Director of Finance and Resources** **Director of Strategy and Planning** **Director of Strategy and Planning**

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	The Deputy Chair concluded the item and asked if all Board members were in agreement with the proposals and recommendations. All Board members agreed with the recommendations. **Outcome:** The Board received the draft report of the patient and public engagement on service change proposals. Approval was provided by the Trust Board to proceed with the recommendations for service changes including the recommendation to cease providing services in Garforth clinic and close the building, with the implementation of the supporting mitigation. **Action:** The mobilisation of the approved service changes to take place with immediate effect. Progress reports to be included in the next Chief Executive's Board report for the 5 February 2016 Board meeting. The Deputy Chair concluded the item by thanking the Director of Strategy and Planning and the Patient and Public Involvement team for their work.	**Director of Strategy and Planning**
2015-16 (86)	**Equality and diversity strategy** The Executive Director of Nursing introduced the report. The report identified the activity and progress that Leeds Community Healthcare NHS Trust had made in gaining an overall NHS Equality Delivery System2 (EDS2) grading of 'achieving'. The Trust was currently reported as 'achieving' four specific goals: • Better health outcomes for all • Improved patient access and experience • Empowered, engaged and well-supported staff • Inclusive leadership at all levels A Non-Executive Director (JM) queried the differences between the two proposed approaches as outlined in the report. The Executive Director of Nursing said that the Senior Management Team had supported the approach whereby equality objectives were assigned to and became embedded in existing work streams and were overseen by committees. A Non-Executive Director (JM) noted this suggestion but added that an over-arching strategy would be more impactful. A Non-Executive Director (BC) queried the strategic oversight, ownership and progression of the work. It was suggested by the Deputy Chair that the Executive Director of Nursing takes this forward through the Senior Management Team, which was agreed by the Chief Executive. A Non-Executive Director (IE) suggested an equality and diversity champion be required at a senior level. The Chief Executive advised that the Trust Chair is the lead on equality and diversity matters. A Non-Executive Director (TD) commented on the reported declining numbers of staff with a declared disability, he asked what actions could be taken to remedy this issue. The Deputy Chair proposed that the Executive Director of Nursing investigate further and report findings to the Business Committee. **Action:** Investigations to take place and report to the Business Committee on the drop in and low numbers recorded of staff declaring disabilities.	**Director of Workforce**

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	Action: Equality goals to be identified for the Quality and Business Committees by a timescale of 31 March 2016 for inclusion in 2016/17 reporting. **Outcome:** The Board received and noted the activity and progress as outlined in section three of the report.	**Executive Director of Nursing**
2015-16 (87)	**Board assurance framework (BAF)** The Chief Executive introduced the report which outlined the principal risks to the organisation. The Board had last received the BAF in full at its Board meeting in August 2015. The summary paper provided an update of strategic risks, risk scores and review dates following discussion at Senior Management Team level. The Chief Executive said the report included a deeper review of the principal risks to the Trust's strategic objectives around how the Trust engages with stakeholders, service users and communities to deliver improved services, especially integrated care and care closer to home across the city and provided assurances about work with which the Trust is involved. A Non-Executive Director (JM) said she felt that describing actions to mitigate risks could be enhanced by including the level of assurance. She added that audit outcomes could be included to give more factual indicators of assurance. **Outcome:** The Board received and noted the current BAF, the in depth review of risks arising from the Trust's strategic objective related to the care and care closer to home and considered further ways in which the Board wished to gain assurance on integration; and noted the BAF enhancements.	
2015-16 (88)	**Corporate risk register** The Chief Executive presented the report and corporate risk register. The Chief Executive advised the Board of one new risk included on the register (ID 798 – unsafe caseload management in children's dietetic services). The Executive Director of Operations advised this risk had been progressed, mitigating action put in place and the risk was now less severe. A Non-Executive Director (JM) made reference to the number of high risks (score 8-15) and if these had been progressed through the two sub-committees. It was confirmed the risks of eight and above are reviewed at the Business and Quality Committees. **Outcome**: The Board noted the report, the contents of the risk register, movements within the risk profile and improvement actions.	
2015-16 (89)	**NHS Trust Development Authority (TDA) monthly report on Board compliance statements and Monitor's licence conditions** The Director of Strategy and Planning introduced the NHS TDA monthly report and advised of the Trust's unchanged position from last month. **Outcome:** The Board approved the assessment of full compliance with the TDA Board Statements, the assessment of non-compliance with Monitor ConditionG8, and noted that this will be progressed.	

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2015-16 (90)	**Board work plan** The Chief Executive presented the Board work plan (public business) which was for information. **Outcome**: The Board noted the work plan.	
2015-16 (91) **(91a)** **(91b)** **(91c)** **(91d)**	**Minutes of Board committees** The Board noted the following final approved committee meeting minutes and formally accepted those minutes. Audit Committee: 24 July 2015 Quality Committee: 21 September 2015 and 26 October 2015 Business Committee: 23 September 2015 and 28 October 2015 Approved minutes from external organisations were received. Leeds Safeguarding Adults Board: 11 August 2015 Leeds Safeguarding Children Board: 24 September 2015 Leeds Health and Wellbeing Board: 10 June 2015	
2015-16 (92)	**Notes of the Leeds Community Healthcare NHS Trust AGM 2015** The Deputy Chair advised that the notes from the Leeds Community Healthcare NHS Trust AGM of 16 September 2015 are for information.	
2015-16 (93)	**Close of the public section of the Board** The Deputy Chair thanked everyone for attending and concluded the public section of the Board meeting.	
	Date and time of next meeting **Friday 5 February 2016, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds**	

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AGENDA ITEM 2015-16 (97b)

Leeds Community Healthcare NHS Trust
Trust Board meeting action log: 5 February 2016

Agenda number	Action agreed	Lead	Timescale	Status
Meeting held on 3 July 2015				
2015-16 (34)	**Safer nurse staffing report** The Trust Board to receive a six monthly report which demonstrates evidence on the expectations set out in the nine principles.	Executive Director of Nursing	February 2016	Completed
2015-16 (38)	**Nursing and midwifery revalidation** The Trust Board to be updated on progress on the revalidation at its meeting on 2 October 2015.	Executive Director of Nursing	(revised from October 2015)	Closed: superseded by action (77)
Meeting held on 7 August 2015				
2015-16 (49)	**Integrated performance report: well-led workforce indicators** The effectiveness of management development initiatives and measurement of outcomes to be reviewed and further reported to 25 November 2015 Business Committee.	Director of Workforce	January 2016 (revised from November 2015)	Closed: covered at the Board workshop (Jan 20160 and OD strategy item (Feb 2016); audit in 2016
2015-16 (53)	**Board assurance framework** Links to BAF risks to be referenced in committee papers and meeting minutes.	Company Secretary	April 2016	Update: to be incorporated in new cover paper template
Meeting held on 2 October 2015				
2015-16 (62i)	**Nominations and Remuneration Committee: Associate Non-Executive Director post** Appropriate processes for the appointment of an unremunerated associate Non-Executive Director post to be agreed with Director of Workforce.	Company Secretary	January 2016	Closed: action superseded by recruitment of NEDs
2015-16 (78b)	**Safeguarding annual report 2014/15** A brief summary of PREVENT responsibilities to be circulated to Trust Board members.	Executive Director of Operations	December 2015	Completed
Meeting held on 4 December 2015				
2015-16 (77)	**Patient story** Patient story to be included as an agenda item at subsequent Board meetings	Executive Director of Nursing	February 2016	Completed
2015-16 (76b)	**Nursing and midwifery revalidation** Updates on the nursing and midwifery revalidation to be included in future Chief Executive's Board reports.	Executive Director of Nursing	February 2016	Completed

2015-16 (78civ)	**Programme management office** An update to be provided on the electronic patient records programme, as part of the six monthly update, at the 5 February 2016 Board meeting.	Executive Director of Operations	February 2016	Completed
2015-16 (79)	**Chief Executive's report: winter planning** An update on winter planning resilience to be provided at the 5 February 2016 Board meeting.	Chief Executive	February 2016	Completed
2015-16 (81)	**Integrated performance report: Child and adolescent mental health service (CAMHS)** An accurate forecast for CAMHS waiting times for the year end position to be reported back to the 5 February 2016 Board meeting in the integrated performance report	Executive Director of Finance and Resources	February 2016	Completed
2015-16 (83)	**Quality improvement plan: staff survey** An update on the staff survey outcome to be included in the Chief Executive's report for the 5 February 2016 Board meeting, with a further report to the 31 March 2016 Board meeting.	Chief Executive/ Director of Workforce	February 2016 March 2016	
2015-16 (85)	**Patient and public engagement on service location proposals** An update on plans for Garforth clinic to be reported to the 5 February 2016 Board meeting.	Executive Director of Finance and Resources	February 2016	Completed
2015-16 (85)	**Patient and public engagement on service location proposals** The Director of Strategy and Planning to provide a written response to Councillor Dobson's questions on the service relocation proposals.	Director of Strategy and Planning	December 2015	Completed
2015-16 (85)	**Patient and public engagement on service location proposals** The final version of the service change proposals to incorporate the changes as agreed and approved at the 4 December 2015 Board meeting.	Director of Strategy and Planning	February 2016	Completed
2015-16 (85)	**Patient and public engagement on service location proposals** The mobilisation of the approved service changes to be implemented.	Director of Strategy and Planning	February 2016	All actions due to date completed
2015-16 (86)	**Equality and diversity strategy** The drop in and low numbers recorded on staff declaring disabilities to be investigated and reported to the Business Committee.	Director of Workforce	March 2016	Data to be included in quarterly report to Business Committee
2015-16 (86)	**Equality and diversity strategy** Equality goals to be identified for the Quality and Business Committees, by a timescale of 31 March 2016 for inclusion in 2016/17 reporting.	Executive Director of Nursing	March 2016	

Key		
Total actions on action log	**18**	
Total actions on log completed since last Board meeting 4 December 2015	**15**	
Total actions not due for completion before 5 February 2016 progressing to timescale	**3**	
Total actions not due for completion before 5 February 2016 achieving agreed timescales and/or requirements is at risk or has delayed	**0**	
Total actions outstanding as at 5 February 2016: not meeting agreed timescales and/or requirements	**0**	

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Leeds Community Healthcare NHS
NHS Trust

Agenda item
2015-16
(97ci)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Audit Committee 11 December 2015: Committee's Chair assurance report
Responsible Director: Chair of Audit Committee **Report author:** Company Secretary
Previously considered by: Not applicable

Summary
This paper identifies the key issues for the Board arising from the Audit Committee 11 December 2015 and indicates the level of assurance based on the evidence received by the Committee.

Internal audit
The Committee noted completion of one audit as part of the 2015/16 internal audit plan: budgetary control and cost improvement plan which had been assigned a 'reasonable assurance' opinion; findings had related to the alignment of budgets with cost improvement plans.

Because of the scheduling of a significant number of audits towards the end of the financial year, the Committee noted the necessity for the completion of audits to be concluded in a timely manner

A draft internal audit plan for 2016/17 based on the strategic plan and risk areas was in the process of drafting by internal auditors and will be refined by Senior Management Team and shared with committees' chairs for input prior to consideration at Audit Committee.

Sickness absence management
The Committee received a report on sickness absence management actions from the Director of Workforce. The report had been requested following receipt of an internal audit report that had received reasonable assurance but had left a number of outstanding concerns amongst Committee members. A further report was sought in order to give greater assurance of actions aligned to the specific audit report recommendations.

The Committee concluded that, pending the receipt of further assurances, the item had provided limited assurance only and requested a further report to be provided to Committee members prior to Christmas.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Information governance
The Committee received further information on the Information Commissioners' Office investigation into the data breach in August 2014; the Information Commissioners' Office had, as a result, required the Trust to sign an undertaking relating to training compliance. The requirement being to achieve 95% of staff having complied with training requirements by 31 March 2016 and that this is to be updated annually (rather than three years as previously).

The current compliance with training requirements and the consequences of under-performance were discussed. Options around enforcement, whilst safeguarding service provision were also discussed.

Whilst good progress was evidenced, within the challenging timescale, the Committee felt that current systems and processes provided limited assurance only at this stage and sought a further update at the February 2016 meeting.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Risk management
The Committee noted revisions to systems and processes introduced over the last six months.

In line with the agreed workplan, the Committee received an updated risk management strategy. The document had been split into two parts: a strategy and a procedure. Whilst the new approach was welcomed there was debate as to whether the 'strategy' was more akin to a policy. It was concluded that the Committee should further consider the changes made and invite the Board to delegate responsibility for approval of the changes to the Audit Committee.

Evidence of progress with updating risk management systems and processes provided significant assurance.

Assurance level							
Full		**Significant**	**X**	**Limited**		**No**	

External audit
The Committee noted the progress with audit planning for 2015/16 and the scale of fees for completion of the audit work.

A revised approach to 'value for money' audits was noted.
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Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015-16 (97cii)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Quality Committee 25th January 2016: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Executive Medical Director
Previously considered by: Not applicable

Summary

This paper identifies the key issues for the Board arising from the Quality Committee on 25 January 2016 and indicates the level of assurance based on the evidence received by the Committee.

Integrated Performance Report
The Committee scrutinised the Quality elements of the integrated performance report (focus on the *safe, caring and effective* cohorts of indicators). The Committee noted:

- Pressure ulcers remain a concern. The committee acknowledged the comprehensive Pressure Ulcer Action plan and the length of time that the plan will need to embed but could only be partially assured as Pressure Ulcers continue to show an increase in numbers in all categories.
- The committee noted the reduction in medication incidents within HMP healthcare and the reduction in falls with the lowest recorded number from April to November 2015.
- The committee requested a deep dive report into End of Life Care for March 2016 to understand the complexity and reasons for not being able to achieve the 90% target.

Director of Nursing: quality and safety report
The Committee acknowledged that the report allows for a wider range of quality and safety information to be reported and discussed and were significantly assured on the processes in the Trust. The committee has requested a substantive report on the safety domain across the Trust against the CQC Key Lines of Enquiry for March 2016 to continue to focus on areas for quality improvement.

Assurance level							
Full		**Significant**	**X**	**Limited**		**No**	

Quality Account
The committee agreed the Quality Account timeline, action plan and retirements. The Committee discussed and revised (to include tightening the indicators) the draft priorities.

Quality Improvement Plan
The committee noted the CQC's revised expectation about timing of re-inspection and current position in relation to its approach to re-inspection. The committee noted SMT's approval for extension of timelines from the 11 January 2016 and were concerned regarding slippage. The committee debated and agreed the extensions acknowledging that the extensions were to ensure change had been embedded and quality Improvement could be better evidenced.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Quality Strategy
The Committee received and agreed the Quality Strategy with minor revisions and recommend the strategy to the Board for approval.

Serious incidents
The Committee received the Serious Incident report and noted the improved picture of overdue actions. The committee remains concerned with regard to the numbers of serious incidents with the majority being pressure ulcers. This concern had been discussed under the integrated performance report.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Thematic Analysis of Incidents: *1 April 2015 – 31 December 2015*
The Committee received the first report of a thematic review of all the incidents reported within the organisation from 1 April 2015 to 31 December 2015. The committee received some assurance on the process and learning on incidents within the organisation. The committee noted that the majority of incidents reported are no or minimal harm (88%) and had already considered the concerns related to pressure ulcers and numbers of serious incidents. The Trust remains in the highest 25% of reporters identified by the National Reporting and Learning System (NRLS).

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Risk Register
The Committee were encouraged by the progress made with the risk register and discussed the three new clinical risks scored 8 and above. These related to: waiting times in Adult Business Unit exceeding 18 weeks as a result of an increase in demand, reduced capacity and process issues in key service areas diabetes, continence (CUCS) and neighbourhood teams (score 12); delivery of specialist wound prevention and management advice as a result of reduced capacity and increased demand (score 12): and risk of high staff turnover in prison service as a result of the loss of the prisons tender (score 9). Increased waiting times arising from increased demand, complexity of referrals and capacity in child and adolescent mental health services (CAMHS) remains an extreme risk (score15+). The committee received some assurance on the controls and actions relating to the new risks and extreme risk and requested a review of the proposed de-escalation of risk 716 'reduced level of care arising from recruitment issues in twilight services' due to concerns with covering the shifts.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Outcome Measures
The Committee received an update on the current position for each business unit on service level outcome measures. The committee was disappointed with the length of time taken to develop outcome measures across the whole Trust and requested that SMT should consider the resource required to progress this area and requested a clearer trajectory going forwards.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

NICE guidance compliance exceptions report 2012 – present
The Committee had requested and welcomed the NICE guidance compliance exceptions report from 2012 to the present date. The Committee received significant assurance on the Trust process and compliance against NICE guidance.

Assurance level							
Full		**Significant**	**X**	**Limited**		**No**	

Well Led Framework
The Committee was concerned about the delay in progress of the proposal and reporting of the Well Led Framework in particular the role for Quality Committee in relation to the quality areas of the framework. A verbal update was provided to the Committee and there was concern that there would be no opportunity for the chair or the Committee to review the proposal before it went to Board. It was agreed that the Chair would be given the opportunity to review the proposal after SMT and prior to Board.

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015-16 (97ciii)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Business Committee 27 January 2016: Committee's Chair assurance report
Responsible Director: Chair of Business Committee **Report author:** Executive Director of Finance & Resources
Previously considered by: Not applicable

Summary
This paper identifies the key issues for the Board arising from the Business Committee 27 January 2016 and indicates the level of assurance based on the evidence received by the committee.

Integrated performance report
The Committee undertook scrutiny of the integrated performance report with a particular focus on the *responsive and well-led* cohort of indicators. The Committee noted that:

- The overall figure for reported falls (68 in November 2015) remained high however the Committee further noted that the volume of falls in community wards had reduced and was at its lowest level in 2015/16 to date
- The scrutiny by the Trust's Mortality Surveillance Group was outlined as the mechanism by which unexpected deaths were reviewed
- The Trust's waiting times performance was considered and debate took place about the results from weekly validation of waiting times data. Only 1% of patients were waiting in excess of 18 weeks across a small number of specialties; this represented a considerable reduction
- In relation to workforce indicators, the improvement in appraisal rates was welcomed; the 89.1% figure in the report had further improved and was over 90% as of the date of the Committee
- Significant change in staff turnover (7.9%) was reported as being a consequence of assertive recruitment activity and efforts to improve retention rates

The Committee concluded that there had been a marked and welcome improvement across a number of the business areas – and fully recognised the significant work that had led to the improvements. It was still early days and the Committee believed that until evidence of sustained improvement was evident, then the assurance level should remain at limited. It greatly welcomed the improvement.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Heat map
The Committee received a set of 'heat maps' which gave a graphic representation of performance of services against a suite of performance indicators. The heat maps were primarily seen as of benefit to operational services and the Senior Management Team, both of which reviewed the data regularly.

The Committee concluded that it would wish to see a quarterly report that focussed on the top three issues drawn from the heat map data, but was significantly assured of the heat maps' benefits as an important management tool.

Assurance level							
Full		**Significant**	**X**	**Limited**		**No**	

Child and adolescent mental health services
Child and adolescent mental health services waiting times remain the highest within the Trust; and were viewed in the context of the important challenge of clinical risk versus waiting times. The arrangements for triaging referrals by clinical priority (immediate, urgent and routine) were reported as resulting in reduced overall waiting times. All patients waiting over 12 weeks will have appointments scheduled prior to 31 March 2016. With immediate effect, any new referrals would have a maximum waiting time of 10 weeks.

The waiting times for autism assessments were noted as a particular challenge; in part resulting from the lack of commissioned and available capacity to meet demand.

Overall, the Committee remained concerned about progress and took only limited assurance from the information, pending further positive reports.

Assurance level							
Full		**Significant**		**Limited**	**X**	**No**	

Finance
The Committee noted that the Trust's financial position has continued to improve towards the end of 2015. The Trust was reporting that it would achieve its financial targets in 2015/16.

The Committee received an early indication of the financial planning assumptions for 2016/17 as published through the dissemination of national business and financial planning guidance. A significant national priority is to return the NHS to financial balance. The Executive Director of Finance and Resources reported on three significant financial pressures for 2016/17 in addition to cost improvement requirement. Together these would place undoubted strain on the Trust to deliver the required financial efficiencies.

Nevertheless, the Committee concluded that the report provided significant assurance that the management processes were aligned to achieving the financial objectives for 2015/16.

Assurance level							
Full		**Significant**	**X**	**Limited**		**No**	

Estates management
The Committee received the first quarterly estates management report; a requirement placed on Leeds Community Ventures (the Trust's estates management provider). The Committee noted the statement of statutory compliance and concluded the update provided significant assurance.

A number of estates-related topics were discussed in terms of determining the Trusts' strategic perspective of the best use to be made of available estate. A draft estates strategy is to be considered by the Committee in May 2016.

Assurance level							
Full		**Significant**	**X**	**Limited**		**No**	

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015-16 (98)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Chief Executive's Report
Responsible Director: Chief Executive
Report author: Chief Executive
Previously considered by: n/a

EXECUTIVE SUMMARY

This report sets out the context in which the Trust works and helps to frame the Board papers. In particular, this month's report focuses on a number of developments covered in more depth by Board discussions on later items, namely:

- Service and business developments
- Winter pressures and the impact on services
- Staffing matters including junior doctors industrial action and recruitment and retention activities
- Non-executive director vacancies
- NHS planning guidance 2016/17 to 2020//2021

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

RECOMMENDATION

The Board is recommended to:

- Note the contents of this report

Links to Strategic Objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community and with a relentless focus on value for money
Links to Principal Risks:	This report sets out a context that is relevant to each of the principal risks.
NHS Constitution:	The values of the NHS Constitution underpin service provision within the organisation: • Working together for patients • Respect and dignity • Commitment to quality of care • Compassion • Improving Lives • Everyone counts
CQC Outcomes:	Outcome 4: Care and welfare of people who use services • People should get safe and appropriate care that meets their needs and supports their rights. Outcome 6: Cooperating with other providers • People should get safe and coordinated care when they move between different services. Outcome 13: Staffing • There should be enough members of staff to keep people safe and meet their health and welfare needs.
Equality and Diversity:	An equality analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	N/A
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act

1. PURPOSE OF THIS REPORT

This report sets out the context in which the Trust works and helps frame the Board papers. The paper describes a number of local developments and, in addition, refers to a small number of external or national announcements that have the potential to impact on the Trust.

2. LOCAL ISSUES

Patient and public engagement in service re-locations

At its December 2015 meeting, the Board received and approved a paper which summarised the outcomes of patient and public engagement in proposals related to the disposition of a range of community services across the city. The proposals contained a number of changes and adjustments which together aimed to ensure a planned approach to the location of services. Furthermore, the changes involved the reduction to the number of locations from which some services are provided and a proposal to cease providing services in Garforth Clinic.

Having approved the proposals, the trust has moved to implement the agreed changes which are as follows:

- Adult dietetics: reduction in clinics provided, from 30 locations locations across Leeds including removal of GP clinics with the exception of provision in Rothwell/Oulton area
- Children's speech and language therapy: reduction in clinics provided, from 23 locations to 12 locations across Leeds, plus changes to referrals, waiting lists and episodes of care
- Psychological therapies: reduction in clinics provided, from 54 locations including removal of GP clinics with the exception of provision in the Compton Centre, Harehills
- Podiatry: reduction in clinics provided, from 25 locations to 19 locations including removal of GP clinics
- Newborn hearing: consideration of options for delivery in hospital and/or fewer locations
- Cardiac rehabilitation: reduction in locations where groupwork programmes provided, from six leisure centres to four leisure centres
- Continence, urology and colorectal service: reduction in clinics provided, from 14 locations to 10 locations
- Changes to Garforth Clinic: moving all services currently provided and closure of the building

To support the changes, a programme of communication with those patients and their families who may be affected by the changes is well underway and is a combination of direct communication with patients, notices within health centre locations and coverage within the media.

Community Ventures Limited has been engaged to advise on the options for the empty Garforth Clinic; and to ensure that the Trust acts in accordance with NHS property regulations and guidance. They will ensure that once the property is fully vacated it will be secured whilst it remains in Trust ownership.

South Leeds independence centre

The South Leeds Independence Centre (SLIC) was commissioned two years ago. Since that time, in response to the local health needs, the unit has accepted patients of a higher acuity than the original commissioned model. The Trust's review of inpatient "safer staffing" identified that the dependency levels of the SLIC patient cohort required higher staffing levels. The CQC and other inspections also required SLIC to increase some aspects of its staffing.

The clinical quality, staffing and financial aspects of the service model were discussed with commissioners during the latter part of 2015. As a consequence, there was an agreement to revert to the original commissioned model. With the support of additional funding from commissioners to meet the demands of the required staffing complement on a non-recurrent basis until March 2017, the centre now operates 40 beds of which 10 are for residential care clients. The ongoing funding for the service is an element of contract negotiations for 2016/17.

Patient care: reducing the incidence of pressure ulcers

The Trust has long been concerned about the incidence of pressure ulcers. Any single incidence is viewed seriously and the Trust wishes to make sure that services and staff are in a position to avoid the occurrence of pressure ulcers to patients under the care of the Trust.

This month has seen the start of the Trust's *Pressure Ulcer Prevention Campaign*. The prevention of pressure ulcers is a measure of the quality of care the Trust provides. Reducing the incidence of pressure ulcers is therefore a top priority for the Trust and all staff. Key to the campaign is the launch of the *Ten Priorities for Pressure Ulcer Prevention*.

Each member of staff from allied health professionals, administration, doctors and nursing teams has a role to play. The campaign is running between January-March 2016 and includes a suite of training initiatives, guidance for staff plus assessment and care management tools. It has started with the neighbourhood teams and then will be rolled out across all the services within the Trust. The key aim being for staff to understand that pressure ulcer prevention is everybody's responsibility.

Health and social care across Leeds: winter pressures

The Trust has played an active role in the system resilience arrangements to ensure the continuity of services across the winter period:

- Early on in the financial year, the Trust was successful in securing funding for a number of schemes aimed at assisting services to be more resilient through the difficult winter months.
- At the end of 2015, there had been a steady but significant decrease in delayed transfers of care. This work has focused on streamlining processes, reducing bureaucracy and early escalation of complex issues related to individual cases.
- There have been changes in the type and number of community beds in the system eg change of classification and management of the community intermediate care unit, the opening of residential beds at SLIC and additional capacity purchased within the independent sector
- Leeds Teaching Hospitals NHS Trust has continued to experience higher than average levels of activity over recent weeks including accident and emergency attendances and emergency medical admissions. The Trust's approach to partnership working is assisting in mitigating the impact of potential unnecessary admissions and delayed discharges from hospital care.

Impact of winter weather: flooding in Leeds

As a result of the severe weather over the Christmas and New Year period. The Assisted Living Leeds (community equipment) service at Clarence Dock was flooded. The site was so severely compromised that it was forced to close. The service moved quickly to set up a temporary warehouse facility. The service, once up and running, prioritised equipment for people being discharged from hospital and for end of life care.

As at 21 January 2016, the service continues to provide services from its disaster recovery site at Cross Green and a warehouse facility operational at the Roseville Enterprises building.

Whilst every endeavour is being made to supply stock to peripheral stores at health centres across the city and to support hospital discharges and end of life care, service provision is still under severe pressure. The service would like to thank all assessors for adapting to the circumstances. Work is being carried out to determine the extent of remedial works and further updates will be provided.

Public health: reductions in funding

The Board has been previously advised of the potential negative impact of reductions in public health services' budgets.

The impact on Leeds is in the context of a requirement for £200 million reduction in public health budgets across the country in 2015/16. A proportionate percentage reduction for Leeds would amount to £2.8 million; from a total budget of £40.5 million of which 85% is spent on a range of commissioned services. Services affected by the budget reductions include: services like smoking cessation, sexual health services, winter wellbeing services, oral health and healthy schools work.

Junior doctors' industrial action

Following a ballot of its members, the British Medical Association (BMA) announced that its junior doctor members would engage in industrial action on three dates in January and February 2016. The planned action was in response to a national dispute in respect of the proposed imposition of new terms and conditions of employment.

The Trust has only nine doctors in training who were contacted to determine their intentions in order to facilitate contingency planning. The Executive Medical Director and clinical leads coordinated business continuity plans to manage the potential for impact on services with the aim of safeguarding services to patients; in effect the impact for the Trust was minimal.

Nursing and midwifery revalidation

Currently, all registered nurses, midwives, community and public health nurses wanting to practice in the UK have to be registered by the NMC; they have to renew their registration every three years. In 2015, the Nursing and Midwifery Council (NMC) set out proposals to strengthen the current requirements for nurses to meet a range of revalidation requirements designed to show that fitness to practice is being maintained. From April 2016, nurses will have to declare adherence to a suite of evidenced revalidation requirements, including: hours in practice, professional development, practice related feedback, declaration of health supported by third party verification of revalidation requirements.

The Trust has undertaken extensive awareness raising amongst its over 1,000 nurses; 410 of whom will need to be subject to the new revalidation processes in 2016/17. Over 400 staff have attended awareness raising workshops and participants have indicated that the process is straightforward. Those staff who need to revalidate in 2016/17 have received personal letters; each clinical lead is aware of those staff with a requirement to revalidate.

Recruitment and retention

The Trust continues to make considerable progress with the recruitment of staff in a very competitive market and is now beginning to report more positive figures. The actual contracted staff for November 2015 is 2,758.5 whole time equivalent; this compares with December 2014 figures of 2,562.7 whole time equivalent.

The staff turnover figures are also reporting a more positive position. December 2015 saw a turnover percentage of 7.9% and the rate was 6.8% in November 2015 (target 9-13%); each of which compare favourably with rates of over 10% for each month for the earlier part of 2015/16.

Despite this more positive outlook, retention of staff remains a focus of concern and is subject to close scrutiny by the Business Committee.

2015 NHS national staff survey

The 2015 national staff survey closed at the end of November 2015.

The survey was open to all employees and everyone was encouraged to take part. The Trust believes that everyone's views are important as the results provide a picture of what it is like to work for the Trust. The higher the survey response rate, the more confident the Trust can be that the survey findings are representative of the views of staff as a whole. 51% of staff have responded compared to a response rate in 2014 of 34%. The outcomes from the survey will be reported to the Board at its 31 March 2016 meeting.

Leeds health and social care workforce plan

Workforce leaders across Leeds are pooling expertise and insights in order to build a city-wide workforce plan. The approach, being developed by a workforce enabling group is seeking to develop a plan whereby:

- The workforce is aligned to the design of future health and social care and meets future citywide needs of a diverse population of all age groups
- There is a sustainable and affordable workforce that meets the health and social needs of a diverse population of all ages groups in Leeds
- An integrated and shared resourcing approach is in place for the education and training of the health and social current and future workforce to meet citywide needs

Therefore workforce leaders agree to change the health and social care workforce to align around a people centred approach by:

- Engaging and motivating the workforce to deliver Leeds health and wellbeing outcomes
- Building the workforce around care delivery models that meet the forecast needs of the population of Leeds
- Integrating the workforces through shared values and behaviours and flexible and collaborative ways of working
- Fostering training and enhancing and appropriately incentivising the workforce to ensure effective and high quality services
- Participating in a city wide approach to attract people, particularly young people, into health and social care jobs and careers
- Recognising that Leeds Teaching Hospital Trust is a provider of some specialist services for the region and further afield and these will also be subject to change drivers outside the local population
- Using/testing the Calderdale framework approach to workforce redesign, and to develop and share trained capacity across the city to support modernisation projects

Board membership: non-executive director vacancies

The Trust has to report that two of the non-executive members of the Board have decided to step down from their Board roles as at 31 March 2016.

Robert Lloyd will be leaving after some five years with the Trust including a period as Acting Chair; Robert has served as the Trust's Deputy Chair, Senior Independent Director and has been a member of the Audit Committee, Business Committee and the Nominations and Remuneration Committee.

Professor Ieuan Ellis, having completed his contracted term with the Trust, has concluded not to seek a further extension to his term of office when this lapses at the end of March 2016. Ieuan has been an active member of the Trusts' Quality Committee and Audit Committee and has chaired the Mental Health Act Governance Group.

Both Robert and Ieuan have made considerable contributions to the Trust and will be greatly missed by everyone.

3. NATIONAL ISSUES

NHS planning guidance 2016/17 to 2020/21

On 22 December 2015, planning guidance was published by NHS England, in partnership with the five bodies (NHS Improvement (Monitor and TDA), Health Education England, the National Institute for Clinical Excellence, Public Health England and the Care Quality Commission).

This year's guidance has been published in the context of the spending review announcements, and is explicitly positioned to set out how the sector is expected to deliver the Five Year Forward View by 2020, 'restore and maintain financial balance' and 'deliver core access and quality standards for patients'

This year, organisations within the NHS will be required to produce two plans:

- All trusts are required to develop and submit one year operational plans for 2016/17. Plans need to be consistent with longer term (five year) plans and be produced in time to enable contract sign off by the end of March 2016.
- All local health and care systems will be required to develop a five year sustainability and transformation plan (STP), covering the period October 2016 to March 2021 subject to a formal assessment in July 2016 following submission in June 2016.

The guidance gives requirements for the coming year, these are:

- Return the system to aggregate financial balance; all operational plans will need to demonstrate: reconciliation of finance with activity and planned contribution to efficiency savings
- A local plan to address the sustainability and quality of general practice including workforce and workload issues

- Access standards for A&E and ambulance waits (95% patients wait no more than four hours in A&E and that ambulances respond to 75% of Category A calls within eight minutes)
- NHS Constitution standards for referral to treatment (more than 92% patients on non-emergency pathways wait no more than 18 weeks from referral to treatment)
- Constitutional standards on cancer care, including 62 day cancer waiting standard and the constitutional two week and 31 day cancer standards, making progress in earlier diagnosis and improving one year survival rates
- Two new mental health access standards (more than 50% people experiencing a first episode of psychosis will commence treatment with a NICE approved package within two weeks of referral; 75% referrals to IAPT will be treated within six weeks and 95% within 18 weeks)
- Local plans to transform care for people with learning disabilities including enhanced community provision, reducing inpatient capacity and rolling out care and treatment reviews
- Affordable plan to make improvements in quality particularly for organisations in special measures. Providers are required to participate in the annual publication of avoidable mortality rates by individual trust.
- In addition, the planning guidance draws particular attention to the delivery of seven day services and the development of new care models

For the first time, local NHS planning will become the application process for additional national funding through a sustainability and transformation fund. This protected funding will be for initiatives including the spread of new care models, primary care access and infrastructure, technology roll-out and clinical priorities such as diabetes, learning disabilities, cancer and mental health.

The planning guidance has been amplified by a joint letter from Jim Mackey (Chief Executive, NHS Improvement) and Professor Sir Mike Richards (Chief inspector of Hospitals) asking Boards to consider quality and finances on equal footing in their planning decisions.

NHS Leaders' Planning Event

In December 2015, NHS leaders were invited to a planning event in Leeds which included presentations from Simon Stevens (Chief Executive NHS England) and Jim Mackey (Chief Executive, NHS Improvement). Amongst many matters there was a clear expectation that organisations should focus on three key priorities:

- Financial performance: early financial 'grip' is essential.
- Achievement of targets
- Service re-design: doing 'more and faster' whilst reconciling quality and financial challenges

4. RECOMMENDATION

4.1 The Board is recommended to:

- Note this report

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM
2015-16
(99)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Outline financial planning assumptions 2016/17
Responsible Director: Executive Director of Finance and Resources **Report author:** Executive Director of Finance and Resources
Previously considered by:

EXECUTIVE SUMMARY

This paper sets out the financial context for 2016/17 at a national level and describes the consequences for the Trust. This paper is being presented today rather than as part of the more detailed consideration of the Trust's financial plans over the next few weeks leading up to budget approval, as a result of a specific requirement of boards by 8 February 2016.

The Chief Executive and the Executive Director of Finance and Resources will explain the position and report on discussions with colleagues at the NHS Trust Development Authority over the past week. At the time of writing, it is the intention to submit a financial plan to deliver a 1% surplus, ie the Trust does not believe that it can achieve the control target of £2m without affecting service delivery.

RECOMMENDATION

The Board is asked to agree that, on current assumptions, the Trust cannot achieve the £2m surplus control total.

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community & with a relentless focus on value for money
Links to principal risks:	All
NHS Constitution:	All
CQC Outcomes:	All
Equality and diversity:	An Equality Analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	n/a
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act

1. NATIONAL FINANCIAL CONTEXT

As announced in the recent Spending Review, the government has committed to provide an additional £8.4 billion real-terms funding for the NHS by 2020/21. The increase in funding available for 2016/17 totals £3.8 billion in real terms, a £5.4 billion cash increase. It includes a £1.8 billion Sustainability and Transformation Fund (S&T Fund) for the provider sector in 2016/17.

NHS Improvement (Monitor and the TDA until 31 March 2016) states that this is a good settlement for the NHS in times of public spending constraint when the majority of government departments are facing real-terms funding reductions. However, this settlement is dependent on the NHS provider sector delivering a deficit of not more than £1.8 billion in 2015/16 and breaking even in 2016/17 after application of the fund.

To realise this settlement, NHS Improvement has set out what all boards must urgently do during the remainder of the 2015/16 financial year. As the Trust expects to achieve its agreed financial target, this paper does not consider this element of recent communications.

2. 2016/17 FINANCIAL FRAMEWORK AND PLANNING.

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21. sets out the steps to help local organisations deliver a sustainable, transformed health service and improve quality of care, wellbeing and NHS finances. It included details of the operational planning approach for the next financial year and set out a pragmatic approach to tariff setting and business rules, with the aim of supporting system stability and recovery in 2016/17. The key details of this package, which NHS Improvement say is favourable for most NHS providers, are set out below:

- A cost uplift of 3.1%, reflecting a stepped change in the cost of employers' pension contributions.
- Additional funding to cover the aggregate increased cost of CNST contributions. In addition to the general cost uplift, the majority of the increase in CNST contributions will be targeted at particular HRG chapters.
- An efficiency factor of 2%, which results in a net prices uplift of 1.1%.
- An increase in the marginal rate for emergency admissions to 70% for all providers.

Other system management changes relevant to this Trust include:

- Commissioners are required to plan to spend 1% of their allocations non-recurrently, consistent with previous years. For provider funds to insulate the health economy from financial risks, the 1% non-recurrent expenditure should be uncommitted at the start of the year.
- The requirement for commissioners and councils to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. Further, BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care.

3. £1.8 BILLION S&T FUND FOR 2016/17

The planning guidance introduced the £1.8 billion S&T Fund for 2016/17. The fund will be used to support providers move to a sustainable financial footing and will be deployed in a way that creates a balanced aggregate financial position in the NHS trust and foundation trust sector in 2016/17.

As such, the 2016/17 S&T Fund will have two elements:

- a 'general element' which will be distributed to all providers of acute emergency care and be linked to the setting of agreed control totals
- a 'targeted element' to support trusts drive efficiencies and go further faster; this will be targeted at leveraging greater than 1:1 benefits from providers.

Details on how to access the targeted element of the fund will be made available later in the planning process. This will be particularly relevant for mental health ambulance, and community services providers who are unlikely to be eligible for the general element of the fund.

This additional funding is conditional on the NHS provider sector breaking even in 2016/17. To ensure this happens, every NHS trust and NHS foundation trust will have to deliver **an agreed financial control total for 2016/17**. This will be a core part of the new financial oversight regime that NHS Improvement will put in place.

An impact assessment model has been developed by NHS Improvement that models a range of known factors at an individual provider level. The outcome of this work will be used to allocate acute emergency care providers with an indicative payment from the S&T Fund and all providers with a control total for 2016/17.

Details on how to access the targeted element of the fund will be made available later in the planning process. This will be particularly relevant for mental health ambulance, and community services providers who are unlikely to be eligible for the general element of the fund.

4. CAPITAL

The NHS settlement for 2016/17 relies on tight financial management of the capital budget. We will need to work very closely with providers to develop a capital framework which enables them to operate within the resource available. Providers should develop their capital plans for 8 February 2016, distinguishing essential expenditure from strategic investments. This should prepare providers for restrictions to both access to external finance and deployment of existing cash reserves to ensure the NHS does not exceed its capital budget. Providers that have agreed local capital to revenue transfers for 2015/16 will not be disadvantaged by these agreements in 2016/17.

5. LEEDS COMMUNITY HEALTHCARE NHS TRUST

The Trust has been informed by NHS Improvement that our control total is £2m. This is some £550k more than a 1% surplus would generate.

As expected the Trust has not been allocated any of the “general” S&T Fund.

NHS Improvement has asked all trusts to confirm by 8 February 2016 that they accept the control total.

Whilst this seems aimed at trusts in receipt of general S&T Fund, Leeds Community Healthcare NHS Trust will be required to accept this control total with an expectation that it does so and that this is reflected in initial planning submission to NHS Improvement on 8 February 2016.

The Board should be aware of the potential consequences of this. At the time of writing contract negotiations with CCG commissioners have just commenced and all the indications are that this will be a difficult negotiation. Leeds City Council, as commissioner of the public health services has already indicated a position based on the known cut to its public health funding in 2016/17 and beyond.

In addition, the Trust faces significant internal cost pressures totalling over £2.3m as a result of increased charges for occupation of LIFT buildings, transfer of cost of SystmOne from NHS England to the Trust and the loss of contribution and margin from the loss of the adult prison service. Taken with the impact of the control total these issues take our implied efficiency level from the national 2% to 4% in themselves.

On capital, the Trust would not ordinarily be concerned about capital but the tightening of the regime, whether or not providers have access to the cash for investment, is concerning when a significant investment in replacement premises will be required in addition to further investment in technology to modernise services.

6. RECOMMENDATION

The Board is asked to agree that, on current assumptions, the Trust cannot achieve the £2m surplus control total

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM
2015-16
(100)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Integrated Performance Report
Responsible Director: Executive Director of Finance and Resources **Report author:** Executive Director of Finance and Resources
Previously considered by: Senior Management Team: 21 October 2015 Quality Committee: 25 January 2016 Business Committee: 27 January 2016

EXECUTIVE SUMMARY

Prior to consideration by the Board, the Quality Committee has examined in detail the on safe, effective and caring domains and the Business Committee has examined the responsive and well led domains whilst maintaining an overview of performance across all key performance indicators**.**

Current Quality Key Points

Pressure Ulcers: Patients continue to acquire category 2, 3 and 4 pressure ulcers with a continued overall peak in pressure ulcers for the second month and three category 4 pressure ulcers being reported in November 2015.

Patient Falls: Fourteen falls were reported in community wards in November 2015. This was the lowest recorded number from April to November 2015. 75% of falls occurring April to November 2015 have resulted in no harm. Four falls resulted in harm (28.6%) all of which were minimal harm.

Medication Incidents: There has been a reduction in medication incidents within HMP healthcare.

Current Performance Key Points

Appraisal: The appraisal position in December 2015 shows the Trust achieving 89.1% of available staff appraised. This represents a significant 5.5% improvement on the November 2015 position. Action will continue towards achieving the target.

Statutory and Mandatory Training : Delivery of the statutory and mandatory training target has improved significantly in December, with the current position being 87.2%, a rise of 6.1%. This demonstrates the significant strides being made towards compliance around Information Governance training.

Income and Expenditure: There is high confidence that the target surplus agreed with the NHS Trust development Authority will be achieved.

RECOMMENDATION

The Board is asked to assess the Trust's performance against all its performance objectives.

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community & with a relentless focus on value for money
Links to principal risks:	All
NHS Constitution:	All
CQC Outcomes:	All
Equality and diversity:	An Equality Analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	n/a
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act

Leeds Community Healthcare NHS Trust

for you, for life

Agenda item
2015/16
(100)

Leeds Community Healthcare NHS Trust

Integrated Performance Report, December 2015

Board - 5 February 2016

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Executive Summary

This report sets out the performance of Leeds Community Healthcare (LCH) against key national and contractual targets. It provides a summary of performance against targets and indicators, highlighting areas of note by exception and adding additional information where this would help to explain current or forecast performance.

Balanced Scorecard – KPIs, December 2015

Safe	Freq	Source	YTD Target	Lead	Q1	July	Aug	Sept	Oct	Nov	Dec	YTD	Forecast
Patient Safety Incidents Reported in Month Reported as "Harmful"	M	TDA	30%	MP	35.5%	33.1%	32.2%	32.8%	32.8%	32.0%	39.3%	33.6%	●
Patient Safety Incidents Reported in Month Reported as "No Harm"	M	TDA	70%	MP	64.5%	66.9%	67.8%	67.2%	67.2%	68.0%	60.7%	66.4%	●
Potential Under-reporting of Patient Safety Incidents	M	TDA	-	MP									
S.I.s	M	TDA	0	MP	22	8	9	10	10	17	9	85	●
Harm Free Care (Safety Thermometer)	M	TDA	95%	MP	93.9%	94.0%	94.8%	94.2%	93.8%	93.2%	94.4%	-	●
%age New Harms (Safety Thermometer)	M	TDA	TBC	MP	3.3%	2.4%	3.1%	2.4%	3.4%	4.3%	1.8%	-	
VTE Risk Assessment	M	TDA	95%	MP	89.3%	93.1%	91.1%	86.3%	80.0%	95.5%	91.4%	-	●
Safety Thermometer - VTE	M	TDA	100%	MP	94.7%	100%	98.3%	96.6%	86.3%	100%	100%	95.8%	●
5% Falls Reduction Target - IP beds	M	Local	72.7	MP	20	10	5	4	6	4	6	55	●
5% PU Reduction Target (Grade 2 and 3)	M	Local	143.2	MP	80	31	24	19	35	33	32	254	●
CAS Alerts Outstanding	M	TDA	0	MP	1	0	0	0	0	0	0	1	●
Best Start - Children with Complex Needs	Q	CQUIN		MP									●
Child Protection Supervision	Q	Contract	85%	SP	88.4%	92.2%			93.5%*				●
Medication errors causing major harm	M	TDA	0	MP	0	0	0	0	0	0	0	0	●

** The child protection supervision data is not yet complete. The figure quoted will be representative, but is not the final figure. This will be updated as soon as possible.*

Effective	Freq	Source	YTD Target	Lead	Q1	July	Aug	Sept	Oct	Nov	Dec	YTD	Forecast
Patient Contacts	M	Contract	1791735	SP	572430	201721	183599	193774	205146	197248	189958	1743874	●
Breast Feeding - Coverage	Q	National	95%	SP	95.5%	98.2%			97.2%			97.2%	●
Breast Feeding - Prevalence	Q	National	44%	SP	46.0%	48.5%			47.6%			47.6%	●
National Child Measurement Yr R	M	National	32.4%	SP	93.4%	97.9%	-	0.0%	2.1%	15.7%	26.6%	-	●
National Child Measurement Yr 6	M	National	17.6%	SP	86.4%	95.8%	-	0.1%	9.4%	16.2%	17.6%	-	●
IAPT - Completion as Moving to Recovery	M	Contract	2678	SP	700	210	211	220	166	219	220	1,946	●
Caring	**Freq**	**Source**	**YTD Target**	**Lead**	**Q1**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**YTD**	**Forecast**
Staff FFT % Recommended - Care	Q	TDA	-	SE	76.8%	78.0%							
Inpatient Scores from FFT - % +ve	M	TDA	100%	MP	97%	97%	92%	100%	95.4%	94.7%	100.0%	-	●
Inpatient Scores from FFT - % -ve	M	TDA	0%	MP	1%	0%	8%	0%	0%	0%	0%	-	●
FFT % Recommended	M	TDA	-	MP	94.2%	94.2%	93.8%	93.5%	93.6%	95.5%	94.5%	-	
% Complaints Acknowledged within 3 Working Days	M	QA	100%	MP	94%	92%	100%	100%	100%	100%	100%	97%	●
% Complaint Responses Sent within Statutory Guidance (6m)	M	QA	100%	MP	100%	93%	100%	100%	100%	100%	100%	100%	●
Written Complaints - Rate	M	TDA	-	MP									
Dementia (Community Matrons & Inpatients) Case Finding	Q	CQUIN	90%	MP	92.5%	92.1%			87.3%				●
Appropriate Assessment	Q	CQUIN	90%	MP	90.0%	94.1%			94.1%				●
Care Plan on Discharge	Q	CQUIN	90%	MP									
End of Life Care - Preferred Place of Death	M	Contract	90%	MP	83.2%	81.3%	78.2%	80.7%	87.6%	79.8%	78.9%	83.9%	●

Responsive	Freq	Source	YTD Target	Lead	Q1	July	Aug	Sept	Oct	Nov	Dec	YTD	Forecast
% of patients treated within 18 weeks	M	TDA	95%	SP	99.9%	99.7%	100%	99.7%	100.0%	99.9%		-	●
% of Patients currently waiting under 18 weeks (RTT Incomplete)	M	TDA	92%	SP	99.9%	99.9%	99.8%	100.0%	99.8%	99.9%		-	●
Referral to Treatment >52 week waiters	M	TDA	0	SP	0	0	0	0	0	0		0	●
DM01 - Diagnostics (<6 Weeks)	M	TDA	99%	SP	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	●
% Patients waiting over 18 weeks (non reportable)	M				2.0%	1.4%	1.2%	1.5%	1.1%	1.0%	1.4%	-	
CAMHS - Reduce Waiting Times	M	CQUIN	15 wks	SP	106	161	194	215	239	179	116	-	●
DTOC	M	TDA	7.5%	SP									
Cancellation Rate (S1 data only)	M	TDA	-	SP	6.1%	5.9%	5.8%	6.5%	6.5%	5.1%	6.7%	6.0%	
CAMHS - 4 hour response for young people who self-harm	M	Contract	90%	SP	96.0%	96.8%	91.7%	94.1%	92.3%	100.0%	93.5%	95.3%	●
Health Needs Assessment completed in 20 working days - LAC	M	Contract	95%	SP	98.4%	90.9%	100%	100%	100%	100.0%	100%	98.6%	●
IAPT - Number Entering Service	M	Contract	10710	SP	3265	1084	845	962	1025	1084	844	9,109	●
IAPT % Treated within 18 weeks	M	TDA	95%	SP	100%	100%	100%	100%	100%	100%	100%	-	●
IAPT % Treated within 6 weeks	M	TDA	75%	SP	99.5%	99.6%	98.8%	97.8%	97.8%	98.6%	99.2%	-	●

Well Led	Freq	Source	YTD Target	Lead	Q1	July	Aug	Sept	Oct	Nov	Dec	YTD	Forecast
Overall Safe Staffing Fill Rate - Inpatients	M	TDA	-	SE	101.2%	100.3%	102.3%	100.1%	100.0%	102.1%	101.0%	101.1%	●
Temporary Staff Spend on Clinical Staff	M	TDA	10.7%	BM	12.3%	13.5%	12.6%	12.0%	11.6%	10.9%	9.3%	-	●
Staff Sickness	M	TDA	4.2%	SE	5.0%	5.2%	5.3%	5.2%	6.0%	5.7%	5.8%	5.4%	●
Staff Appraisals	M	Local	95%	SE	80.8%	80.1%	81.3%	83.3%	82.9%	83.6%	89.1%	89.1%	●
Staff Turnover	M	TDA	9-13%	SE	15.5%	16.8%	16.0%	19.2%	15.7%	6.8%	7.9%	14.6%	●
6 universal Statutory and Mandatory training requirements (Avg)	M	Local	95%	SE	87.6%	88.3%	89.0%	89.3%	89.8%	81.1%	87.2%	87.2%	●
No of HVs	M	National	166.4	SP	160.88	159.78	158.00	159.90	169.40	166.43	165.58	-	●
Staff FFT Response Rate	Q	TDA	-	SE	19.8%	23.0%							
Staff FFT %age Recommend Work	Q	TDA	-	SE	43.0%	44.0%							
Inpatient FFT Response Rate	M	TDA	-	MP	2.7%	3.6%	1.5%	1.4%	2.4%	2.1%	2.5%	-	
FFT Response Rate	M	TDA	-	MP	25.1%	29.3%	15.9%	9.5%	20.0%	17.3%	1.0%	-	
Monitor Governance Rating	M	TDA	-	MP								-	●

Finance	Freq	Source	YTD Target	Lead	Q1	July	Aug	Sept	Oct	Nov	Dec	YTD	Forecast
Monitor Sustainability & Financial Performance Risk Rating (CSRR to Aug)	M	TDA	4	BM	4	3.5	4	4	4	4	4	4	●
Actual Efficiency Recurring/Non Recurring Compared to Plan - YTD	M	TDA	£3.3m	BM	£1.0m	£0.4m	£0.8m	£0.3m	£0.4m	£0.4m	£0.4m	£3.7m	●
Actual Efficiency Recurring/Non Recurring Compared to Plan - Forecast	M	TDA	£5.3m	BM	£5.0m	£5.0m	£5.0m	£5.0m	£5.0m	£4.6m	£4.6m	£4.6m	●
Net Surplus(-)/ Deficit(+) (£m) - YTD	M	TDA	-£0.8m	BM	-£0.3m	£0.4m	-£0.3m	£0.1m	-£1.0m	£0.2m	-£1.1m	-£2.0m	●
Net Surplus(-)/ Deficit(+) (£m) - Forecast	M	TDA	-£2.2m	BM	-£1.5m	-£2.2m	-£2.2m	-£2.2m	-£2.2m	-£2.2m	-£2.7m	-£2.7m	●
Forecast underlying surplus	M	TDA	-£1.5m	BM	-£1.5m	-£1.5m	-£1.5m	-£1.5m	-£1.5m	-£0.8m	-£0.8m	-£0.8m	●
Forecast Year End Charge to Capital Resource Limit	M	TDA	£2.4m	BM	£2.4m	£2.4m	£2.4m	£2.4m	£2.4m	£2.4m	£1.9m	£1.9m	●

Current Quality Key Points			
Description	Strategic Objective	Risk Register	Update
Pressure Ulcers	High Quality, Safe Services	Yes	Patients continue to acquire category 2, 3 and 4 pressure ulcers with a continued overall peak in pressure ulcers for the second month and three category 4 pressure ulcers being reported in November.
Patient Falls	High Quality, Safe Services	Yes	Fourteen falls were reported in community wards in November 2015. This was the lowest recorded number from April to November 2015. 75% of falls occurring April to November 2015 have resulted in no harm. Four falls resulted in harm (28.6%) all of which were minimal harm.
Medication Incidents	High Quality, Safe Services	Yes	There has been a reduction in medication incidents within HMP healthcare.

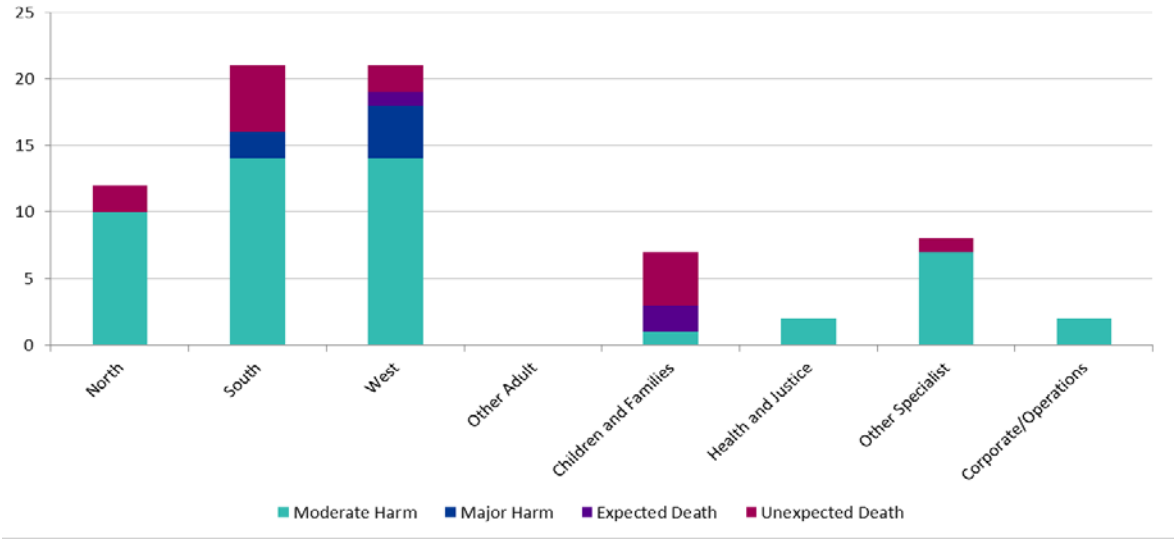
Current Performance Key Points			
Description	Strategic Objective	Risk Register	Update
Appraisal	Engage and Empower Staff	No	The appraisal position in December shows the Trust achieving 89.1% of available staff appraised. This represents a significant 5.5% improvement on the November position which is significant. Action will continue towards achieving the target.
Statutory and Mandatory Training	Engage and Empower Staff	Yes	Delivery of the statutory and mandatory training target has improved significantly in December, with the current position being 87.2%, a rise of 6.1%. This demonstrates the significant strides being made towards compliance around Information Governance training.
Income and Expenditure	Value for money	Yes	There is high confidence that the target surplus agreed with the TDA will be achieved.

1 Measure : Safe

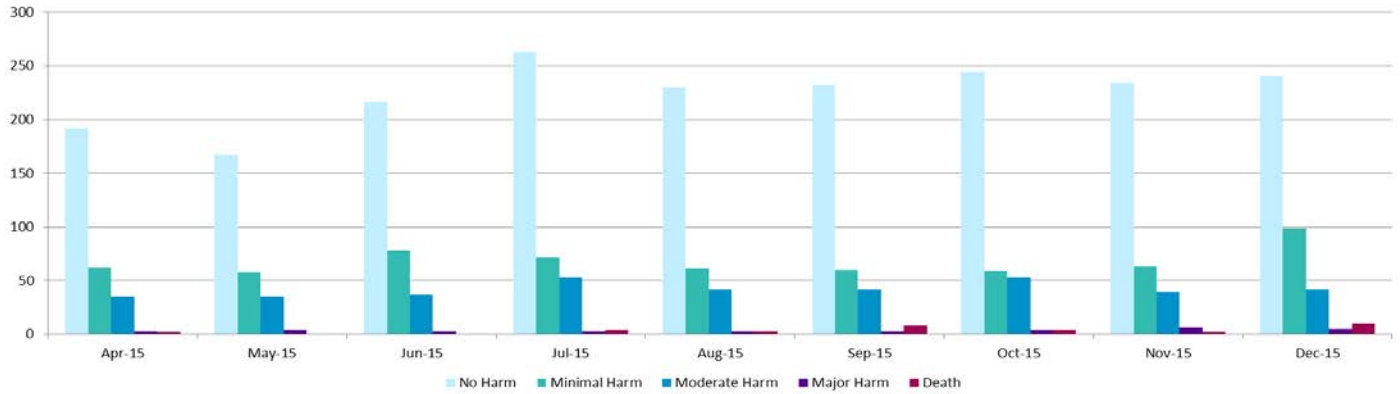
1.1 Patient Safety

The graph and table below shows the number of incidents reported during December, by locality/department, where the severity is moderate harm, major (severe) harm or death. 57 of the 73 incidents were patient safety incidents (PSIs)*.

(NPSA defines a Patient Safety Incident as: Any unintended or unexpected incident(s) that could have or did lead to harm for one or more person(s) receiving NHS funded healthcare)*



The graph below shows all PSIs reported, by degree of harm, from 1 April 2015 to 31 December 2015.



1.1.1 Moderate Harm Incidents *(NPSA definition: short term harm, patient(s) required further treatment or procedure)*

8.9% (50) of all incidents (561) reported in December 2015 resulted in moderate harm. Seven of these were not patient incidents (Staff, Trust or Visitors) and 43 were patient incidents; 42 were patient safety incidents (PSIs).

Of the 42 PSIs, 28 occurred in LCH care. Of these 9 were category 3 pressure ulcers, 3 were unstageable pressure ulcers and 8 falls, the remaining 8 were a wide spread of categories.

Where a specific issue is identified from moderate harm reports, the relevant experts are made aware of them and take appropriate action to support their local management (e.g. Fire Officer, Health & Safety and Safeguarding). Themed incidents are also reported to the relevant committee.

There was an increase in reported PSIs in the Specialist BU. The increase is attributable to the reporting of incidents that occurred in other organisations and a patient who fell in their own home, who was not a patient known to be at risk of falls.

In October 2015 the Children's BU launched a unit wide approach to support the investigation of all PSI more robustly to ensure lessons are shared across teams and services. Little Woodhouse Hall has experienced 10 minor PSIs relating to one young person self-harming. There is a considerable amount of work going on to support the staff in dealing with this and in continuing to improve the environment to reduce the risk of self-harm occurrence. In each case there was minimal harm and the appropriate clinical care was immediately provided. Regular re-assessment of the clinical risks involved is being carried out and appropriate escalation to senior managers has been undertaken.

1.1.2 Major Harm

(NPSA definition; permanent or long term harm)

Six major harms were reported in November:

- 2 occurred in Specialist BU at HMP Leeds: 1 Suspected suicide and one attempted suicide that required resuscitation on site
- 4 occurred in Adult BU:
  1 category 4 pressure ulcer (Meanwood NHT)
  1 Fractured Neck of Femur following fall at home reported by Seacroft NHT
  1 delayed diagnosis/admittance to hospital for surgery
  1 patient reviewed in nursing home following CT scan, reporting increased pain, returned to hospital via PCAL and Fractured Neck of Femur found

Five major harms were reported in December, all within Adult BU:

2 Fractured Neck of Femur occurring in patient homes reported by Yeadon NHT
1 category 4 pressure ulcer reported by Yeadon NHT (not in LCH Care)
1 Fractured Neck of Femur occurred in Middlecross nursing home – reported by Armley NHT
1 missed visit to patient that may have contributory factor to patient requiring surgery- reported by Kippax NHT

1.1.3 Unexpected Deaths

There were 14 unexpected deaths reported during December. Nine occurred in Adult services, 1 in Specialist Services and 4 in Children's services. Children's services began reporting their expected and unexpected deaths on Datix in December 2015; this has contributed in the rise in unexpected deaths reported.

Unexpected deaths are reviewed by the Mortality Surveillance Group.

1.2 No harm

In the overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 October 2014 to 31 March 2015 (most recent data available) "nationally, **71 per cent** of incidents are reported as no harm, and just under 1 per cent as severe (*major*) harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult".

The table below breaks down all, patient and PSIs and shows the percentage of 'no harm' PSIs to be **60.7%** for December 2015 **(Trust target 70%)** with a YTD figure of 65.7%. Consideration will be given to the 2016/17 target at year end 2015/16.

	All Incidents 15/16	Patient Incidents	Patient Safety Incidents *	LCH Patient Incidents	Harm Caused % No Harm
Apr-15	456	377	294	286	65.3%
May-15	529	402	264	329	63.3%
Jun-15	490	386	334	298	64.7%
Jul-15	540	420	394	324	66.8%
Aug-15	486	371	339	298	67.8%
Sep-15	472	351	345	270	67.2%
Oct-15	510	374	364	293	67.0%
Nov-15	555	399	344	309	68.0%
Dec-15	561	437	397	324	60.7%
YTD	**4599**	**3517**	**3075**	**2731**	**65.7%**

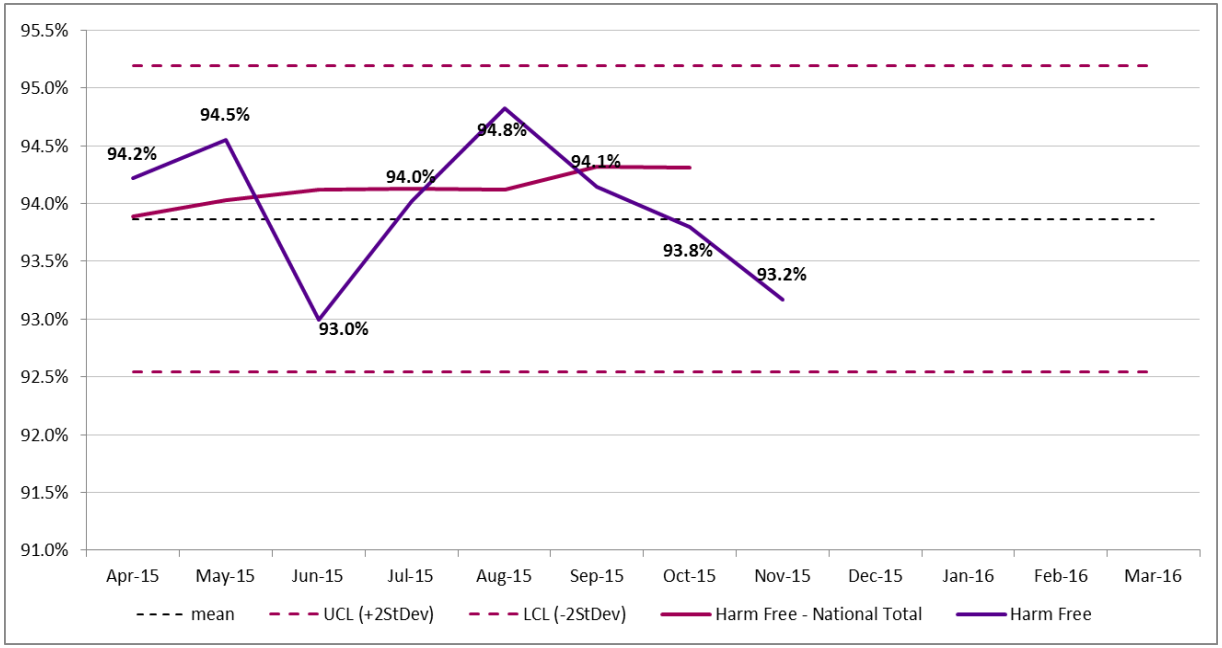
Children's BU remains above the 70% no harm target.

It is recognised that the percentage of no harm PSIs has continued to sit below the Trust target over the nine month reporting period and December's figures is the lowest of all sitting 5% below the YTD average. Further exploration of this relies on the availability of more detailed analysis; the available data is currently being reviewed in order to identify any emerging issues or trends; any significant feedback will be reported over Quarter 4.

1.3 Safety Thermometer

At the time of writing, the ST information for December was under review for validation purposes and was therefore unavailable to include. December's ST data will therefore be included in the February's report.

The harm indicators show consistency in the **percentage** in all areas, as seen in the graph and table below. To provide context upper and lower limits have been applied to the graph though a statistical process control (SPC) and it can be seen from the chart that the 'harm free' values remain within the normal tolerance levels at 93.2% albeit there has been a continual decrease over the last 3 months of reporting from 94.8% in August.



1.4 VTE

The table below shows the number of reported VTEs between April and November 2015 with no new occurrences to report for November. All occurred within the Adult Business Unit.

VTEs by Type (all in the Adult Business Unit)

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Old DVT	0	2	1	0	6	0	0	0
New DVT	0	0	0	0	0	0	0	0
Old PE	0	0	1	1	2	0	0	0
New PE	0	0	0	0	0	0	0	0
Old Other	0	1	0	0	0	0	0	0
New Other	0	0	2	0	0	0	0	0
Total	**0**	**3**	**4**	**1**	**8**	**0**	**0**	**0**

1.5 Falls

From 1 April 2015 to 31 November 2015 548 were reported. Sixty nine falls were reported in November 2015 and 68 (98.6%) of these occurred within the Adult Business Unit. The one remaining fall occurred in the Specialist BU. The table shows the overall level of harm relating to these incidents, by month.

Number of Falls by Severity in Adult Business Unit

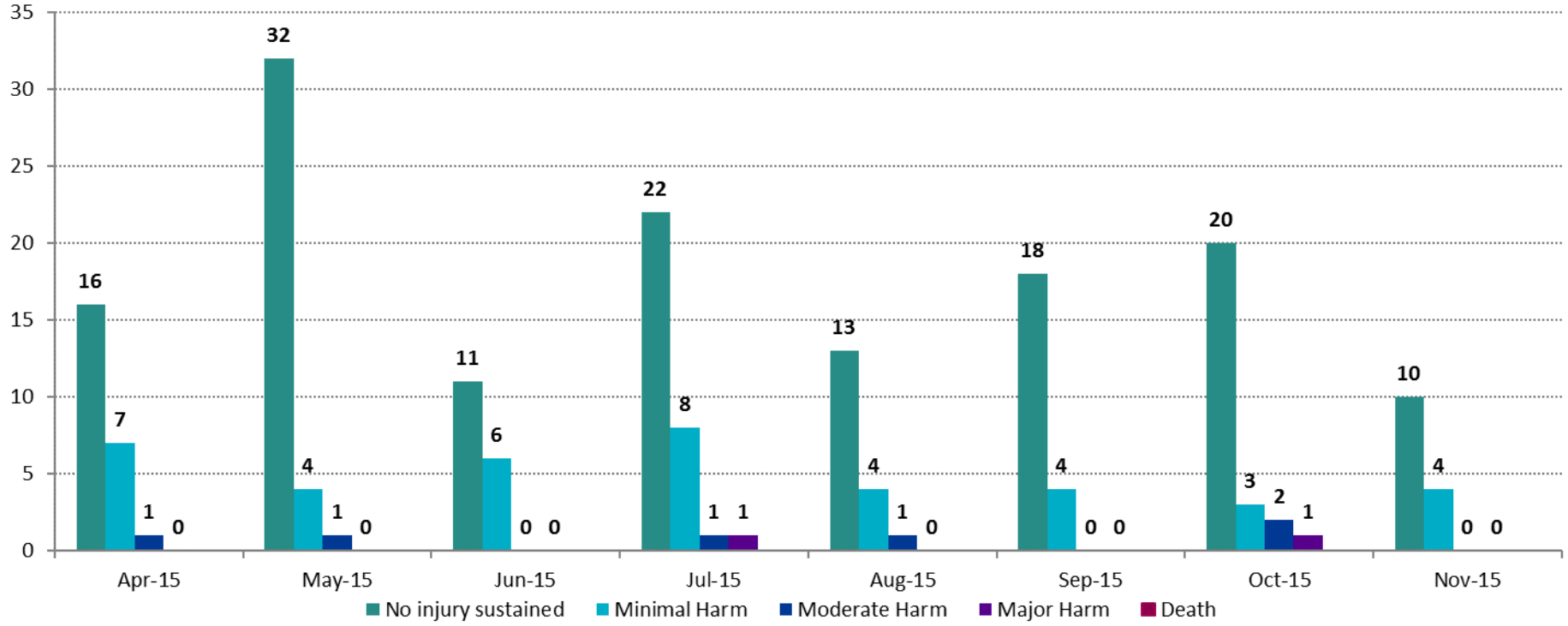
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
No injury sustained	30	55	38	53	34	41	32	45
Minimal Harm	16	18	21	19	14	14	10	17
Moderate Harm	8	6	2	7	5	7	11	5
Major Harm	3	2	2	3	1	2	2	1
Death	0	0	0	0	1	0	0	0
Total	**57**	**81**	**63**	**82**	**55**	**64**	**55**	**68**

One hundred and eighty nine falls (34.5% of all) were reported in inpatient units from April 2015 to November 2015. Fourteen falls were reported in community wards in November 2015. This was the lowest recorded number from April to November 2015.

The table and graph below demonstrates the level of harm resulting from falls in inpatient areas, for April to November 2015, by severity and month. 75% of falls occurring from April to November 2015 have resulted in no harm. During November 2015, 4 falls resulted in harm (28.6%) all of which were minimal harm.

Number of Falls in Community Inpatient Units by Severity (All in Adult Business Unit)

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
No injury sustained	16	32	11	22	13	18	20	10
Minimal Harm	7	4	6	8	4	4	3	4
Moderate Harm	1	1	0	1	1	0	2	0
Major Harm	0	0	0	1	0	0	1	0
Death	0	0	0	0	0	0	0	0
Total	**24**	**37**	**17**	**32**	**18**	**22**	**26**	**14**
Total Falls Resulting in Harm	**8**	**5**	**6**	**10**	**5**	**4**	**6**	**4**

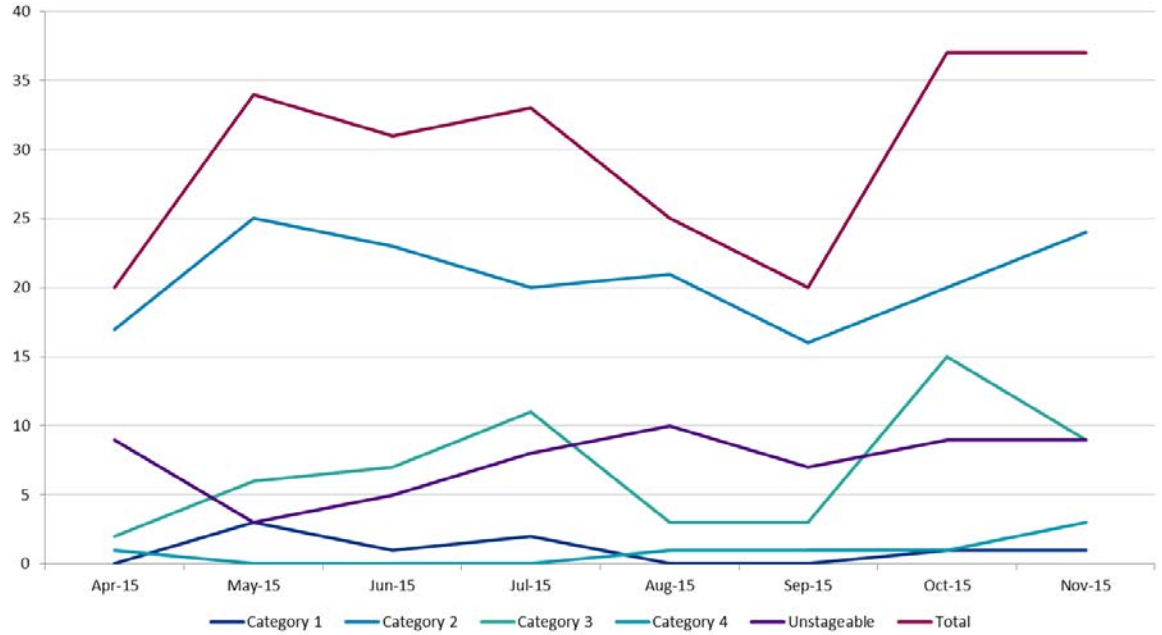


1.6 Pressure Ulcers

The following table shows the number of patients acquiring Grade 2, 3 & 4 pressure ulcers broken down by location during April to November 2015. Thirty three patients developed pressure ulcers, this being slightly above average (31.7) for the period April to November 2015. 67% of pressure ulcers occurred in the patient's home in November 2015 and an increased number of 8 occurred in nursing/residential homes (24%).

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Community In-patient or service based in a Hospital Setting	2	1	1	0	0	4	2	1
Nursing or Residential Care Homes	3	3	8	4	6	2	4	8
Patient's Home	14	27	21	26	18	13	27	22
Other Location	0	0	0	1	0	0	2	2
Total	**19**	**31**	**30**	**31**	**24**	**19**	**35**	**33**

The graph below demonstrates the rise in category 2, 3 and 4 pressure ulcers. Monitoring of this will continue over the remainder of Q3 and Q4 and work to reduce the occurrence of pressure ulcers within the Trust will continue via the plans implemented through the Pressure Ulcer Steering Group.



A monthly Pressure Ulcer Steering Group was established in September 2015 with key work streams and deliverables being as follows. There has been some slippage in three areas* and good progress/completion with regards to all other milestones. One further deliverable has been added for 'Awareness raising'.

Work stream	Deliverables	Complete by
Implement new policy	• Draft new policy ensuring clarity in assessment and reassessment timescales • Send out to stakeholders • Send to policy group/ Quality Committee * • Implement new policy*	Complete Complete 03/16 04/16
Ensure robust data collection	• Implement one system shared between ABU and CPD • Agree 'intelligent' solutions to capturing data across different sources and ways to capture data on dashboards • Agree and implement safety reporting tools across the neighbourhoods*	Complete Complete TBC
Ensure fit for purpose clinical tools and documentation	• Review all tools and paperwork and agree way forward • Simplify Purpose T paperwork • Review and implement clearer suit of assessment tools • Review, amend, implement new RCA template • Implement new paperwork and ensure embedded within EPR project role out	All complete
Ensure timely fit for purpose RCA process for category 3 pressure ulcers	• Agree roles and responsibilities throughout process • Trial new RCA template • Address cat 3 RCA backlog • Address unstageable RCA backlog • Implement 30 day panel validation process for all cat 3's • Refresh where required RCA investigator training • Continue work to establish if current systems for equipment ordering are supporting the prevention of pressure ulcers.	Complete " " 01/2016 Complete " "
Awareness raising	• Training work stream established • Review, adapt, implement new training • Launch PU key preventative messages on STOP THE PRESSURE DAY • Establish web page on ELSIE • Pressure Ulcer campaign to deliver the key messages	Complete 01/2016 Complete " " 02/16

The new Pressure Ulcer Policy will clarify various 'must do's' for staff to ensure consistent and safe practice. Completion of the policy has been delayed hence it will now be presented to the March Policy Group and Quality Committee.

The work to address the numbers of outstanding Category 3 and Unstageable pressure ulcers awaiting panel continues with progression with a view to moving to the 30-day streamlined process.

1.7 Infection Control

From April to December there have been no cases of MRSA BSI attributed to LCH. This compares with one case attributed during 2014/15.During the reporting December 2015, two MRSA Bloodstream Infections (MRSA BSIs) were notified to LCH that required joint exploration with stakeholders. These required a Post Infection Review (PIR) to be undertaken within 14 working days and a Public Health England (PHE) survey to be completed for the patient's CCG.

There have been a number of suspected and confirmed cases of Norovirus reported during to Public Health England (PHE) during December; from a range of establishments including care homes and nurseries.

At the end of December 2015 62.55% of front line staff had been vaccinated. The national NHS England target is currently 75%. The campaign will continue until the end of January 2016.
Last year LCH achieved a position of 2nd in country amongst community Trust and are aspiring to reach this goal for 2015/16.

1.8 Safer Staffing

	Day				Night				Day		Night	
Ward name	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Hannah House	757.5	757.5	847.5	847.5	307.5	307.5	412.5	412.5	100.0%	100.0%	100.0%	100.0%
CAMHS In-Patient	945	945	1140	1140	330	330	412.5	412.5	100.0%	100.0%	100.0%	100.0%
CRU	187.5	345	375	352.5	82.5	82.5	165	165	184.0%	94.0%	100.0%	100.0%
South Leeds Independence Centre	1,395.0	1,342.5	2,325.0	2,370.0	697.5	682.5	465.0	465.0	96.2%	101.9%	97.8%	100.0%

Staffing levels at LCH's in-patient units remained good during December with only a small number of instances where required staffing numbers were not met. Where this occurred it was due to a variety of factors incl. short-term staff unavailability. Staffing levels at the Community Rehabilitation Unit were in a number of cases higher than would ordinarily be required, in order to support staff training.

%age Agency Staff

	Ward									
	CICU		CAMHS		Hannah House		SLIC		CRU	
	Nurse	Clinical Support	Nurse	Clinical Support	Nurse	Clinical Support	Nurse	Clinical Support	Nurse	Clinical Support
Apr	17.19%	17.75%	0.00%	2.05%	6.71%	7.65%	28.11%	34.07%		
May	11.64%	18.95%	0.00%	1.44%	0.55%	10.78%	35.23%	39.83%	19.05%	15.87%
Jun	18.77%	32.47%	0.00%	20.79%	0.00%	7.82%	28.44%	40.35%	23.94%	5.31%
Jul	18.59%	38.21%	0.00%	6.35%	0.00%	18.64%	29.05%	54.98%	33.73%	0.00%
Aug	24.72%	30.96%	0.00%	15.34%	0.00%	26.21%	41.33%	0.00%	23.26%	47.17%
Sep	29.70%	39.03%	0.00%	21.92%	0.00%	16.41%	7.08%	34.04%	38.38%	5.38%
Oct	22.91%	23.40%	0.00%	24.87%	1.19%	11.11%	28.09%	0.00%	9.13%	28.64%
Nov	-	-	0.00%	10.58%	3.18%	10.69%	12.60%	21.63%	20.69%	0.82%
Dec	-	-	0.00%	12.56%	4.23%	13.69%	11.85%	22.75%	8.77%	10.14%

Levels of agency use were generally stable compared with previous months though the deployment of temporary staff remained necessary in some instances to ensure safe staffing levels.

2. Measure : Effective

2.1 Improving Access to Psychological Therapies (IAPT) - Completion

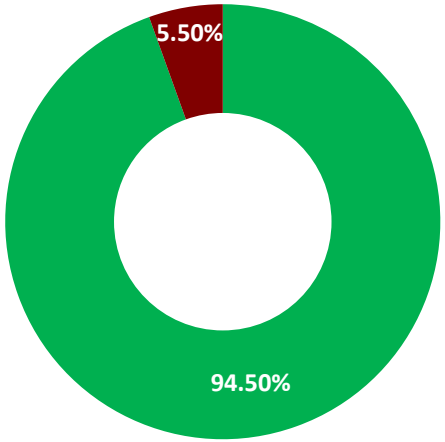
The recovery rate within month for December is 45.5% which is an increase on November's recovery rate but still lower than the target recovery rate of 47.7% citywide by December. With the recovery rate city wide target increasing further to 50% from January this is a concern and an ongoing area of focus for the performance group. December's in month recovery rate is the highest YTD. However, it is acknowledged that fewer patients will have been discharged in December which would have affected the recovery rate favourably. Like the November recovery rates, December's recovery rates continue to be more consistent across the CCGs.

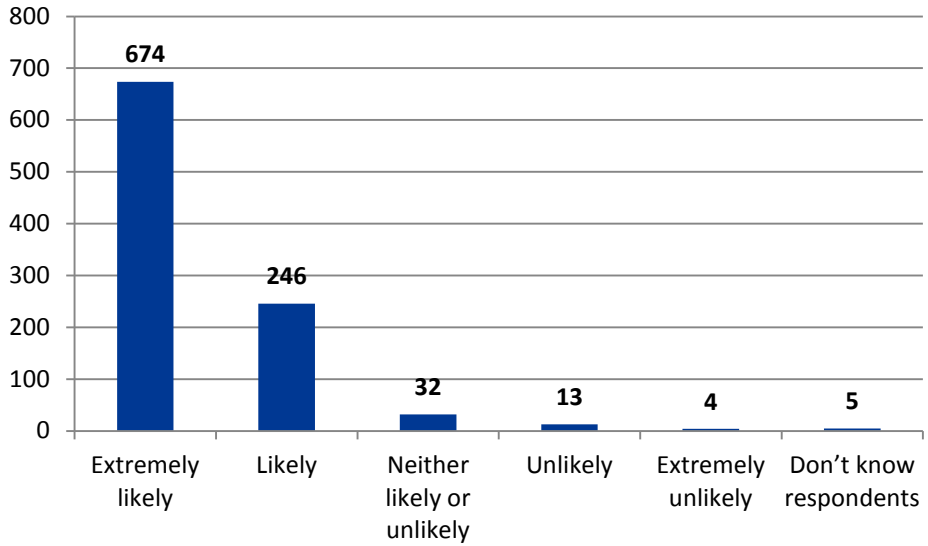
Following the recent audit of 100 unrecovered cases that been carried out by Northpoint it was highlighted that 30% of cases had two or less recorded contacts, which was identified as a significant factor contributing to the depression of the in month recovery rates. The service has had further conversations with NHS England around exploration of the possibility of supporting telephone assessors to record first sessions as `Assessment only` where their clinical judgement determined that effectively no treatment was offered in the first session. The service recognised that this might have an adverse impact on the `Entering Treatment` to treatment rate, but that benefits to the recovery rate would arise through the removal of what are effectively assessment cases from the recovery figures. However, NHS England have advised against any activity recording changes and have instead suggested that longer-term, a healthier recovery rate is likely to arise from continuing to increase access at the front-end and reducing overall waiting times so that access to treatment is a true reflection of what is happening for patients – an improved recovery rate (uncontaminated with artificially completed cases) should then flow from that.

The service and commissioners have planned to meet with the NHS England IAPT Support Team on the 18th January to discuss further service improvements including recovery rates.

3. Measure : Caring

3.1 Friends and Family Test (FFT)





The overall FFT percentage of people recommending LCH services for December 2015 was 94.5%, which represents a 1% decrease on 95.5% for November; this sits above the 12 month cumulative score of 93.83%.

The total number of completed surveys received was 974. A total of 849 comments were received. The below table demonstrates a sample of comments. The Patient Experience & Inclusion Manager is meeting with MES in January to look at the functionality of the analytical tool with will provide themed comments reports.

Following the Patient Experience and Inclusion Manager's visit to the Adult BU and the Neighbourhood co-ordinators' meeting there has been a significant increase in the number of "Neighbourhood" satisfaction responses (including the FFT question). Visits to the Wound Prevention, Community Neurology, Cardiac, Diabetes and Respiratory services will take place by 8 February 2016 with the aim of providing understanding of the process and to highlight the value of the FFT to teams. Meetings with the Expert Patient Programme and Family Nurse Partnership have taken place.

In the Children's BU the FFT rates of response and feedback of comments has been identified as an area for improvement by services through the Quality Challenge submissions. As a result of work to address this, the unit expect to see an increase in the responses from January 2016.

Positive comments	Negative comments /areas for improvement
Very grateful for the treatment received, thank you all so very much.	The nurses seemed to be under pressure to get from one patient to another and could do with more support with extra time.
I have been paying fortnightly to see a chiropractor for over a year. I got more out of my four visits than I got in that year of private treatment.	I would have felt happier if the nurse had brought some basic materials e.g. apron, gloves and sterilized packs. If my surgery nurse hadn't provided these her visit would have been useless.
Took time to talk and understand my problem.	More appointments to be based at Leeds LGI - as I work in town
To let me come here regularly as inpatient I have not only improved physically but mentally I am stress free. I can achieve my goals with regular stays.	Well, I suppose waiting times could be shorter. But the wait was worth it.
Nothing - the service is excellent as are the staff who run the service.	If the text service not only reminded of appointments but what its for i.e. blood test, scans etc.
Carry on what you are doing, helping people lead a better quality of life.	I hate these forms. Just ask one or two of us each course and close the statistical department. Fifth form
Made my son feel comfortable and he enjoyed his appointment.	A pedestrian entrance to SILC at Farnley academy would be brill. I don't drive, and found was a struggle to get in/out.
Care and attention	None, just hoping my pain stays at bay and I will continue the exercises given.
Seemed a well-planned programme of treatment	Instead of once a week make it twice.
Very pleased with service and positive results - thank you :)	Children's physiotherapy needs more funding, struggle with lack of support available.

3.2 PALS, Concerns and Complaints

The PALS service can be accessed by members of the public and service users by email, telephone or in writing. On average the service receives between 5 and 15 calls per day which are signposted to other organisations. The Patient Experience Team is considering the options for tracking these calls to identify any patterns in the types of enquiry received.

In December 2015 the Trust recorded 5 contacts via PALS which were enquiries for LCH services and in keeping with those recorded for November 2015.

Twelve concerns were received in December 2015 and these were broken down into Children's BU (2), Specialist BU (9) and Operational Support services (1).

Work in underway within the QPD team to ensure concerns are categorised by services to enhance the quality of thematic data available. All concerns received in December were logged with subject data; eight of the concerns were related to Appointments. Other issues included clinical treatment and access to buildings for disabled patients.

Complaints Received 2015/16	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	35	23	25	10	33	37	28

**Data available from June 2015*

Twenty eight complaints were received in December 2015, **100%** of which were acknowledged within the statutory 3 working-day target.

Of the thirty three complaints were closed in December, **100%** were within the statutory time frame of 6 months (180 days).

One complaint was re-opened during December 2015. There are currently four re-opened complaints on the caseload.

Three complaints are currently being reviewed by the Parliamentary & Health Service Ombudsman.

There are currently 72 cases open i.e. those not with the PHSO or awaiting consent (8). A short term action and recovery plan is being implemented to address any complaints that have been unreasonably delayed within the Patient Experience Team or within services. A detailed breakdown and full update on progress will be provided in February's report.

3.3 Learning from experience

Means of identifying actions and learning from complaints and experience are currently being developed. This will be reported through the PSEGG and the Incident, Experience and Learning Group.

The Investigator Pack is now attached to all new complaint records; this includes a Learning and Action table for investigators to complete. The weekly complaints tracker includes sections to show which complaints have action plans outstanding and ongoing. From January 2016 the tracker will be updated with this information using the details of closed complaints.

4. Measure : Responsive

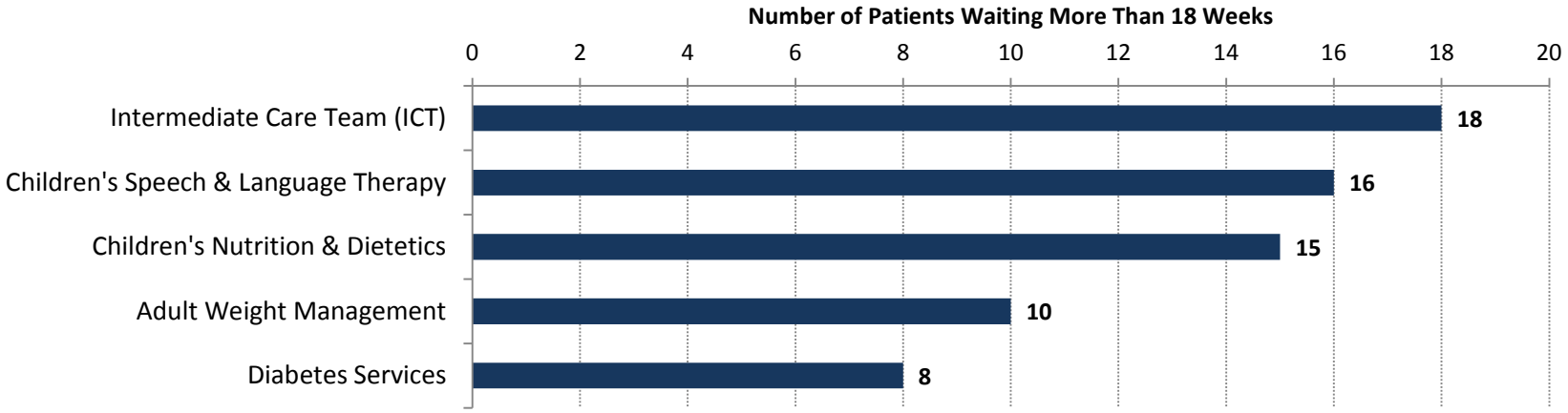
4.1 Waiting Times for Services

4.1.1 Reportable Waiting Times

The Trust is consistently meeting the target for waiting times in reportable services. Recent breaches were described in last month's report.

4.1.2 Non-Reportable Waiting Times

Manually validated information indicates that a number of patients listed as waiting more than 18 weeks is 1.0%.



Data as of 19th January 2016

Pressures in the Children's Speech and Language Therapy Service continue to result in a relatively high number of patients waiting more than 18 weeks. Ten of the sixteen patients waiting are waiting for a Speech and Language Therapist to be available. Eight of these patients are on caseloads in the Yeadon area.

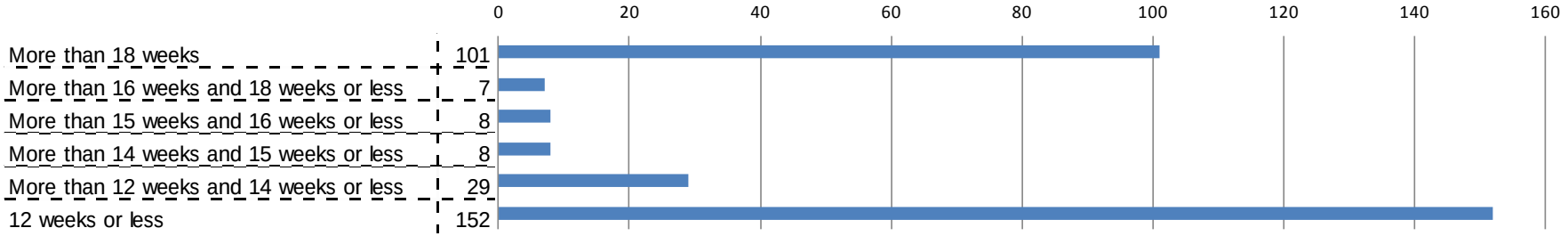
There are currently 15 patients waiting more than 18 weeks for the Children's Nutrition and Dietetics Service. A locum dietician has recently been brought into post and will be concentrating on those patients on the waiting list. The number of patients waiting is therefore expected to drop in the coming months.

As of 19th January 2016 there were 10 patients waiting more than 18 weeks in the Adult Weight Management Services. This is due to disinvestment from the public health commissioner reducing capacity within the service to respond to referrals.

The number of patients waiting more than 18 weeks in the diabetes service has fallen again from 15 last month to 8 this month. The fall in the number of patients has been consistent since summer 2015. Increased commissioner funding and local action has reduced the impact of an increased referral rate to the service.

4.1.3 CAMHS Waiting Times

Distribution of Current CAMHS Waiters (as of 31st December 2015)



The number of Young People waiting for a first appointment has reduced to 305. No young people are now waiting over 52 weeks.

A paper presented to the Business Committee on 27 January 2016 provided detail of the current position, action that has been taken, the forecast position at 31 March 2016 and further action planned to lead to a sustainable position.

The paper reported that 112 young people are waiting more than 12 weeks for routine consultation clinic assessment. These all have an appointment allocated to them which will be before the 31st March 2016. In addition, the service is, with effect from week commencing 18 January, booking young people in for assessment who have been waiting 10 weeks. There is cautious optimism, therefore, that by the end of March 2016, CAMHS will be offering appointments to young people within 12 weeks of referral in a sustainable model. Cautious optimism is balanced against the reality of delivering a service to young people who sometimes present as high risk. If planned clinical capacity allocated for self-harm referrals or urgent referrals is exceeded by demand then clinical capacity badged against routine consultation clinic assessments (ie the CQUIN) must be shifted into the higher risk clinical presentations. The service is maintaining a record of young people who may still show as waiting in excess of 12 weeks but who have chosen to defer an appointment offered or where other clinical/health priorities counter-indicate consultation clinic assessment at this time. Waiting times for therapeutic interventions triaged as not being urgent have increased as clinical capacity has been shifted to addressing highest risk and then routine consultation clinic assessments.

4.2 IAPT – Number of Patients Entering Therapy

The number of patients entering therapy has decreased in December in comparison to the previous month. However, this was not unexpected because of the loss of three working days due to bank holidays and increased staff annual leave taken over the festive period.

The drop in referrals was amplified by the fact that the Direct Access portal was not live from the 18th December. The service had hoped that patients would be able to self-refer into the service on bank holidays and weekends in December. However, it was agreed by the performance group that the portal needed to be taken down temporally due to the higher than anticipated number of high risk patients trying to access the service via the portal. This resulted in the process requiring revisions to ensure the service was able to put a more robust safety measure in place with clear accountability for the management of these referrals. The service has work closely with PCMIS to implement the changes required and restore the Direct Access portal from early January.

All substantive PWP posts have been now been recruited to. Recruitment is ongoing for an additional PWP to further increase screening capacity using non-recurrent commissioner monies held with Northpoint. The service has also employed an agency PWP utilising unspent LCH vacancy turnover monies that will be in post for 9 weeks from January to March. The PWP will been working on the telephone screening fulltime to increase the number of telephone screenings. Finally, the three trainee PWPs having completed their assessment module and will be starting to deliver screenings under supervision from January onwards.

5. Measure : Well Led

5.1 Sickness

<table>
<tr><td></td><td></td></tr>
<tr><td>Performance</td><td>

Sickness absence target for December 2015 – 5.15%
Sickness absence rate for December 2015 – 5.82%
Year to date sickness absence actual - 5.39%

<table>
<tr><th>Business Unit</th><th>December 2015 sickness absence rate</th></tr>
<tr><td>Adult</td><td>7.27%</td></tr>
<tr><td>Children</td><td>4.15%</td></tr>
<tr><td>Specialist</td><td>5.03%</td></tr>
<tr><td>Corporate</td><td>4.78%</td></tr>
<tr><td>Estates & Ancillary Staff (Operations)</td><td>7.94%</td></tr>
</table>
</td></tr>
<tr><td>Actions</td><td>Whilst the overall sickness has risen to 5.82%, which is above the target set, this is lower than the same time the previous year. Points to note, sickness within Children’s Business Unit has continued to decrease for the past 3 months and is now within the overall Trust target of 4.6%.

Sickness within Adults Business Unit continues to be variable and remains above Trust targets. During January new guidelines are being piloted within this Business Unit regarding the management of sickness absence and reviewing the role of Management Support Officers within the process.

Sickness within Corporate continues to increase, with three episodes of long-term sickness. One member of staff returned to work in January.

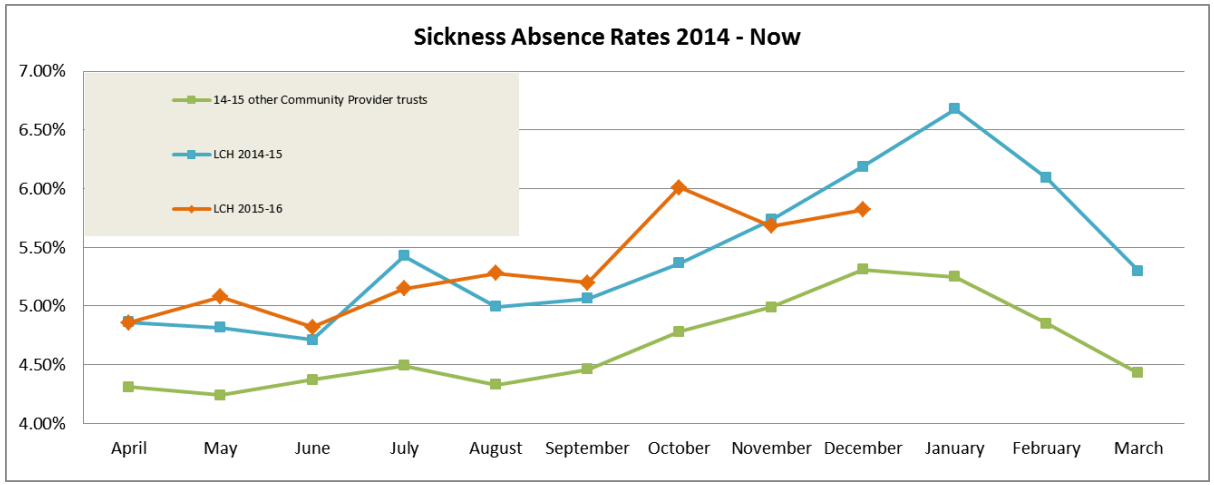
<u>In terms of support/statistics:-</u>

The Health and Wellbeing Team have supported managers at 69 formal stage sickness meetings throughout December.

Health and Wellbeing Officers continue to pro-actively contact managers to inform them which members of staff have reached trigger points within the policy, and 148 reminders sent to managers reminding them that staff required a meeting with HWB team intervention. This intervention of the HWB team is currently being reviewed.

The regular monthly sickness absence workshops continue, in addition to attending teams to deliver be-spoke training/information giving.</td></tr>
</table>

The graph below benchmarks LCH sickness absence against other organisations this year and last.



The sickness rate for the trust has risen from last month to 5.82%, an increase of 0.14%. This puts us 0.37% below last year, and 0.67% above our monthly target required for an overall 4.6% year rate.

5.2 Appraisals

Performance	The staff appraisal performance shows marked improvement since November though it remains below target.
Issue	89.1% of available staff are registered as having had an appraisal within the last 12 months which is a significant improvement across all units, and with some teams now on 100%.
Current Action	- A programme of training around ESR Business Intelligence is equipping managers with the skills to access the data around appraisals and take action to ensure these take place and are recorded. - The topic of appraisal receives continued focus from senior leaders and is raised at each business unit's monthly performance panel. The Executive Director of Operations receives a weekly update on the appraisal rate. - SMT has discussed the Trust wide appraisal position and have focused on how many, and how long appraisals are outstanding by service area. - Each Business unit has an appraisal recovery plan. A number of gaps in the management structure within the Adult business unit have hampered progress in this regard but vacancies are starting to be filled and improvements should continue to be seen.

5.3 Statutory & Mandatory Training

	Universal Statutory and Mandatory Training
Performance	The level of staff compliance with **universal** statutory & mandatory training is below target. It has improved significantly since November due to a good proportion of staff complying with changes, mandated by the Information Commissioner, around Information Governance training.
Issue	The overall average level of compliance with universal mandatory training for available staff is below target at 87.2%.
Current Action	It is now a requirement that all LCH staff will have completed Information Governance training during the financial year 2015-16, where previously this training was only to be completed every 3 years. Already since April 2015, three quarters (74.95%) of staff have completed the training. The change in the requirement has now been communicated to Senior Managers and all staff via Community Talk. Additional contact will be made on an individual basis. It is notable that, following a campaign to follow-up staff with expired training, the level of fire training compliance is high at 95.1% in December and remains within the target range. A programme of work encouraging managers to access and review this performance data is on-going. Managers and staff receive reminders both 4 months and 1 month before training is due to expire. Further work is on-going to understand how corporate teams can best support staff to remain up-to-date with training.

	Clinical Mandatory Training
Performance	The level of staff compliance with **clinical** mandatory training is below target.
Issue	The overall average level of compliance with clinical mandatory training for available staff was below target at 85.8%, which represents a 0.4% deterioration against the November position.
Current Action	Programme of work encouraging managers to access and review this performance data has commenced. Managers and staff receive reminders both 4 months and 1 month before training is due to expire. The drop in compliance with clinical mandatory training is partially due to a lack of available places on CPR courses. Capacity is currently being investigated.

	Safeguarding Children Training
Performance	The level of staff compliance with Safeguarding Children mandatory training is below target.
Issue	The overall average level of compliance with Safeguarding Children mandatory training for available staff was below target though shows an deterioration of 0.5% reaching 90.9% in December.
Current Action	The Safeguarding Team receive information each month as to those staff not currently compliant with Safeguarding Children training and take action to notify staff and request they complete training. Work is on-going to refresh guidance to staff around Safeguarding Children, in line with national guidance.

	Safeguarding Adults Training
Performance	The level of staff compliance with Safeguarding Adults mandatory training is below target and shows slight deterioration in December across the two components.
Issue	The level of compliance with Safeguarding Adults mandatory training for available staff was below target and showed deterioration to 89.5% with Mental Capacity Act compliance showing slight improvement to 87.6%.
Current Action	As above, a programme of work encouraging managers to access and review this performance data is underway. Managers and staff receive reminders both 4 months and 1 month before training is due to expire.

5.4 Turnover

	Staff Turnover
Performance	The level of turnover for December 2015 is again *below* the target range at just 7.9%. The figure for the rolling year has dropped again to 14.6%, though this remains above target. It must be noted that the figure for the latest period is an annualised monthly figure and as such is susceptible to relatively small changes in number of leavers.
Issue	The annualised turnover rate for December 2015 was below the target range of 9-13%, a significant change against the position earlier in the year. On a rolling year basis, turnover within all business units with the exception of Children's continued to exceed the 13% upper target limit with the highest levels seen in corporate / leadership functions at 19.8%. There were a total of 19 permanent leavers during this month. Of the leavers, there were 16 resignations, and 3 staff who retired. Of those staff who chose to resign and left in December, the reason is not recorded in 4 cases – a monthly process runs following this report to capture the reason for leaving in these cases. Of those cases where a reason for resignation was recorded, 3 to continue further education or training, 3 were due to promotion, 2 to obtain a better reward package, and 1 each due to poor health, a perceived lack of opportunities, relocation, and work-life balance. The trust is actively using Business intelligence data such as predicted leavers by band to inform recruitment and retention and for the Adult Neighbourhood Teams a Recruitment Plan for 2016 is in development.
Current Action	The Trust has a specific workstream and plan on recruitment. A revised retention plan, following discussion at November Business committee, with focus on career development for therapy staff, flexibilities within working arrangements and pension schemes has been developed with lead roles and action timescale and has now been circulated .

5.5 Workforce Race Equality Targets

	Workforce Race Equality Targets
Performance	The original target across the Trust for representation of BME population in employment related to the 2001 census and was at 11%. This target has been consistently met by LCH.
Issue	The 2011 census has changed to increase the BME population such that the figure defined as working age are 14.7% We have undertaken analysis and can evidence that BME staff are underrepresented in all groupings as follows: 11.5% at bands 1-4 7.4% bands 5-7 3.1% at band 8+ The December 15 Board received an update on the Equality Delivery system, which described the NHS wide race equality standards and expectations on trusts.
Current action	The Business committee has approved that we concentrate on recruitment and section and improving numbers specifically in bands 1-4 as that where we draw from the full population pool. This will be monitored on a quarterly basis. An invitation to the group of BME staff at more senior levels to identify supportive actions has been issued and a meeting date set for March 16.

5.6 Regulatory Requirements

Monitor's new sustainability and financial performance risk rating and the existing Governance Rating are important indicators for the Trust as they are key indicators that Monitor uses in assessing authorise Foundation Trusts compliance with Monitor's Foundation Trust License Conditions. The sustainability and financial performance risk rating is an early indicator of financial risk and financial failure threatening the ongoing provision of key services. The Governance Rating compromises national Operating Framework access and outcome metrics, plus specific workforce and patient satisfaction metrics, significant concerns (enforcement/warning notices) from CQC and other third parties. There is no change in the status of the Governance Rating (green), and the new sustainability and financial performance risk rating is 4 this month, the lowest risk rating.

As expected the Trust's TDA escalation score remains at 4 reflecting the CQC inspection "requires improvement" rating.

5.7 Financial Position

5.7.1 Summary & KPIs

The financial position at the end of quarter 3 is an underspending of £0.3m; £0.4m last month, this is consistent with the forecast outturn of £2.2m. In month the Trust has agreed a capital to revenue transfer of £0.5m which will increase the forecast outturn surplus to £2.7m non-recurrently. There is an overall surplus of £2.0m year to date which is slightly ahead of the planned position for December.

The biggest risks to the recurrent financial sustainability of the Trust is the implementation of the £5.3m cost savings planned for this year, the continued delivery of prior year savings and the level of agency staff expenditure. The Trust continues to have high levels of costs for agency staff which are driving the current forecast overspending on pay.

Delivery of efficiency savings continues to be closely monitored by the Programme Management Board and the senior management team continues to scrutinise the use of agency staff.

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure 1.5% retained surplus (£2.2m)	(£2.0m)	(£0.3m)	(£2.2m)	G
Additional I&E surplus in respect of capital to revenue transfer			(£0.5m)	G
Remain with EFL of £1.166m			£1.166m	G
Remain within CRL of £1.9m	£1.2m	(£0.5m)	£1.9m	R
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	98%	3%	95%	G
BPPC NHS Invoices Value 95%	100%	5%	95%	G
BPPC Non NHS Invoices Number 95%	95%	0%	95%	G
BPPC Non NHS Invoices Value 95%	94%	-1%	95%	A/G
Trust Specific Financial Objectives				
Sustainability & Financial Performance Services Risk Rating	4	-	4	G
CIP Savings £5.3m recurrent in year	£3.7m	-10%	£4.6m	R
CIP Savings £0m non recurrent in year	-	-	£0.7m	G

5.7.2 Income & Expenditure

The Trust continues to report an underachievement of contract and other income this month. Pay costs continue to be in line with planned expenditure in month and non-pay costs are underspent by £0.7m this month. There are 143 whole time equivalent vacancies this month (150 for November).

The annual plan reflects the stretch target and the capital to revenue transfer is shown as a £0.5m variance to forecast.

Table 2 Income & Expenditure Summary	December Plan WTE	December Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	December Forecast Variance £m	Forecast Variance last month £m
Income									
Contract Income			(108.3)	(108.2)	0.1	(144.9)	(144.7)	0.2	0.0
Other Income			(7.1)	(7.0)	0.1	(9.0)	(9.2)	(0.2)	0.3
Total Income			***(115.4)***	***(115.2)***	***0.2***	***(153.9)***	***(154.0)***	***(0.1)***	***0.4***
Expenditure									
Pay	2,901.5	2,758.5	85.6	85.6	0.0	113.7	114.1	0.4	0.3
Non pay			25.4	24.8	(0.7)	33.9	33.3	(0.6)	(0.6)
Reserves & Non Recurrent			1.3	0.3	(1.0)	2.1	0.4	(1.7)	(1.9)
Additional calls on reserves				1.1	1.1		1.5	1.5	1.7
Total Expenditure	***2,901.5***	***2,758.5***	***112.3***	***111.7***	***(0.6)***	***149.7***	***149.3***	***(0.5)***	***(0.4)***
EBITDA	**2,901.5**	**2,758.5**	**(3.1)**	**(3.5)**	**(0.3)**	**(4.2)**	**(4.7)**	**(0.5)**	**(0.0)**
Depreciation			1.0	1.0	0.0	1.3	1.3	0.0	0.0
Public Dividend Capital			0.5	0.5	0.0	0.7	0.7	0.0	0.0
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Payable			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Retained Net Surplus	**2,901.5**	**2,758.5**	**(1.6)**	**(2.0)**	**(0.3)**	**(2.2)**	**(2.7)**	**(0.5)**	**(0.0)**
	Variance =	**(143.0)**							

5.7.2.1 Income

The Trust's contract income YTD and forecast outturn has been updated this month to reflect the current agreements with Commissioners. The CCG has agreed not to impose the penalties for the temporary closure of the Community Rehabilitation Service and a further £75k relating to a performance measure for 2014/15 to assist the Trust with achieving the stretch target. This is in line with NHS England guidance. The impact of the non-recurrent in year defund of the public health funding has been reflected; this is being partially offset by the CCG. There continues to be small under and over achievements of other income for traded offer to schools and estates recharges which net to 0.1m overall.

The planned contract income and forecast outturn reflect the decision by Commissioners not to fund the SLIC safer staffing costs; assumes the Trust receives support from the CCGs towards achieving the stretch target and the outturn also assumes that all the CQUIN income will be achieved. The continued shortfalls in the Trust's traded offer to schools and estates recharges in other income year to date are driving the forecast year end variance.

The forecast income reflects an additional £0.5m from the Department of Health for an agreed capital to revenue transfer to be transacted in January in support of the national NHS position. This will mean a one off increase in the surplus this year of £0.5m.

5.7.2.2 Pay

Table 3 Year to Date Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Cost of staff directly employed	79,890	73,869	(6,021)	(5,283)	
Seconded staff costs	2,235	2,056	(179)	(202)	
Vacancy Factor	(2,414)		2,414	2,113	
Sub-total Direct Pay	**79,712**	**75,925**	**(3,787)**	**(3,373)**	
Bank Staff	146	1,253	1,107	989	
Agency Staff	5,717	8,415	2,698	2,549	
Total Pay Costs	**85,575**	**85,593**	**18**	**165**	**372**

Pay costs continue to be in line with planned costs overall for December. Agency costs are £0.75m this month.

The Trust anticipated increased agency costs for the early part of the year to cover the resilience schemes which have been extended again. As reported last month higher levels of agency staff were forecast for the first 9 months of the year as substantive recruitment schemes were implemented. As Table 3 shows, the reported expenditure continues to be over and above what was planned as a result of there being more vacancies than expected and the continuation of the temporary staffing for the resilience projects. The unplanned additional costs of resilience projects are covered by additional income.

From October to March the Trust's expenditure on nursing agency staff has been capped by the TDA at 4% of total expenditure on nursing pay. The planned recruitment campaigns for adult community nursing and health visiting should reduce the Trust's agency nursing costs in the second half of the year however there remains a risk this target will not be achieved.

Table 4 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	Sept £k	Oct £k	Nov £k	Dec £k	Totals for the Year £k
Directly employed staff	7,986	8,047	8,234	8,191	8,089	8,104	8,388	8,392	8,439	73,869
Seconded staff costs	153	233	146	245	157	493	190	207	233	2,056
Bank staff	128	116	154	133	149	124	138	168	142	1,253
Agency staff	722	1,236	1,143	1,182	991	734	775	882	750	8,415
Total Pay Costs	**8,988**	**9,633**	**9,676**	**9,752**	**9,386**	**9,454**	**9,491**	**9,649**	**9,563**	**85,593**

The main areas of agency expenditure and associated vacancies are:

- Health and Justice Services £1,542k 30.69 wte less than planned
- Adult Community Nursing £1,572k 43.45 wte less than planned
- Out of Hospital Care £1,932k 15.12 wte less than planned
- Corporate Services £1,383k 27.12 wte less than planned

The proportion of expenditure on temporary staff (bank and agency) is 11.3% for December, (11.55% Oct 11.98% Sept).

The existing run rate (ie monthly spend) has been adjusted for:

- Staff being recruited to resilience posts which will be funded over and above our core income
- An assessment of the continued use of agency staff until new nursing recruits are fully absorbed into the productive workforce.

5.7.2.3 Non Pay

Non-pay expenditure is £0.7m underspent year to date and is consistent with last month. The year-end forecast outturn is £0.6m underspend which will mitigate the overspending on pay.

Table 5 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	1,707	1,656	(51)	(56)	
Clinical Supplies & Services	5,829	5,890	61	80	
General Supplies & Services	2,156	2,105	(52)	(95)	
Establishment Expenses	5,452	5,382	(70)	(77)	
Premises	8,796	8,313	(483)	(473)	
Other non pay	1,466	1,398	(69)	(58)	
Total Non Pay Costs	**25,407**	**24,744**	**(663)**	**(679)**	**(597)**

5.7.3 Reserves

The Trust currently has £2.1m of reserves. Almost all of the planned expenditure is now in budgets a residual £0.4m remains to mitigate financial risks such as redundancy costs that will arise as a result of known changes for 2016/17. The Trust has a further £1.5m to fund additional costs not in the planned position; these include the increase in the LIFT buildings lease costs and the write off of asset for the prison service which will cease at the end of the financial year. All un-committed reserves have been released.

The Trust remains on target to achieve the £2.2m surplus required by the TDA; however there is no remaining flexibilities and all Commissioner support in achieving the stretch target has been included in the forecast financial outturn.

5.7.4 Service Line & Contract Performance

Table 6 Service Line	Annual Budget £m	Budget WTE	Actual Contract WTE	Variance WTE	YTD Budget £m	YTD Actual £m	YTD Variance £m	YTD Plan Activity	YTD Actual Activity	YTD Variance Activity	Corr-elation
Specialist Services	36.9	665.9	631.0	(34.8)	27.7	28.2	0.5	859,509	845,738	(13,771)	•••
Childrens Services	30.4	747.6	748.1	0.5	22.9	22.2	(0.7)	282,408	254,531	(27,877)	•••
Adults Services	46.1	1,092.1	1,029.6	(62.5)	34.9	34.6	(0.3)	721,593	643,605	(77,988)	•••
Ops Management & Equipment	1.2	48.5	41.5	(7.1)	0.8	1.1	0.2				••
Service Line Totals	**114.6**	**2,554.0**	**2,450.1**	**(103.9)**	**86.3**	**86.1**	**(0.2)**	**1,863,510**	**1,743,874**	**(119,636)**	•••
Corporate Support & Estates	24.0	347.5	308.3	(39.2)	17.5	17.2	(0.3)				
Total All Services	**138.6**	**2,901.5**	**2,758.5**	**(143.0)**	**103.9**	**103.3**	**(0.5)**	**1,863,510**	**1,743,874**	**(119,636)**	•••

Services continue to have high levels of staffing vacancies and are predominantly covering the posts with agency staff to ensure service delivery is maintained.

Activity continues to run behind profile across all services this month by -6.42% (-7.21% for Nov, -7.79% for Oct).

For November:

- Specialist services are -1.6% less than planned (-1.9% Nov, -3.0% Oct),
- Children's services are -9.9% less than planned (-11.9% Nov, -11.6% Oct), and
- Adult services continue to be -10.8% less than planned (-11.7% Nov, -12.0% Oct).

5.7.5 Cost Improvement Plans

The year to date and forecast efficiency savings are consistent with last month. At the end of quarter 3 savings are £390k behind plan this relates to the corporate review and service review cost reductions for children's school nursing and adult's nursing services. Progress against savings targets continues to have close monthly monitoring by the Programme Management Board.

The £0.7m recurrent shortfall in table 7 will impact on the Trust's underlying £1.5m surplus if recurrent substitutions are not found for any savings that fail to be delivered. This will be addressed through the 2016/17 annual planning.

Table 7 Project	2015/16 YTD Plan £k	2015/16 YTD Actual £k	2015/16 YTD Variance £k	2015/16 Annual Plan £k	2015/16 Forecast Outturn £k	2015/16 Forecast Variance £k	2015/16 Forecast Variance %	Trend	2015/16 Recurrent Forecast Delivery £k	2015/16 Recurrent Forecast Variance £k
Service Reviews	1,667	1463	(203)	2,309	2,038	(271)	12%	S	2,040	(269)
Reserves funding to support delayed service reviews	673	673	0	810	810	0	0%	S	810	0
Corporate Service Review	189	0	(189)	252	252	0	0%	S	252	0
Drugs	21	21	0	28	28	0	0%	S	28	0
Estates	686	686	0	764	764	0	0%	S	313	(451)
Non Pay	278	278	0	370	370	0	0%	S	370	0
Procurement	115	115	0	153	153	0	0%	S	153	0
Contribution from service developments	137	137	0	182	182	0	0%	S	182	0
Travel	188	188	1	250	250	0	0%	S	250	0
Stationery	38	38	0	50	50	0	0%	S	50	0
Contracted out services	75	75	0	100	100	0	0%	S	100	0
Total Efficiency Savings Delivery	**4,064**	**3,673**	**(390)**	**5,268**	**4,997**	**(271)**	**5%**	**S**	**4,548**	**(720)**

5.7.6 Capital Expenditure

Table 8 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Approved Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.6	0.0	(0.6)	0.7	0.2	(0.5)
Equipment/IT	0.4	0.2	(0.2)	0.5	0.4	(0.1)
Electronic Patient Records	1.2	1.0	(0.2)	1.2	1.3	0.1
TDA agreed revision to capital plan	(0.5)		0.5	(0.5)		0.5
Totals	**1.7**	**1.2**	**(0.5)**	**1.9**	**1.9**	**0.0**

Following a request from the Trust Development Authority for all organisations to contribute whatever they could to addressing the significant overspending at a national level the Trust has agreed to defer £0.5m planned capital expenditure to next year. This will be transferred to revenue, be invoiced to the Department of Health and returned to the Trust improving the bottom line income and expenditure performance.

Capital expenditure at the end of quarter 3 totals £1.2m against an amended plan of £1.7m; this is an underspending of £0.5m.

Bids for capital equipment have been approved by SMT and budget holders are placing orders for the transactions. One bid requires Business Committee approval due to its value. Approval will be sought before the end of January.

5.7.7 Statement of Financial Position

The December statement of financial position (balance sheet) is below at Table 9.

The Trust's statement of financial position (balance sheet) at the end of quarter 3 overall is £0.3m ahead of plan, representing the favourable variance against plan on the Income and Expenditure account. The forecast outturn reflects the £0.5m overachievement on the retained earnings in respect of the capital to revenue transfer.

Trade and other receivables are £1.1m more than planned in December. The variance relates largely to accrued income totalling £3.6m; including CQUIN income of £0.8m and £1.9m for contract income.

Table 9 Statement of Financial Position	31/12/15 Plan £m	31/12/15 Actual £m	31/12/15 Variance £m	*Opening 01/04/15 £m*	Planned Outturn 31/03/16 £m	Forecast Outturn 31/03/16 £m	Forecast Variance 31/03/16 £m
Property, Plant and Equipment	29.1	28.0	(1.1)	*27.8*	29.0	29.0	0.0
Intangible Assets	0.1	0.1	0.0	*0.1*	0.1	0.1	0.0
Total Non Current Assets	**29.2**	**28.1**	**(1.1)**	*27.9*	**29.1**	**29.1**	**0.0**
Current Assets							
Inventories	0.1	0.1	0.0	*0.1*	0.1	0.1	0.0
Trade and Other Receivables	6.5	7.6	1.1	*5.2*	6.2	6.2	0.0
Cash and Cash Equivalents	16.2	16.8	0.6	*16.5*	15.3	15.3	0.0
Total Current Assets	**22.8**	**24.5**	**1.7**	*21.8*	**21.6**	**21.6**	**0.0**
TOTAL ASSETS	**52.0**	**52.6**	**0.6**	*49.7*	**50.7**	**50.7**	**0.0**
Current Liabilities							
Trade and Other Payables	(14.5)	(14.5)	0.0	*(13.3)*	(12.5)	(12.5)	0.0
Provisions	(0.5)	(0.8)	(0.3)	*(0.6)*	(0.5)	(0.5)	0.0
Total Current Liabilities	**(15.0)**	**(15.3)**	**(0.3)**	*(13.9)*	**(13.0)**	**(13.0)**	**0.0**
Net Current Assets/(Liabilities)	**7.8**	**9.2**	**1.4**	*7.9*	**8.6**	**8.6**	**0.0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**37.0**	**37.3**	**0.3**	*35.8*	**37.7**	**37.7**	**0.0**
Total Non Current Liabilities	**(0.1)**	(0.1)	**0.0**	*(0.3)*	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**36.9**	**37.2**	**0.3**	***35.5***	**37.7**	**37.7**	**0.0**
TAXPAYERS EQUITY							
Public Dividend Capital	1.0	1.0	0.0	*1.0*	1.0	0.5	(0.5)
Retained Earnings Reserve	8.2	8.5	0.3	*6.8*	9.0	9.5	0.5
General Fund	18.1	18.1	0.0	*18.1*	18.1	18.1	0.0
Revaluation Reserve	9.6	9.6	0.0	*9.6*	9.6	9.6	0.0
TOTAL EQUITY	**36.9**	**37.2**	**0.3**	***35.5***	**37.7**	**37.7**	**0.0**

Trade and other payables are as expected, whilst provisions are £0.3m higher than planned due to lower utilisation to date.

Cash and cash equivalents are £0.6m more than planned. The differences in payables and receivables compared with plan plus the slippage on capital expenditure of £0.5m and the favourable variance on the planned surplus of £0.3m have led to the Trust having £0.6m more than was planned at the end of December. This reflects organisations bringing their positions up to date for the quarter 3 accounts and agreement of balances submissions.

5.7.8 Working Capital

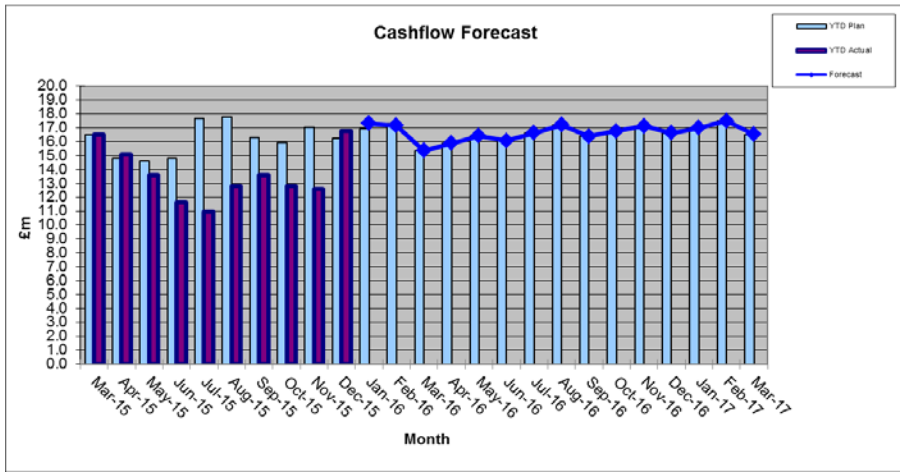


Chart 1

Chart 1 reflects the Board approved revised financial plan submitted to the Trust Development Authority (TDA) in September 2015. The planned, actual and forecast cash positions until the end of March 2017 are illustrated.

The Trust's cash position continues to be very strong in month. Actual cash totals £16.8m which is £0.6m more than planned as described above.

Table 10 Measure	Cumulative Performance This Month	Cumulative Performance Last Month	Target	RAG
NHS Invoices				
By Number	98%	98%	95%	G
By Value	100%	100%	95%	G
Non NHS Invoices				
By Number	95%	95%	95%	G
By Value	94%	94%	95%	A

The Trust's performance against the **Better Payment Practice Code** target remains the same as the last 3 months. The performance on non NHS invoices by value remains 1% below target. The Trust continues to take every measure in an attempt to ensure the target is met however these are not completely sufficient in correcting the performance only in preventing it worsening.

5.7.9 Sustainability and Financial Performance Risk Rating

Table 11 reflects Monitor's revised risk assessment introduced earlier this financial year in response to the increasing number of organisations that are unable to meet their financial targets. The new metric includes the previously reported CSRR metrics plus 2 new metrics to assess financial efficiency. The scores for all of these are then weighted to give a single sustainability and financial performance risk rating for December reported below.

The overall score is 4; this represents the lowest risk in that there are no evident concerns.

Table 11 Criteria	Metric	Performance	Rating	Weighting	Score
Balance Sheet sustainability	Capital servicing capacity (times)	6.6	4	25%	1
Liquidity	Liquidity Ratio (days without WCF)	23	4	25%	1
Underlying performance	I&E Margin	1.72%	4	25%	1
Variance from Plan	Variance on I&E Margin as % of income	0.45%	4	25%	1
Overall Sustainability & Financial Performance Risk Rating					**4**

5.7.10 Conclusion on Financial Performance

The Trust's financial position remains strong this month and is on track to deliver the £2.2m surplus stretch target. In addition the Trust has agreed a £0.5m capital to revenue transfer which will increase the surplus this year to assist the national position. At the end of quarter 3 the year to date surplus position is £0.3m ahead of plan. The cash position is very strong and the SFPRR is 4 based at the end of December. The Trust's continues to meet 3 of the 4 better payment practice code targets. Capital expenditure is behind plan however bids have been approved for most of the remainder of the funds for this year.

Cost savings continue to run less than anticipated for the year to date and forecast to underachieve by 5% at the year end. Pay budgets are forecast to overspend by £0.4m based on current performance; non pay underspendings and reserves will need to be utilised to offset the pay overspend and other financial risks.

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015-16 (101)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Programme Management Office (PMO) Review 2015/16
Responsible Director: Executive Director of Operations
Previously considered by: n/a

EXECUTIVE SUMMARY

This paper provides a review of the work of the Programme Management Office from April 2015-January 2016. This year has been a challenging one for the team with competing demands for their expertise coupled with difficulties in recruiting permanent staff. Nonetheless a significant number of projects have been delivered

This paper gives some detail to the range of projects delivered in year by the team.

RECOMMENDATIONS

The Board is recommended to receive the report

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community & with a relentless focus on value for money
CQC Outcomes:	• Safety – Service users must not receive unsafe care or treatment or be put at risk of any harm that could otherwise be avoided. Risks must be evaluated during any care or treatment pathway, making sure your staff have the qualifications, competence, skills and experience to keep clients safe. • Staffing – Qualified, competent and experienced staff must be in place, ensuring that fundamental standards are met. Staff must receive the support, training and supervision that they need to help them do their job. • Fit and proper staff – You must only employ those who can provide the care and treatment as appropriate to their role, with efficient recruitment procedures in place and relevant checks (eg DBS, formerly CRB) implemented.
Equality and diversity:	• An Equality Analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	• None
Publication Under Freedom of Information Act:	• This paper has been made available under the Freedom of Information Act

1. INTRODUCTION

This paper provides a review of the work of the Programme Management Office from April 2015-January 2016. This year has been a challenging one for the team with competing demands for their expertise coupled with difficulties in recruiting permanent staff. Nonetheless a significant number of projects have been delivered.

This paper gives some detail to the range of projects delivered in year by the team.

2. BACKGROUND

The Programme Management Office (PMO) was established in July 2013 to oversee the delivery of a number of projects primarily associated with the Transformation and Cost Improvement Programme. Since its inception the PMO has overseen the completion of a large-scale programme of service review in addition to a number of smaller projects.

The PMO comprises a team of Project Managers, Business Analysts and Project Support Officers, established to deliver across four key functions:

- Strategy / Governance – the PMO has "joined the dots" between the projects to help identify interdependencies, duplication and gaps. This has been more successful at Business Unit level than from a Trust-wide perspective
- Best Practice / Improvements – the PMO has supported service reviews by identifying best practice from other organisations and providing benchmarking information where available
- Control / Assurance – The PMO has held all projects teams to account in terms of deliverables, finance and timescales
- Project Delivery – the majority of the resources within the PMO have been directed towards front-line delivery

3. RESOURCES

The PMO was established with a recurrent budget of £474K. This provides for a core team comprising:

Head of PMO	1.00 x Band 8b
Project Managers	3.00 x Band 7/8a
Project Support	3.00 x Band 5
Business Analyst	2.00 x Band 5/6
Admin	1.00 x Band 4

Additional funding has been allocated for the Electronic Patient Record (EPR) project and smaller projects over the course of the year:

Better for Me	£30,000
Choose & Book	£100,000
EPR (excluding capital)	£374,336

It has proved difficult to recruit to the substantive posts at band 8a and 7 and agency/contract staff have been used (at a premium) to ensure the completion of projects. The budget is currently in balance but the cost of the resource has meant less support on the ground than anticipated. This has meant the core team/or the service has picked up the majority of the projects

4. PROJECTS 2015/16

4.1 The work of the core team in the current year included:

- **Continuation of the Service Review Programme within Children Business Unit –** The team has now completed reviews in each service except Child and Adolescent Mental Health Services (CAMHS) and Integrated Services for Children with Additional Needs (ICAN), School Nursing and Children Speech and Language. The savings target attached to service reviews in 2015/16 was £2,309K. The forecast outturn is a shortfall of £269K (see appendix I) – the shortfall results from the reviews in School Nursing (£116) and Adult Services (£153K). The specific teams received scrutiny on their plans through the Programme Management Board.

- **Continuation of the Service Review Programme with the Adult Business Unit** – The PMO has supported several projects including integration programme, the move to new service models in the Wounds Management Prevention Service/Long Term Conditions teams and the reduction of waiting times/implementation of a new service model in the Continence, Urology and Colorectal Service. .

- **Project Management Training** - The team has trained 120 staff members in project management, building capacity throughout the organisation.

- **Corporate Review** – The team has supported the review of all corporate services. The review focused on improving processes

- Provided consultative support on front line projects including **Single Point of Access**, **Estates** and **Integration**

4.2 The work of the EPR team in the current year included:

The EPR team consists of Project Managers, Business Analysts and Project Support Officers plus a number of specialist system developers and trainers. In the current year the team has delivered EPR with the associated business change in the following services:

- Children's Business Unit – Children's Nursing; Ophthalmology; Inclusion Nursing; School &Travel Immunisation, Health Visiting and School Nursing
- Specialist Business Unit - Nutrition & Dietetics; Podiatry
- Adult Business Unit – Falls; Continence, Urology and Colorectal Service; Wound Management and Prevention Team; Cardiac and Respiratory teams; initial rollout to neighbourhoods (Armley and Pudsey)

4.3 Additional schemes have included:

<u>Better For Me (B4M)</u>

The core PMO has supported the development and delivery of the Better for Me programme. Specifically they have

- Engaged and supported GPs and frontline clinicians to deliver the programme.
- Completed Phase 1 and 2 roll out pilot programme to 30 GPs (May to Jan 16) – 700+ patients profiled.
- Developed and presented detailed evaluation report on the benefits and success of the B4M project.

<u>Choose and Book (E-Referral)</u>

A specialist subject matter expert was recruited to deliver this programme and day to day support was drawn from the core PMO team. The work included:

- Engaging the frontline, developing the training schedule and successfully delivering the E-Referral programme to MSK, Respiratory and Podiatry
- Transferring the new platform to "business as usual" for these services
- On-going training and support
- Developing proposals for establishing in-house resource to support this going forward as part of the 2016/17 planning work

<u>Workforce – E-Rostering</u>

A specialist project manager and business analyst were recruited to develop the scope and collate the requirements from the Business Units.

- The PMO collated detailed requirements from the business units intelligence from other private and NHS providers on the E-Rostering to inform the business case
- Following SMT and Business Committee to proceed, the team initiated a procurement process in January 2016
- Development of an interim capacity and demand tool which is being used within a number of services within each Business Unit

Workforce – Recruitment and Retention

A Specialist project manager and project support officers from the core PMO were allocated to this project.

- The workforce directorate led a Recruitment and Retention programme with day to day support from the PMO

5. GOVERNANCE/MANAGEMENT ARRANGEMENTS

5.1 The Programme Management Board continues to meet on a monthly basis to provide challenge and rigour to the project management process.

5.2 In autumn 2015 the Senior Management Review conducted a review of portfolios which resulted in the responsibility for the Programme Management Office being transferred to the Director of Strategy and Planning from 1 January 2016.

6. RECOMMENDATION

The Board is recommended to receive the report

28 January 2016

Appendix I - **2015/16 Programme Financial Overview**

Projects	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Forecast Outturn	Forecast Variance	Forecast Variance	Trend	Recurrent Forecast Delivery	Recurrent Forecast Variance
Service Reviews	1,667	1463	(203)	2,309	2,038	(271)	12%	S	2,040	(269)
Reserves for Service Review (2014/15)	673	673	0	810	810	0	0%	S	810	0
Corporate Review	189	0	(189)	252	252	0	0%	S	252	0
Reduced Costs of Medicines	21	21	0	28	28	0	0%	S	28	0
Reduced Estate Costs	686	686	0	764	764	0	0%	S	313	(451)
Non Pay Efficiency	278	278	0	370	370	0	0%	S	370	0
Reduced Costs of Procurement	115	115	0	153	153	0	0%	S	153	0
Contribution from service developments	137	137	0	182	182	0	0%	S	182	0
Reduced Travel Costs	188	188	0	250	250	0	0%	S	250	0
Stationery	38	38	0	50	50	0	0%	S	50	0
Contracted Out Services	75	75	0	100	100	0	0%	S	100	0
Total for 2015/16	**4,064**	**3,673**	**(390)**	**5,268**	**4,997**	**(271)**	**5%**	**S**	**4,548**	**(720)**

AGENDA ITEM 2015 - 16 (102)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Safer Nurse Staffing
Responsible Director: Executive Director of Nursing **Report author:** Executive Director of Nursing
Previously considered by: Senior Management Team

EXECUTIVE SUMMARY

The paper describes the background to the expectations of boards in relation to nurse staffing, outlining where the Trust is meeting the requirements and where there is further work to be undertaken.

RECOMMENDATIONS

The Board is recommended to:

- Support the development of the proposed tender to procure allocation system to provide proactive information
- Continue to develop the staff bank to improve the responsiveness in providing appropriately trained area specific staff when needed and ongoing reduction in the need for agency usage
- Continue the recruitment drive and work to support new staff
- Continue to meet the national monthly collection and publication of staffing data as recommended in “Hard Truths”
- Keep staffing levels under constant review to maintain and ensure they are safe
- Note the contents of the report and the progress being made and support six monthly reviews in a public board meeting.

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community & with a relentless focus on value for money
Links to principal risks:	Risk to achieving the strategic objectives: To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes.
NHS Constitution:	This report supports all of the principles, values, rights and pledges detailed within the NHS constitution.
CQC Outcomes:	This report supports the Trust to meet its obligations across all of the CQC domains.
Equality and diversity:	An Equality Analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	There is no sustainability implications that the committee needs to take into account.
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act.

1. BACKGROUND

1.1 In line with the NHS England requirements and the NQB recommendations, this paper presents the six monthly nursing establishments –workforce review and sets out the approach taken by the Trust to ensure that there is sufficient nursing capacity and capability in all in-patient areas to meet the needs of our patients and maintain safe staffing.

1.2 Staffing levels are kept under regular review on a shift by shift basis by the nurse in charge or Operational Manager in liaison with Clinical Lead and monitored in operations across the trust on a daily basis. The staffing levels are monitored by senior staff and detailed in the monthly board reports and in-depth bi-annual report. This is in line with national guidance, national benchmarking and local outcome measures.

1.3 The determination of safe staffing levels is not a single process but rather an ongoing review taking into account clinical experience in running the wards, the quality of service as determined by outcomes, including patient experience and national guidance and development of further tools. The Trust awaits further national guidance following the reframing of the national work that was being undertaken by NICE. Latest guidance would appear to suggest that safe staffing does include consideration of all team members on duty at a particular time. There are also important changes ahead over the next year with the removal of the student bursary for nurses in training. This may have significant implications in terms of numbers and the profile of those coming forward to take up nurse training. The government in this time period has also introduced new agency caps and rules. This has required considerable work and to date we are on track with the given trajectory in relation to agency spend. However there are some risks in relation to agency use as we are in winter and as we move into handover of the adult prison contract. Agency use is closely monitored and reported on a monthly basis

2. SAFE STAFFING

2.1 Although this paper focuses on nursing numbers and a crude separation of qualified from unqualified staff, it is of course recognised that staffing levels to provide a high quality inpatient service rely on much more than the simple numbers. Other factors that need to be taken into account include the multidisciplinary team including, in particular, medical and therapy staff, the skill mix of all the staff within the team, the leadership and engagement of the staff on the unit or in the team. This is within an overall Trust wide culture which enables staff to feel supported in delivery high quality care, empowered to bring about necessary changes and having no concern about escalating issues to senior colleagues.

2.2 The Trust provides a small number of inpatient beds across care of the older person/rehabilitation, respite care for children with a disability and CAMHS inpatients. The Trust also provides a wide range of community services and home based care. As there is no national definition of safe staffing, a unit or team will be considered to have safe staffing numbers if the numbers of staff allow the following to occur:-

- Patients can be treated with care and compassion.
- All patients have a thorough and holistic assessment of their
- All patients have a care plan which sets out how the goals for their admission, care plan or treatment episode will be set.
- Staffing numbers allow full and timely implication of the care plan.
- Staff numbers are sufficiently robust to allow the team or unit to function safely when faced with expected fluctuations and with the inevitable occurrence of short term sickness of staff.
- Operational Managers and Unit Managers are able to call upon additional resources if this is required by the particular needs of the inpatient group on a particular shift.
- A clear system of outcomes focused on patient experience, patient safety and patient outcomes are in place and the information from these measures informs how the Operational and Clinical Leads run services.
- There is not an undue reliance on temporary staff to fill nursing rotas.

3. THE NATIONAL PICTURE ON SAFE STAFFING

3.1 Following on from the CNO's expectations, a joint letter from NHS England and CQC was sent to all Trusts in March 2014 setting out expectations on the delivery of the commitments. Whilst much of the guidance is focussed at acute hospitals and / or ward environments, it is expected that the principles are rolled out across all settings. In addition the National Quality Board (NQB) published guidance in November 2013 in relation to nursing, midwifery and care staffing capacity and capability. "How to ensure the right people, with the right skills, are in the right place at the right time". This was followed in March 2014 by the "Hard Truths Commitments regarding the publishing of Staffing Data –Timetable of Actions", which made a number of Commitments to make nurse staffing levels more publicly available. The document provides guidance on the information which Trusts should aim to cover in the 6 monthly establishment review.

3.2 NQB "Hard Truths" Requirements and the LCH Compliance

	Hard Truth Expectation	**Compliant**
1	Presentation of nursing establishment review to the Board, every 6 months	Y
2	Staffing information displayed at ward level (planned & actual)	Y
3	Presentation of actual and planned staffing levels & exception report to the board each month	Y
4	Submission of monthly staffing data via Unify	Y
5	Publication of the monthly report on the Trust website & NHS Choices	Y

In addition to the NQB requirements, the NQB (2013) document "How to ensure the right people, with the right skills, are in the right place at the right time", provides guidance on what information the six monthly establishment review should contain for the Board report.

3.3 NQB Guidance and LCH Achievement What the Board must Do

	Details to be covered in the Board Report	Achieved
1	The difference between current establishment and recommendations following the use of evidence based tool(s) (Expectation 3)	Partial due to lack of evidence based tools for community
2	What allowance has been made in establishments for planned and unplanned leave (Expectation 6)	Yes
3	Demonstration of the use evidence based tool(s) (Expectation 3)	Partial as 1
4	Details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent (Expectation 6)	Yes
5	Evidence of triangulation between the use of tools and professional judgement and scrutiny (Expectation 3)	Yes
6	The skill mix ratio before the review, and recommendations for after the review (Expectation 3)	Yes
7	Details of any plans to finance any additional staff required (Expectation 9)	Yes
8	The difference between the current staff in post and current establishment and details of how this gap is being covered and resourced	Yes
9	Details of workforce metrics - for example data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions	yes
10	Information against key quality and outcome measures - for example, data on: safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction	Yes

4. THE LOCAL PICTURE ON SAFE STAFFING

4.1 In line with the NHS England requirements and the NQB recommendations, this paper presents the six monthly nursing establishments –workforce review and sets out the approach taken by the Trust to ensure that there is sufficient nursing capacity and capability in all service areas to meet the needs of our patients and maintain safe staffing.

4.2 LCH has complied with NQB recommendation that monthly planned and actual staffing data is uploaded to Unify. The planned and actual, qualified and care staff hours are calculated to provide a “fill rate” which is then confirmed as accurate

4.3 Several systems need to be in place to support the delivery of safe nursing numbers on each service area. These include, but are not limited to:

- The Trust operates a staffing bank and works in partnership with other staffing agencies, which enables managers to call upon additional skills as required whilst complying with the new agency rules and requirements. .
- The Trust has invested in over 50 new nurses who have had a bespoke induction and mentorship programme to ensure that new staff are to date with the key skills necessary to deliver high quality care.
- Clear systems are in place to ensure that there is feedback from patients and carers who use the services and that reflection and concerns from patients and carers are acted upon.
- The Quality Challenge has been reviewed and is about to be re-launched.
- The Trust is preparing a tender to procure an allocation system to support safe staffing
- The daily reporting tool and Trello system continue to be developed to support safe staffing in community teams

5. WORKFORCE METRICS

5.1 The Trust reports separately on a monthly basis to board on figures in relation to staff sickness, absence and recruitment and retention

5.2 Workforce Management: LCH is investing in a Workforce Management project, a key part of which is set to procure and implement an E-Roistering application for the Trust. This will help to streamline work around roistering of staff, providing enhanced management information, improve demand and capacity management both within Neighbourhood Teams and across the city and deliver improved patient safety, clinical effectiveness and efficiencies through increased productivity. Implementation of an automated solution will provide an opportunity for the Trust to streamline processes, achieve cost savings and free clinicians up to deliver patient care. It will release significant administrative time creating off-duty rosters and enable managers to be more productive and better informed. The significantly improved visibility around resources should lead to an overall reduction in the use of temporary staff, as permanently employed staff are deployed more effectively. For staff, it will mean greater visibility of planned shifts and more flexibility to either swap their shifts or request to work additional shifts where there is a gap in the rota. Further it should help to ensure they are allocated only the right amount of patient visits, ensuring they are able to deliver the best possible patient care.

6.0 CURRENT POSITION

6.1 The Board receives information on a monthly basis for inpatient units as part of the integrated performance report. The Trust began collecting data on each of its in-patient units in April 2014 with the first staffing report published externally in May 2014. A six monthly review was provided to the Quality Committee in November 2014 but did not provide a formal review of establishments and was not discussed at a public board meeting. The units reviewed were:

- Community Intermediate Care Unit
- Hannah House
- Little Woodhouse Hall

- Community Rehabilitation Unit
- South Leeds Independence Centre

6.2 Attached at Appendix 1 is the LCH current position against the CNO expectations.

6.3 **Inpatient units**

There have been a number of changes in relation to inpatient beds over the last six months. As the board are aware ward J31is being run by LLTH for a six month pilot over the winter period and a successful transition plan was implemented. The model of care in Richmond House in relation to nursing input is currently under review.

6.4 **SLIC**

Following discussions in October and November 2015 with the Leeds CCG commissioners a request was made for SLIC to return to the commissioned model with an increase in the proportion of lower acuity individuals.
SLIC returned to the model originally proposed of 30 nursing and 10 Residential beds. The admission criteria have been revised to support the admission of a lower acuity cohort of patients. Returning to being a 40 bedded unit under the original staffing model means we will provide the following.

There will be up to 8 High, 12 moderate, 10 low dependency beds and 10 residential beds, with some flexibility of the exact proportions of these numbers when supported by the unit manager after a review of the current patient cohort needs are understood.

Daytime 2 wings/ 1 floor will be assigned for the higher needs individuals with staffing levels at 2 RNs and 3 CSWs. Daytime 2 wings / 1 floor will take only low dependency and residential people with staffing levels at 1 RN and 2 CSWs.

At night the staffing levels are 3 RNs and 2 CSW for 40 beds across 2 floors

The staffing levels are supported during the daytime period by the Therapy staff that work across the 7 day week. Safe staffing levels are monitored on both the day and night shifts on a daily basis and escalated to the Adult Business Unit Leadership team when any forecasted or immediate shortages occur. Any short and longer term shortages will be primarily filled by the LCH bank CLaSS Service. The approach is to limit the use of agency staffing whenever possible.

Agency Staffing – The unit is proactively working on the recruitment to all our grades of staff so that we can significantly reduce the numbers of agency staff we require. The unit is looking at using the non-registered workforce more imaginatively with increased responsibilities for the Care Workers, Healthcare Assistant roles such as Discharge planners and Technical Instructors (Assistant therapy Practitioners) who can undertake tasks currently provided by registered staff.

In relation to Key quality indicators

Indicator	July	Aug	Sept	Oct	Nov	Dec
FFT	98%	98%	98%	98%	98%	98%
Safety Thermometer	79.5%	90.0%	96.6%	92.0%	96.2%	92.6%
Complaints Concerns PALS						2 1 0
Incidents	33	22	15	16	15	19
Serious Incidents						2 fractures from falls 1 Grade 3 pressure ulcer

6.5 Hannah House

The specialist unit which provides short breaks for children with complex disabilities and long term health needs. Since the last report staffing levels have improved as a number of staff returned from long term illness. The unit maintains safe staffing through use of a small bank of staff. Agency workers are rarely used and there is a careful induction process prior to using any agency registered nurse where not known directly to the unit.

In relation to Key quality indicators

Indicator	July	Aug	Sept	Oct	Nov	Dec
FFT						100%
Complaints, Concerns Pals						0 1 0
Incidents	3	1	1	2	2	0
Serious Incidents	0	0	0	0	0	0

6.6 Little Woodhouse Hall

Little Woodhouse Hall provides our CAMHS inpatient service. Due to the specialist nature of the unit and needs of the young people safe staffing levels are maintained at all times.

Indicator	July	Aug	Sept	Oct	Nov	Dec
FFT						100%
Complaints, Concerns Pals						1 1 0
Incidents	7	9	11	7	7	13
Serious Incidents						0

6.7 **Neighbourhood teams**

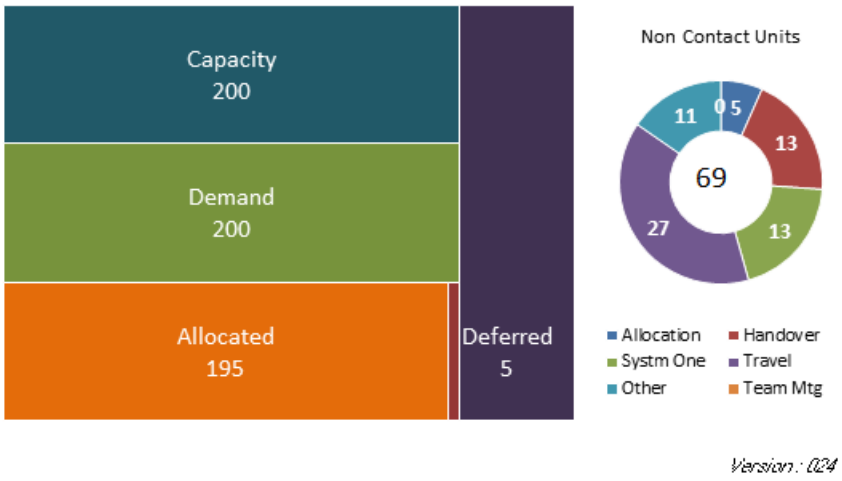
As previously stated there are no nationally agreed staffing levels for community teams or evidence based tools. The Trust continues to develop the work to set safe staffing levels in community teams. The work remains in development and there can be anomalies between what the data is reporting and the felt experience of staff on the ground. There are also existing variations in practice and in the way work is allocated. Integration is also at varying levels across the patch. Plans are being developed for each team to respond to these issues.

Also of note is the work undertaken by the ABU to fully analyse and engage with the whole NT clinical staff group to understand the clinical skills and competencies required by the NT nurses and therapists, this will be beneficial in the efficient recruitment, training and deployment of staff. Additional work is also required in neighbourhood teams as currently we do not undertaken routine patient/caseload dependency scoring.

Neighbourhoods Demand & Capacity Tool

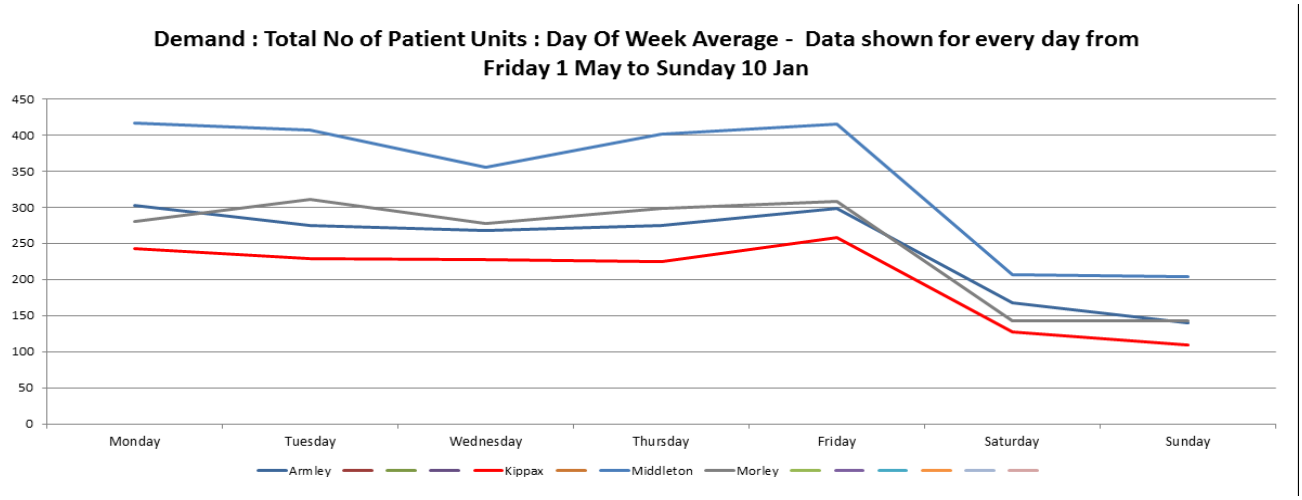
The Neighbourhoods Capacity & Demand Tool has been in use since May 2015 and provides a wealth of information, collected in each Neighbourhood Team each day. It gives front line staff an indication of the staffing level for the next day, relative to the amount of patient care to be delivered. It is reviewed on a daily basis by managers to understand the relative capacity situation of the teams and direct appropriate action. The tool also helps better understand non-contact time supporting work around service re-design and productivity.

Figure 1: Graphical display of demand & capacity for clinicians



The tool permits analysis of trends over time, around patient demand, capacity and absence levels in the teams. It allows the data to be broken down by Neighbourhood Team or reviewed city-wide and analysed by day of week, month by month and to be charted against each other over time. Each team also receives a ranking of the various indicators enabling cross-comparison. A sample analysis can be seen in figure 2.

The tool allows managers to be confident that staffing levels are appropriate to meet patient demand, to ensure resources are deployed appropriately according to need and to be alerted and take action where either a change in capacity or patient demand necessitates it.



7. CONCLUSION

This paper presents the second six monthly reviews to Board in relation to safe staffing. The paper demonstrates that the Trust has maintained safe staffing in the six months. It also sets out and describes where the Trust has work in place to support and further develop work. The Trust will continue to monitor national guidance as released as this is likely to have significant impact.

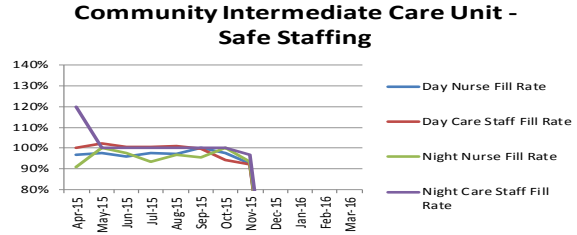
8. Recommendations

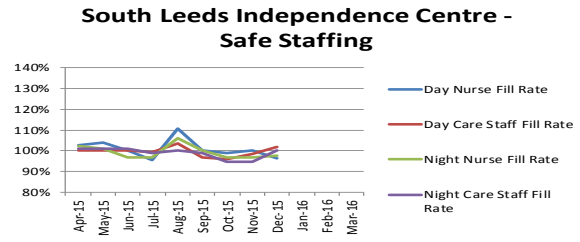
The Board is asked to:

- Support for development of the proposed tender to procure allocation system to provide proactive information
- Continue to develop the staff bank to improve the responsiveness in providing appropriately trained area specific staff when needed and ongoing reduction in the need for agency usage
- Continue the recruitment drive and work to support new staff
- Continue to meet the national monthly collection and publication of staffing data as recommended in “Hard Truths”
- Keep staffing levels under constant review to maintain and ensure they are safe
- Note the contents of the report and the progress being made and support six monthly reviews in a public board meeting.

Append

Community Intermediate Care Unit				Hannah House				CAMHS In-Patient				Community Rehabilitation Unit				South Leeds Independence Centre			
Day		Night		Day		Night		Day		Night		Day		Night		Day		Night	
Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)
97%	100%	91%	120%	100%	100%	100%	100%	100%	100%	100%	100%					103%	100%	102%	101%
98%	102%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	180%	96%	164%	68%	104%	100%	101%	101%
96%	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	153%	113%	100%	100%	100%	100%	97%	101%
98%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	159%	111%	100%	100%	96%	99%	97%	99%
97%	101%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	164%	99%	100%	94%	111%	103%	106%	100%
100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	205%	75%	94%	92%	100%	97%	100%	99%
98%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	185%	110%	100%	100%	99%	96%	97%	95%
92%	92%	94%	97%	100%	100%	100%	100%	100%	100%	100%	100%	163%	128%	147%	74%	100%	98%	97%	95%
N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	184%	94%	100%	100%	96%	102%	98%	100%
N/A	N/A	N/A	N/A																
N/A	N/A	N/A	N/A																
N/A	N/A	N/A	N/A																





Community Intermediate Care Unit			
Day Nurse Fill Rate	Day Care Staff Fill Rate	Night Nurse Fill Rate	Night Care Staff Fill
97%	100%	91%	120%
98%	102%	100%	100%
96%	100%	98%	100%
98%	100%	94%	100%
97%	101%	97%	100%
100%	100%	96%	100%
98%	94%	100%	100%
92%	92%	94%	97%
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A

	South Leeds Independence Centre			
	Day Nurse Fill Rate	Day Care Staff Fill Rate	Night Nurse Fill Rate	Night Care Staff Fill
Apr-15	103%	100%	102%	101%
May-15	104%	100%	101%	101%
Jun-15	100%	100%	97%	101%
Jul-15	96%	99%	97%	99%
Aug-15	111%	103%	106%	100%
Sep-15	100%	97%	100%	99%
Oct-15	99%	96%	97%	95%
Nov-15	100%	98%	97%	95%
Dec-15	96%	102%	98%	100%
Jan-16				
Feb-16				
Mar-16				

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM
2015-16
(103)

Report to: Trust Board

Date of meeting: 5 February 2016

Report title: Quality Strategy 2016-2018

Responsible Director: Executive Director of Nursing

Report author: Executive Director of Nursing and service improvement Lead

Previously considered by: Quality Committee 25 January 2016

EXECUTIVE SUMMARY

This strategy sets out the strategic approach and direction in relation to quality and quality improvement across the Trust. It is a new style and format of strategy. The strategy set out a framework for quality and is based on the four organisational priorities and six quality objectives and action areas. These are underpinned by the 'magnificent seven' behaviours as enablers.

The strategy is very much situated in the transforming face of health services and in particular community services. Care and quality is wrapped around local communities using primary care and school clusters as frameworks for developing new models of care. A key priority is the provision of out of hospital care. The strategy sets a direction of travel towards 'good'

RECOMMENDATIONS

The Board is recommended to:

- Approve the strategy
- Approve the direction of travel and action areas as set out in the strategy
- Support the on-going work and action as set out

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff
Links to principal risks:	
NHS Constitution:	Principle 3 : The NHS aspires to the highest standard s of excellence and professionalism to Safeguarding people who use services from abuse Principle 4 The NHS aspires to put patients at the heart of everything is does
CQC Outcomes:	Safe; Effective; Caring; Well Led; and Responsive
Equality and diversity:	• An Equality Analysis has been completed and considered
Sustainability Implications:	*None.*
Publication Under Freedom of Information Act:	• This paper has been made available under the Freedom of Information Act; or

for you, for life

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM
2015/16
(103)

Quality Strategy
2016:2018

Quality Strategy	
Author	Marcia Perry Executive Director Nursing
Service and **Clinical Lead**	**Leeds Community Healthcare NHS Trust** Quality and Professional Development
Applies to	All business units
Document Version	3
Document Status	For approval
Date approved	To be inserted
Date issued	To be inserted
Review date	2 years from ratification date

Introduction

We would like to welcome you to this new style of Quality Strategy. Leeds Community Healthcare NHS Trust is proud to provide health services to the local population of Leeds. We also provide a number of services with a regional footprint such as those we provide in partnership with Health and Justice. We provide a range of community services for adults and children including community nursing, health visiting, physiotherapy, community dentistry, Improving Access to Psychological Therapies (IAPT), Healthy Living Services, sexual health and health and justice services. Our vision is to provide the best possible care to every community in Leeds across the ages and to be the key provider of out of hospital care. We have worked over the last year to respond to the areas outlined in our last inspection by the Care Quality Commission and are committed to continue to develop good and excellent services and improving outcomes for patients.

We will continue to focus on the quality, safety and effectiveness of the services we offer. Working in partnership with patients is central to this. This work begins with our approach of individualised and patient centred care. Our teams work to create an individual assessment and care plan for every patient we work with. This varies from a health visitor working with a new family, a school nurse working with a young person to a patient accessing our services at York Street. Services are designed to support patients to regain independence and self-care as quickly as possible. We work closely with hospital colleagues to support self-care in areas such as administration of long term medication beginning in hospital. The trust is committed to continuing to recognise and develop services in line with parity of esteem and the shared focus on physical, mental and emotional health and wellbeing.

At Leeds Community Healthcare NHS Trust we recognise that our staff are our most important asset. We understand that the high quality of our clinical services depends on our ability to recruit and retain highly skilled, motivated and committed people whilst recognising the valuable contributions that both individuals and teams make to patient services. We recognise that in order to provide services which better meets the needs of our service users we need a workforce which broadly reflects our community in terms of diversity. We continue to support and develop different entry routes into work such as the newly formed Leeds integrated apprentice pilot.

We are also part of the wider Leeds system and we continue to work to develop and further strengthen partnerships both with other organisations and with local communities. Going forward we anticipate that this work will have a particular focus around working with GP's and Primary Care in developing multi-disciplinary neighbourhood teams wrapped around local communities and developing new models of care. These models will strengthen local services and the alternative to admission to hospital. This increases choice to the local population who we provide services too. New models of service delivery will particularly support the older person or those with long term medical conditions. We continue to work closely with partners in areas such as education, youth justice, early years and children's services in shaping services for children and young people.

Leeds continues to focus on reducing health inequalities and our teams play a significant role in addressing the wider determinants of health. We will continue to develop our staff in order that they can better support individuals and communities in making healthy lifestyle choices though for example a model called Health Coaching and other models of patient activation. We want to strengthen patient and public engagement in our services and their development. This includes a number of key areas:

- Better understanding patient experience, responding to feedback and most importantly feeding back on what we did as a result of this.
- The way we provide our care and our way of being as set out in our 'Magnificent Seven' framework
- Ensuring care is always safe, effective and responsive to each patient's needs
- Focus on our workforce and that they are valued and key to delivering every aspect of our quality strategy

This Quality Strategy sets out our programme of work and what we want to achieve through our four key organisational objectives, six quality objectives and six action areas. This is

underpinned by the enablers of our 'Magnificent Seven' which we recently developed with our staff. This is a set of behaviours and ways of being which will support the delivery of this Quality Strategy. Our quality performance and improvement are monitored monthly through our Quality Committee and reported annually in the Quality Account and we will continue to actively engage our staff, members, partners and stakeholders in shaping and taking this work forward.

Neil Franklin (Chair)

Thea Stein (Chief Executive)

Dr Tony Dearden (Chair Quality Committee)

Our Approach

Leeds Community Healthcare NHS Trust aims to provide safe, high quality care for the patients and communities that we are proud to provide a service to. The trust provides care services to 772,000 residents of the Leeds Metropolitan Area and employs around 3000 staff. We also deliver a number of services which are provided on a regional basis.

The NHS Five Year Forward View clearly sets out that quality healthcare is enshrined in law includes three key aspects, patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to best serve patients. Our Vision is here in LCH is to **'To provide the best care to every community in Leeds'** and to achieve good and outstanding across our services**.**

In order to support and deliver the vision the Trust has set out 4 strategic objectives and these include:

1. **Provide high quality, safe and effective services by:**

   - Protecting patients from harm
   - Improving our learning from incidents, complaints and audit
   - Improving sharing the learning from incidents
   - Developing outcome measures and quality indicators for all of our services
   - Support staff to reflect and learn through clinical supervision
   - Ensuring our services are patient cantered and personalised

2. **Work together with others to deliver integrated care closer to home by:**

   - Integrating adult neighbourhood teams with GP practices to improve care for older people and develop our services around the whole population e.g. children with complex health needs and those with long term health conditions and or disabilities.
   - Developing child friendly and flexible services for the local community and developing wrap around care for children and young people with partners
   - Establishing new specialist services e.g. police custody and sexual health
   - Developing new ways of working or further integrate services to improve patient care
   - Develop new ways of working through promotion of technology and digital patient care

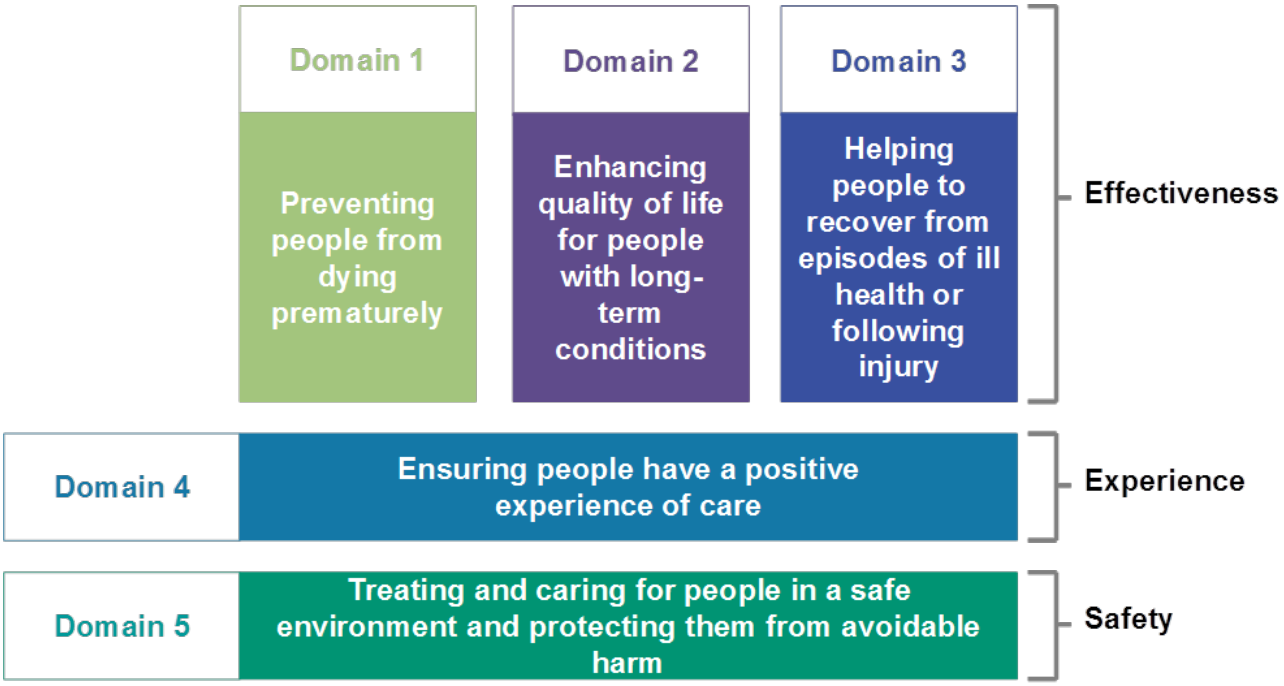
3. **Recruit and retain the best people by**:

   - Strengthening leadership and a positive culture across the organisation
   - Strengthening recruitment
   - Listening to our people
   - Supporting and training our people and providing rewarding career pathways
   - Making everyone's working life as good as it can be through ensuring our IT and estates strategies support our clinical teams and patient care
   - Ensuring our people have the freedom to act and to improve the care they provide

4. **Ensure we are financially viable and sustainable organisation by:**

   - Ensuring services are ready for tenders so that we are able to retain and grow our services
   - Maintaining our financial stability and generating funds to reinvest in our services
   - Clinical engagement in 'adding value' and making every contact count

In 2015 we worked with staff to review our values and behaviour framework. This work culminated in the development of 'The Magnificent Seven' and these underpin every aspect of our approach to the services we provide. This also sits alongside a clear commitment and action plan to deliver the five pillars of quality and safety as set out by the Care Quality Commission and within the NHS Five Year Forward View Outcomes Framework 5 Domains (see diagram below) and our own internal Leeds Community Health Care NHS Quality Challenge.



Our Progress 2014-2015

LCH Quality strategy 2014-2015 aimed to put in place a vision for quality for all healthcare that we provide. The quality model and approach adopted was based on the three dimensions of quality first established by Lord Darzi in High Quality Care for All (Department of Health, 2009): safety, experience and clinical effectiveness. The strategy considered systems, processes and infrastructure (such as Quality Framework, clinical leadership and risk management) as well as other strategies that supported the development of quality (such as the organisational development and leadership strategies).

The aims of the strategy were to:

- Improve patient safety and reduce harm to patients
- Ensure that patients using our services have the best possible experience
- Demonstrate our success in outcomes, backed by clinically effective interventions and better patient reported outcomes/experience and that we responded to their feedback

Each aim had some specific objectives defined within the strategy which were reviewed and broken down further each year within the quality account priorities. Our quality accounts since 2012 have demonstrated the progress we have made and the focus on quality improvement for each year.

Our achievements as a result of this strategy include:

Safety

- A culture of incident reporting evidenced through the number of incidents reported and particularly those that caused no harm. We are consistently above the national average on the percentage of no harm incidents reported.
- All serious incidents have root cause analysis investigations and action plans to address learning in a timely way.
- Learning from patient safety incident memos are produced when learning is identified and services are supported to implement any recommended learning.

- A Quality Impact assessment tool (QIA) has been developed in order to risk assess the potential impact on quality of service reviews and transformation plans.
- Managers have timely access to incident data through Datix (our incident and reporting system) and can review this at service/team level. Incident data is also reviewed at the Business Unit Performance Panels and clinical forums to identify any actions needed.

Experience

- High levels of patient satisfaction across services and where a need for improvement is identified actions are taken to address this.
- We have a variety of methods to capture patient experience and feedback including patient survey, compliments, complaints and comments and focus groups. In 2014 the friends and family test was introduced across all services in line with national requirements. Feedback is reported monthly to the Quality Committee and Board through patient stories and the integrated performance report.
- Services are regularly visited by Board members and members of the CCG with an established process for reporting the outcomes of these visits.
- Trust members are actively engaged in Trust business. Examples include recruitment, service redesign, focus groups, staff awards, research and inspection assessments. A programme of 'members meet' sessions has been implemented.
- Services continue to promote self-care and several initiatives support this. These include workshops on personalised care; working closely with GP colleagues to identify high users of services to target support; training programmes delivered to patients.

Clinical Effectiveness

- Outcome measures have now been identified by some services though not all are yet actively reporting as further support is needed to develop data collection tools and support with analysis. The majority of services have a range of key performance indicators which are monitored and reported on.
- We have an embedded process for receiving, cascading and monitoring compliance against NICE standards. Where services have assessed they are not compliant, action plans are developed and progress against these are monitored.
- All clinical services undertake service specific and an annual documentation standards audit. In 2014 the clinical audit process was amended to assist services in identifying priorities for clinical audit in order to focus work in areas with the most impact and embed this as an integral part of practice. We also participate in Sign up to Safety.
- In 2013 and 2014 services presented their audit work at the Yorkshire Effectiveness and Audit Regional Network (YEARN) conference.
- We are early adopters of national initiatives in both adult and children's services including integration, best start and better care.

Improving quality is an iterative process so we still have work to do in each area including:

Safety

- Reducing the incidence of pressure ulcers and falls. Causes can be complex and multifactorial and focussed work is being undertaken citywide to address this. Progress against action plans are monitored through the Quality Committee.
- Improving systems for sharing learning from incidents across the organisation. Further work is being undertaken to routinely review if learning has been implemented and if a change in practice has been sustained.
- Strengthening data analysis and adopting approaches recommended by the Leeds Institute for Quality in Healthcare (LIQH).
- Improving triangulation of data across quality information, workforce information and performance data to improve understanding interrelated factors and risks and ongoing development of the Integrated Performance

Report.
- Embedding a clinical supervision policy and flexible framework across services

Experience

- The Trust promotes a culture of being open to feedback and enabling systems to ensure that the patient and family voice can be heard, and support offered not solely in response to complaints. Examples include help, support and guidance within the Single Point of Access (SPA) model, duty clinician and Patient Advice and Liaison Service (PALS).
- Courses offered within LIQH uses the Patient Lived Experience as a teaching and training strategy – encouraging recognition of the whole patient journey and how this is experienced and can be further improved
- A common theme in complaints received by the Trust relate to poor communication which suggests this remains an area for further improvement.
- Continue to improve complaints management processes.
- Increase the number of patient satisfaction and friends and family returns each month to strengthen assurance.
- Strengthen processes for monitoring progress against action plans developed as the result of patient feedback and moving towards a model of coproduction with patients

Effectiveness

- Further developing the collection, recording and analysis of outcome measures.
- Change the focus of audit work from process to impact and share audit outcomes across the organisation.

How the Strategy was developed

Over the last weeks and months we have been gathering information and listenining to staff an patients in order to inform and shape this new Quality Strategy. This has taken a number of formats such as:

- Team meetings
- Professional forums
- 1:1 conversations
- Patient story at Board
- 1:1 conversations with patients and carers

There are also a number of important data sources that we have and will continue to shape this strategy and include:

- Patient Friends and Family Test
- Staff Friends and Family Test
- Staff Survey
- Analysis and learning from complaints and incidents
- Internal and external service reviews
- Good practice from other Trust's
- Feedback from CQC and NHSI as it develops
- Members feedback
- Research and audit

This strategy will be shared with stakeholders in particular :

- Commissioners
- Healthwatch
- Members
- Leeds City Council

We also continue to learn from national and reviews and reports and ensure that local action is taken where required to support patient safety and quality of care. Through this process we have developed our four organisational objectives and six quality objectives and action areas to support our journey towards good and excellent care and services.

Objective 1 - Provide Safe, Effective and High Quality Services

Always do the right thing' (Safety and Caring domains)

Our aim is to always to do the right things for patients and to provide the right care, at the right time, every time and in the right place.

We have clear systems and processes to support and monitor the quality of care and these include:

- Incident reporting
- Complaints
- Mortality reviews
- Serious incident reviews
- Pressure ulcer validation panels
- Strategic and operational quality review meetings
- Safety thermometer
- Risk register
- Leadership
- Audit
- Clinical supervision
- Appraisal and professional development programmes
- Benchmarking

We use these processes to understand and learn when things go wrong in order to identify learning and required action. LCH is viewed as a high reporter of incidents. It is positive that staff identify incidents and are confident in reporting these. Staff across LCH are focussed on providing high quality care for patients and their families.

However, on occasions we do not always get it right. We know for example that there are a number of areas where patients do not always experience the quality of care we would wish and/or do not receive it in a timely manner. Examples of this include our pressure ulcer rates and waiting times to access a small number of services.

These are key areas for action with specific action plans in place.

Objective 2 - Work together to deliver integrated care closer to home

(Responsive and effective domains)

Our aim is to provide care in partnership with patients, families, carers and partner organisations.

Our teams provide high quality and compassionate care to the population of Leeds and wider on a daily basis. However, it is important that patients experience consistent and seamless pathways of care across settings e.g. from hospital to home.

This care will be provided as close to home as possible and wrapped around local communities such as Primary Care and Schools. This is firmly underpinned by the two principles of 'no decision about me without me' and secondly empowering patients in self-care through the use of models such as Health Coaching and patient activation. It is also about ensuring viable alternatives to out of hospital care.

National reports and the NHS Five Year Forward View clearly focus on the fact there are variations in healthcare and parts of the system are not designed to ensure that evidence based care is provided to patients at all times.

We have clear systems and processes to help us support and monitor the effectiveness of care which include:

- Multi-disciplinary team reviews and meetings
- Processes to implement NICE guidance, research and clinical audit
- Agreed safe staffing levels, staffing models across community teams and inpatient settings
- Development of tools such as Trello and heat maps to support early identification of issues
- We are supported in providing effective care though our research services, library services and links with academic partners and LIQH
- Care pathways

- Benchmarking
- Supervision structures and models
- Clinical forum and professional development events for sharing and cascading information and learning

Over the next two years there are a number of areas where we want to develop further work with staff. These include developing clinical outcomes for more service areas and developing our community teams to provide the same high quality care seven days a week. For adult services the drive is to further develop neighbourhood teams wrapped around primary care working with partner agencies. We are working to develop specialist care and services in areas such as children's mental health and a specialist eating disorders unit for young people.

Objective 3 - Recruit and retain the best people

(*Effective and Well Led domains)*

Our aim is to work to ensure that we continue work to recruit and retain a high calibre, engaged and motivated workforce.

As a community trust we have the privileged position of working alongside the majority of our patients within their local clinic, home or care setting. There are specific challenges and or opportunities for us in relation to recruiting and retaining our workforce and these include for example:

- Numbers of nurses and Allied Health Professionals (AHPs) being trained
- Number of trainees in placement
- New agency rules
- Changes to training programmes including funding routes e.g. removal of bursary for student nurses
- Capacity to support student placements and increasing demands for placements
- Career routes, progression, and satisfying careers for senior therapy staff
- Embedding research and audit in daily practice

Our workforce is the cornerstone of each service we provide. The recruitment and retention of staff is crucial to the provision of safe, effective and high quality services. We are fortunate to work in partnership with our local Universities and academic partners in training the future workforce and ensuring the delivery of highly skilled registered and non-registered health care practitioners.

We have a number of systems through which we support and monitor recruitment and retention and these include:

- Specific projects in relation to recruitment and retention
- Regular reporting and data analysis regarding workforce
- Organisational Development strategy and actions plans in place
- Partnership and Leeds system wide projects and strategies
- Clinical supervision
- Team coaching
- Robust support for training and professional development for staff
- The staff wellbeing service.
- Appraisal and exit interview feedback

Objective 4 - Ensure we are financially viable and sustainable

(Well led domain)

Our aim is to ensure that we maintain and improve our financial stability, grow our services where appropriate and remain provider of choice for the delivery of community health care across Leeds and footprint.

The NHS is facing unprecedented financial challenges. This is within the wider context of ongoing service redesign within the local authority, public health and voluntary sectors. It is also within the context of increasing numbers of older people with multiple health needs, children with complex health problems and demands for services. Increasing numbers of services are being tendered. As new models of care are developed and emerge this provides both opportunity and challenge in terms of the financial stability of the organisation.

We have clear systems and processes for monitoring our finances and these include:

- Business Committee
- Audit Committee
- Charitable Funds Committee
- Operations Finance and Performance meetings
- Internal and external audit
- External scrutiny by TDA, NHS England and CCGs

Over the next two years our work will continue to focus on:

- Maintaining financial balance
- Maintaining and defending current portfolio of services
- Delivery of required Cost Improvement Programmes
- Delivering against new CQC finance as further detail is published
- Taking opportunities to develop and grow services in line with business strategy

What Changes will we make that will result in improvement?

This is an ambitious strategy and affirms our commitment to seek continuous quality improvement in relation to the quality, safety and effectiveness of services and patient experience. The engagement and ownership by every member of our services is essential to the successful delivery of the strategy.

The diagram below sets out the areas of work we will we continue to undertake over the next two years. Our work is underpinned by the 'Magnificent Seven' our suite of behaviours and ways of being that underpin every aspect of our work. These will help us to deliver our four organisational objectives and six quality objectives and action areas

The next section then sets out in more detail the suite of action areas and areas of work within each

Key areas that cut across include:

- The focus on real patient engagement and empowerment in every aspect of care
- The promotion of independence and self-care through the use of approaches such as Health Coaching and patient activation
- The relentless drive and focus on quality and continuous quality improvement
- The investment in our workforce recruitment, development and retention

In addition, there are a number of key strategies already in place or in development which support and or sit alongside this Quality Strategy and these include:

- Safeguarding Strategy
- Organisational Development Strategy
- Nursing and AHP Strategy
- Research and Development Strategy
- Medicines Management Strategy
- Workforce Strategy

LCH Quality Strategy

How we work	Our objectives	Our action areas
Caring for our patients	Quality improvement and continuous quality improvement	• Quality improvement plan • Refreshed Quality Challenge • Stop the pressure • Learning from incidents • Mortality reviews • Quality dashboards and huddles • Our approach to continuous quality improvement
Making the best decisions	Empowering patients	• Friends and family test • Individualised care plan • Person centred care planning • Duty of Candour • Health coaching
Leading by example	Our community	• Recruitment and retention • Education and training • New models of care • Neighbourhood teams • Nursing and AHP strategy • Supporting team development
Caring for one another	Leadership and culture	• Board commitment • Magnificent Seven • 6 Cs • 50 Voices • Focus on developing middle managers • Safe staffing
Adapting to change and delivering improvements	Learning systems	• Clinical and professional forums • Learning from incidents • Learning and experience group • Benchmarking and learning from best practice
Working together	Suite of projects	• The range of current and ongoing projects as set out on page 22
Finding solutions		

Action Area 1a - Continuous Quality Improvement

(Effective and responsive domains) *(Objective 1 Quality improvement and Continuous quality improvement)*

1. Our Quality Improvement Ambition

Our ambition is to deliver **the best care we can to every community we serve**. We will achieve this through a relentless focus on patient safety and effectiveness whilst always delivering care with compassion and kindness. We recognise the need to work well with our patients and partners across the health and social care system so that the services we offer are patient centred and integrated.

We will achieve this through sustaining a culture of continuous quality improvement across our organisation. By this we mean:

- **A grass-roots, front-line team based approach** to improving the quality of care, that recognises the complexity and multi-disciplinary nature of care delivery often crossing team, service and organisational boundaries (microsystems)
- A cultural, sustainable way of working with a **systematic intention to improve outcomes**
- **Owned and driven by teams**; becomes part of the way teams work. It looks beyond fighting the fires of today, builds on what we do well and how we can take this further.
- **Underpinned by measurement** so that we are clear on our improvement goals and know how well we are doing against them
- CQI secures **active partnership with service users** in designing improvements
- **Organisational alignment** to support the CQI work of frontline times

2. How we will deliver our ambitions for Continuous Quality Improvement (CQI)

Building on the work we have done on quality improvement over recent years, our approach to delivery of this ambition integrates three fundamental components:

Effective frontline teams: in order for CQI to thrive, we recognise the need for our frontline teams to have great leadership, clarity of purpose, time to reflect and learn freedom to act and effective support from the rest of the organisation.

Improvement knowledge and skills: There are a range of proven and established quality improvement techniques which our teams can utilise to enable their quality improvement work. Our Quality Improvement team will enable our capability building in this area through QI learning

and development for improvement coaches, leaders and staff.

Team Coaching: Teams will be enabled to undertake their quality improvement work with the support of team coaches. This is a cohort of skilled professionals across the organisation with knowledge and skills in effective team working and improvement science and measurement. Team coaches will work with frontline teams around their quality and safety improvement priorities, and in so doing, will build the quality improvement knowledge and skills of our frontline teams.

Our approach to CQI is underpinned by the model for improvement (IHI), and this will be actively used by our clinical leaders and team coaches in their quality improvement work with frontline teams which will enable us to bring a consistent approach to the work we are undertaking across the organisation.

Organisational and Strategic Alignment: The organisation's corporate functions will be better aligned to meet the quality improvement needs of frontline teams; more specifically Informatics and Business Intelligence will actively support quality improvement priority areas with good information and robust measurement tools. We will make better use at team level of the good information sources we already have, including patient experience data (F&FT), clinical incident and risk management information.

Support from our Trust Board: frontline teams will be supported and encouraged in their Quality Improvement work from our leaders at Board level. As well as formal reporting to Trust Board and Quality Committee of key quality improvement projects, there will be informal visits to understand the impact of quality improvement work at team level.

3. Quality Improvement Partnerships

Many of our frontline teams are working in a multi-disciplinary, integrated way with health and social care professionals and colleagues to deliver services. Our team based approach to quality improvement will build on these relationships, thereby enabling learning and implementation beyond the boundaries of our organisation.

We will continue to be an active partner with the Leeds Institute for Quality Healthcare in designing and implementing the six system-wide improvement pathways which are underway across the City:

- Cardiovascular services
- COPD
- Fractured Neck of Femur
- Cancer Care
- Diabetes
- Dementia

We will actively participate in the quality improvement and educational learning programmes offered by LIQH as part of our approach to building improvement capacity and capability.

We will also continue to work with the Yorkshire and Humber Improvement Academy as an excellent resource for supporting and focussing on key quality improvement priorities.

4. Evaluation of our Approach to Continuous Quality Improvement

We will develop a range of key metrics to assess the impact of our quality improvement work and to guide its future development. A number of these metrics will already exist, though we recognise that the use and development of outcome measures will be a key part of our continued success in continuously improving the quality of our services.

Action Area 1b Quality Improvement – monitoring

(Effective, safe, responsive and well led domains) *(Objective 1 Quality improvement and Continuous quality improvement)*

Our ongoing work

- Continue to develop quality, safety and effectiveness sections within the Integrated Performance Report
- Continue to action the implementation and use of audit, research and NICE guidance
- Further develop and expand the new induction and preceptorship programme which commenced in September 2015
- Continue to develop mortality and serious incident reviews and learning from incidents
- Continue to build sustainable and vibrant models of clinical supervision for all services

Additional / new Areas

- Development and pilot of outcomes for services within each business unit
- Roll out refreshed Quality Challenge
- Introduction of quality boards within teams
- Development of quality huddles in the business units
- Implement Stop The Pressure Plan and actions – focus on reducing incidence of avoidable pressure ulcers
- Improved flow of data to teams and use of team level data
- Improve learning from incidents and data sources through the Learning from Experience Group and other frameworks within each business unit

Action Area 2 - Leadership and Culture: The Magnificent Seven

(well led and caring domains) (Objectives 3 and 4, Our Community and Leadership and culture)

Our ongoing work

- Board commitment and leadership of agenda
- Refresh and re-launch of our behaviour framework - The Magnificent Seven
- Our leadership development programme
- 50 Voices Group
- Ongoing focus and commitment to clinical leadership
- Review and refresh of Organisational Development Strategy
- Participation in pan Leeds planning and strategy development
- Developing emerging clinical leaders and having clinical voice in all parts of the organisation

Additional / new areas

- Focus on developing leadership, quality improvement and management skills particularly in relation to clinical middle managers
- Work to understand barriers to staff engagement and ownership
- Targeted use of available resources to support the development of leadership and culture in key service areas
- Embed Duty of Candour
- Commit to understanding safe staffing levels for services and greater clarity in relation to demand, capacity and workloads
- Further develop and enhance our work to attract and retain staff with particular focus in relation to staff appraisal, clinical supervision and support revalidation

How we work

Our values

At Leeds Community Healthcare NHS Trust our shared purpose is underpinned by our values:

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously listening, learning and improving

Action Area 3 - Our Community

(Caring, safe, effective and responsive domains)(Objective 3 our community)

Our ongoing work

- Continued focus and drive in relation to recruitment
- System wide work on recruitment and retention
- Our Support for ongoing education and training for staff
- New models and entry routes into working for LCH e.g. integrated apprentice and students joining CLASS as Health Care Support Workers
- Ongoing integration within neighbourhood teams
- Working to safeguard all vulnerable people. Ongoing participation in pan Leeds and local safeguarding delivery and work and linked to the delivery of the Leeds and LCH Safeguarding Strategy. This includes the ongoing focus on restorative practice.

Additional / new areas

- New models of care, engagement and delivery in pilots
- Development of Health Coaching and patient activation
- On-going development of preventative practice and early health identification models within services for example initiatives driven within Health Visiting and the Infant Mental Health Service
- Focus on team development and with particular reference to the neighbourhood teams
- Development of Nursing and Allied Healthcare Professionals Strategy
- Focus on career development and satisfaction with particular reference to allied healthcare professionals
- Ensuring teams understand the resources available to them and that they can draw upon
- Focus on communication and engagement with all staff groups
- Refresh action plans based on findings of new Staff Survey when published
- Increased co-production with service users regarding both the improvement and development of services

Action Area 4 - Empowering patients / Person Centred Care

(Caring, effective and responsive domains)(Objective 2 and 5, empowering patients and learning systems)

Our ongoing work

- Continue to develop how we respond to and use the information within Friends and Family Test
- Ensuring that each patients care begins with a comprehensive assessment of need which is developed in partnership with the patient and carer and that care plans are individualised. This starts with the outcomes patients wish to achieve.
- Continue to work with members and patients to develop engagement in meaningful ways e.g. development of patient story at board
- Continue to develop our recruitment, induction and preceptorship programmes for our staff embedding the magnificent seven and 6C's as fundamentals.

Additional / new areas

- Focus on no decision without me and embedding Duty of Candour
- Development of learning from patient experience, complaints and FFT through the new 'Learning from Experience' group
- Further development of Health Coaching, patient activation and approaches to self-care
- Further Embed 6C's alongside the 'Magnificent 7' behaviours. This will include the new domain with the 6C's of 'professionals adding value'
- Ongoing work with clinical leaders to understand how we can better embed and support culture change in relation to individualised and person centred care planning

Action Area 5 - Learning Systems

(Safe, well led and effective domains)(Objective 5. Learning Systems)

Within Leeds Community Healthcare NHS trust we have a wider range of systems and processes to support the delivery of quality, safety, effectiveness and patient experience i.e. governance. However, we recognise that we can do more in terms of sharing good practice, sharing learning and systematising our approaches where it makes sense to do so. This action area sets our approach to support delivery.

Our ongoing work

- Ongoing development of professional/clinical forums
- Quality and safety newsletters in the business units
- Learning from incident reporting
- Dissemination of learning
- Embed new committee structure below the Quality Committee
- Continue to seek best practice from other areas and ongoing participation in Community Trust Network
- Ongoing development of Senior Leadership and team meetings
- Continue to participate in LIQH and Academy as it develops

Additional / new areas

- Development of thematic approach to quality improvement across Quality Committee and Board and increased use of Quality narratives
- Develop further methods to share leaning through the Learning From Experience group
- Develop action plans in response to any new national guidance and inspections
- Innovative ways of engaging the patient voice at Senior Management Team and Board.

Action Area 6 - Suite of Projects

(Safe, caring, effective, well-led, responsive and finance domains)(Objective 6, suite of projects)

There is an ongoing programme of work and action plans across the organisation and this plan has been cross referenced with the Quality Improvement Plan. We will continue to focus on these plans through to business as normal.
These projects include:

Safe	Caring	Effective	Responsive	Well Led
Maintain progress in relation to HCAI's	6C's	Mobile working	Allocation system	50 voices
Suite of tools • Trello • Safe Staffing	Magnificent Seven	Neighbourhood Teams	Responding to complaints	OD Strategy • Magnificent 7 • Recruitment • Retention, • Leadership
Pressure Ulcers	Hello My Name Is	Benchmarking	Patient engagement	Board to Floor Visits
Falls	Safeguarding	Outcome measures	Learning from Incidents	Patient Voice at Board
Medication • Errors • Transcription • Optimisation	Individualised and person centred care planning	Appraisal	Personalised care planning	Duty of Candour
Sign up to Safety		Recruitment and retention	Reducing waiting times	
Estates move of CAMHS Tier 4 service premises		Pilot new models of care	Supervision	

Additional / new areas

- Tender for e–roistering system
- Further development of structured handovers in neighbourhood teams including clinical communication and handover
- Focus on Catheter Acquired Urinary Tract Infections
- Ongoing development and focus on Mortality reviews
- Engagement and development of new models of care

Our Framework and next steps

This Quality Strategy sets our commitment to providing safe, effective and good services delivered in partnership with patients. Patients will be supported in self-care and achieving their individual goals. Care will increasingly be wrapped around, local communities, primary care and school clusters.

Delivery of the strategy will be overseen by the Quality Committee and its recently reviewed sub committees. We will continue to take account of national guidance and learning from reviews as they are published such as the emerging recommendations of the Goddard review.

Safety standards continue to evolve and we support clinicians to strive to continually improve using measurement and bench marking where available. Our approach is also aligned to the delivery of effective patient centred services. This is usefully summarised in the proposed framework set out within the Kings Fund report Better Value in the NHS (2015)(appendix one).

Achieving our four outcomes and six quality objectives and action areas will enable us to measure our journey towards 'good' and better enable us to describe what 'good' looks like and supports the delivery of safe, responsive, high quality, well led and effective services.

References

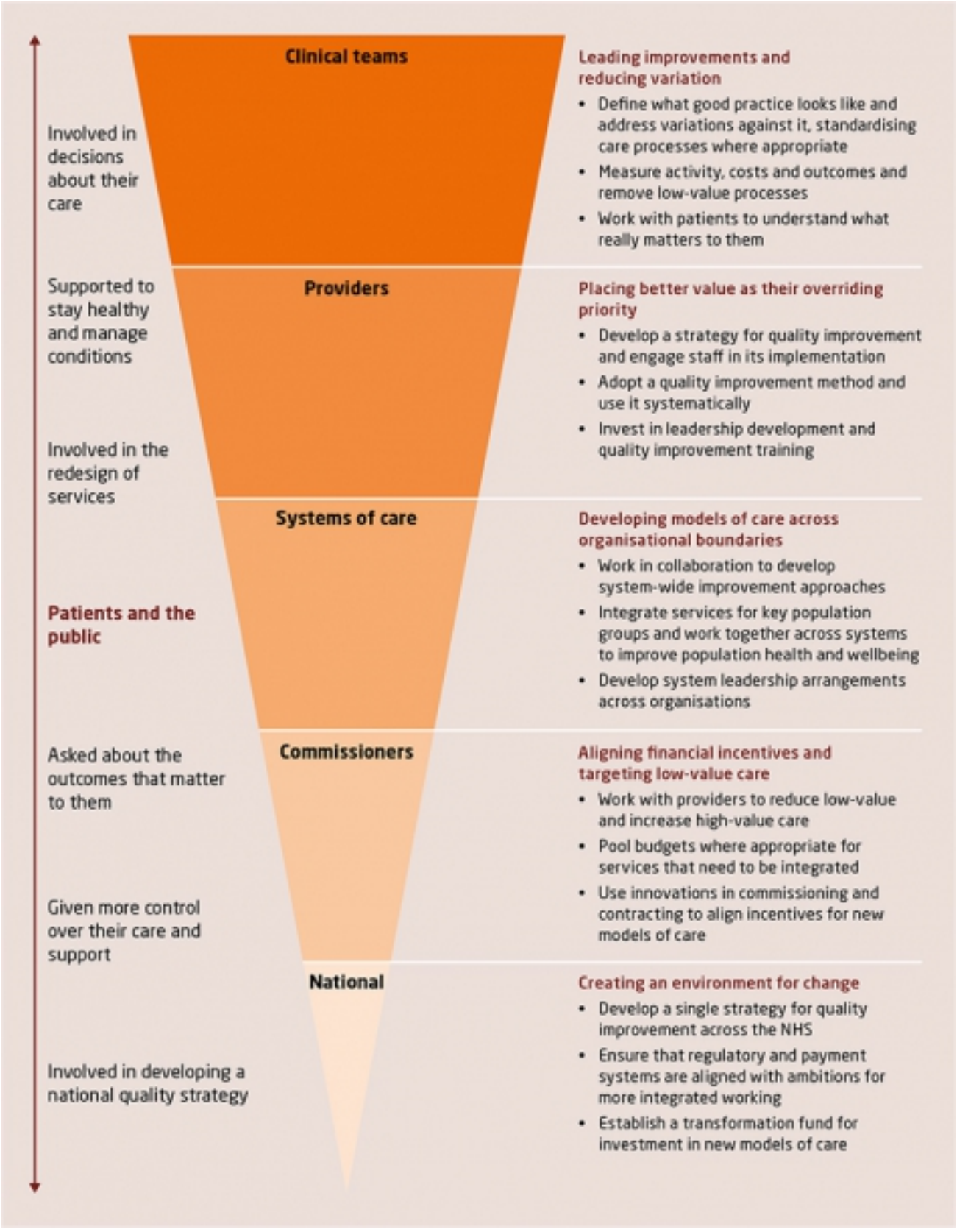
Hugh Alderwick Ruth Robertson John Appleby Phoebe Dunn David Maguire, 2015, *Better value in the NHS The role of changes in clinical practice,* The Kings Fund, London

Care Quality Commission, 2015, *How CQC Regulates Community Health Services-Provider Handbook,* London

Lord Darzi 2009, High Quality Care for All, Department of Health, London

Simon Stevens, *Five Year Forward View*, 2014, Department *of Health, London*

Appendix One



Appendix 2

Equality Analysis (EA) – Relevance Screening Form

<table>
<tr><td>1. Name of the document</td><td colspan="4">Quality Strategy
2016-2018</td></tr>
<tr><td>2. What are the main aims and objectives of the document</td><td colspan="4">This strategy sets the direction of travel, and identifies a range of objectives for staff working for LCH around the quality agenda. The quality strategy is built around our four organizational objectives and six quality objectives and action areas.
It also aims to support the delivery of LCH Strategic Objectives which are:
• To provide high quality, safe services, continuously improving the patient experience and measuring our success in outcomes;
• To work in partnership with service users, communities and to deliver service solutions, particularly around integrated care and care closer to home principles;
• To engage and empower our workforce; ensuring we recruit, retain and develop the best staff;
• To become a viable and sustainable organization, with the ability to invest in the community, and with a relentless focus on value for money.</td></tr>
<tr><td rowspan="2">3. Is this a key strategic document?</td><td colspan="2">Yes</td><td colspan="2">No</td></tr>
<tr><td colspan="2">X</td><td colspan="2"></td></tr>
<tr><td rowspan="2">4. What impact will this document have on the public or staff?</td><td>High</td><td>Medium</td><td>Low</td><td>Don’t know</td></tr>
<tr><td>X</td><td></td><td></td><td></td></tr>
</table>

Explain:
Providing safe, effective, responsive, caring and well led services sits at the heart of the organization. . We will continue to focus on the quality, safety and effectiveness of the services we offer. Working in partnership with patients is central to this. This work begins with our approach of individualized and patient centered care. Our teams work to create an individual assessment and care plan for every patient we work with. Our vision is to provide the best possible care to every community in Leeds across the ages and to be the key provider of out of hospital care.

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM
2015-16
(104)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Safeguarding Strategy 2016 - 2019
Responsible Director: Executive Director of Nursing **Report author:** Lead Nurse Safeguarding
Previously considered by: Safeguarding Committee

EXECUTIVE SUMMARY

This strategy sets out the strategic approach and direction in relation to safeguarding across the Trust. Leeds had worked over the years to safeguard both children and adults and this has been recognised as 'good' in external inspections. The strategy is therefore also set in the context of the wider Leeds safeguarding strategies and approaches.

This strategy sets out the key safeguarding priorities and areas of development within Leeds Community Healthcare NHS Trust over the next three years, while acknowledging the crucial importance of inter-agency collaboration and close co-operation with service users, commissioners and inspectorates to ensure the Trust safeguards the population of Leeds through the delivery of high quality, effective healthcare.
The report sets out six key action areas

- Making safeguarding personal
- Employ fit and proper people and workforce will be confident and competent in all aspects of safeguarding
- Improve health outcomes for children looked after and care leavers
- Regard for duty of candour
- Recognised as effective and valuable partners
- 'Think family, Work family'

RECOMMENDATIONS

The Board is recommended to:

- Approve the strategy
- Approve the direction of travel and action areas as set out in the strategy
- Support the on-going work and action to safeguard adults and children

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff
Links to principal risks:	
NHS Constitution:	**Outcome 7: Safeguarding people who use services from abuse** People should be protected from abuse and staff should respect their human rights. **Outcome 14: Supporting workers** Staff should be properly trained and supervised, and have the chance to develop and improve their skills
CQC Outcomes:	
Equality and diversity:	• An Equality Analysis has been completed and considered
Sustainability Implications:	*None.*
Publication Under Freedom of Information Act:	• This paper has been made available under the Freedom of Information Act; or

Leeds Community Healthcare NHS Trust Safeguarding Strategy 2016 - 2019

‘Safeguarding is everybody’s business and doing nothing is not an option’

Safeguarding Strategy	
Author	Deborah Reilly Head of Service – Safeguarding Designated Nurse – Children Looked After and Care Leavers
Service and **Clinical Lead**	**Leeds Community Healthcare NHS Trust** Safeguarding and Children Looked After & Care Leavers Deborah Reilly
Applies to	All business units
Document Version	5
Document Status	For approval
Date approved	To be inserted
Date issued	To be inserted
Review date	3 years from ratification date

Leeds Community Healthcare
Safeguarding Strategy
2016 - 2019

‘Safeguarding is everybody’s business and doing nothing is not an option’

Contents:

1.0 Introduction

Our population has a right to live free from abuse and neglect.

Sadly, statute, case law, policy and procedure in relation to Safeguarding are often formed in the crucible of questionable and in some instances, poor practice.

Preventing and responding to abuse is essential to achieving optimal standards of health, safety and wellbeing and is integral to all care delivery. Safeguarding is everybody's business – doing nothing is not an option; abiding by this principle and our organisation's vision and values, will ensure we safeguard and protect the people of Leeds.

This three year strategy sets out Leeds Community Healthcare's (LCH) direction of travel and priorities for Safeguarding 2016 - 2019. The strategy outlines the vision of making safeguarding everybody's business, and recognising safeguarding is fundamental to our duty as care providers. This brings together safeguarding activities from across the business units and covers Safeguarding Adults; Children; Mental Capacity Act 2005 (MCA); Sudden Unexpected Deaths In Childhood (SUDIC); and Children Looked After (CLA) and Care Leavers (CL).

LCH is committed to safeguarding our population through effective multiagency working and public engagement in line with our organisation's vision and values while recognising Leeds City Council's Social Work service as the lead agency.

In Leeds this work is coordinated through the Leeds Safeguarding Children's Board (LSCB) and the Safeguarding Adults Board (SAB). LCH is a key partner on the Boards and our strategy supports the objectives of the Safeguarding Boards whilst focusing on priority areas for LCH, in order to move this shared agenda forward.

The rapidly changing world of health and social care requires a proactive approach to safeguarding and the strategy will be reviewed periodically and adapted to reflect this.

2.0 Context

The Local Authority is the lead agency in Safeguarding adults and children, however all agencies have legal and statutory duties to ensure that safety and welfare are promoted. Protection from abuse and neglect is fundamental to care provision and integral to service delivery.

LCH recognises the economic challenges facing health and social care providers and the need to deliver high quality, person-centred care, with a focus on innovation, productivity and prevention of harm. This cannot be achieved single-handedly and safeguarding is most effective when delivered through a partnership approach.

Safeguarding occurs across all services, all settings and within an ever evolving context of:

- learning from patient experiences,
- organisational development,
- regulation and inspection of services,
- statutory guidance,
- local single and multi-agency protocols

and with the delivery of quality healthcare at the heart of everything we do.

2.1 National and Local Drivers

Key national drivers include:

- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2015
- Cheshire West - Supreme Court Ruling 2014
- The Care Act 2014
- The Mental Capacity Act 2005
- Safeguarding Adults – a guide for Health Service Managers and Boards, Commissioners and Practitioners 2011
- The Francis Inquiry 2013 (re Mid-Staffordshire NHS Foundation Trust) which led to the introduction of - Statutory Duty of Candour 2014
- The Lampard Inquiry 2015 (re: Savile)
- The Laming Inquiry 2003 (re: Victoria Climbié)
- The Children Act 1989 and 2004
- The Munro Review 2011 (re: Child-centred Child Protection system)
- Working Together to Safeguard Children 2015
- Promoting the Health and Well-being of Looked After Children 2015
- Safeguarding Children and Young People: roles and competences for health care staff 2014 (intercollegiate document)
- The Jay Report 2014 (re: Child Sexual Exploitation in Rotherham)
- The Goddard Inquiry (2015 onwards)

Local drivers which result from and respond to the national agenda include:

- Strong partnership working at all levels of the organisation
- Executive membership of the LSCB and SAB and representation at sub-groups
- Integration and co-location of services
- LSCB and SAB multi-agency policies, procedures and protocols
- The development of action plans and implementation of learning from:
  - ❖ Domestic Homicide Reviews (DHRs),
  - ❖ Safeguarding Adults Reviews (SARs)
  - ❖ Serious Case Reviews (SCRs),
  - ❖ Learning Lessons Reviews (LLRs)
  - ❖ Sudden Unexpected Death in Childhood (SUDIC) processes
  - ❖ LSCB Case File Audits
  - ❖ Child Death Overview Panel

Alongside these drivers sit various cross-departmental government initiatives and public health campaigns which also impact upon the Safeguarding agenda, such as:

- Prevent (Counter-terrorism Strategy – prevention of radicalisation)
- National Referral Mechanism for Human Trafficking and Modern Day Slavery
- Eradication of Female Genital Mutilation (FGM)
- Dementia Friends campaign

These lists are not exhaustive, but are indicative of the highly complex arena in which front line practitioners, services and our organisation as a whole seeks to ensure the safety and protection of the population of Leeds.

3.0 Vision

The vision and values of LCH feed seamlessly into the Safeguarding agenda. In providing the best possible care to every community in Leeds and abiding by our values we will ensure that, those most vulnerable in our communities will be safeguarded and protected from harm.
LCH believes that safeguarding is everybody's business and essential in exercising our duty of care as health providers. We believe that all service users, their families and carers, have the right to live free from abuse and neglect.

LCH will work in partnership to promote effective communication, shared learning and feedback in order to safeguard vulnerable groups within Leeds. As an accountable organisation we will ensure a confident and competent workforce, who are valued and supported in all aspects of safeguarding work.

3.1 Delivering the vision

This strategy covers a broad range of safeguarding activities and is built around the Care Quality Commissions 'Fundamental Standards' 2015 to give a clear focus and will be achieved through six work streams and associated objectives, which will be delivered through a safeguarding annual work plan.

Over the next three years LCH will focus on six safeguarding work-streams, which are underpinned by the six key principles of; Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability (Department of Health, 2011 Safeguarding Adults: A Guide for Health Service Managers and Boards, Commissioners and Practitioners).

Work-stream One – Making Safeguarding Personal

- All services users will be treated as individuals and their care and protection needs assessed and care plans are outcome focused (year 1 – 3)
- All staff assessing risk for service users over 16 year old will record Mental Capacity and Best Interest decisions (year 1)
- All Deprivation of Liberty Safeguards will be lawful and least restrictive (year 1 – 3)
- Listening to feedback and offer choice, flexibility and control over care (year 1 – 3)

Work-stream Two - Employ fit and proper people and workforce will be confident and competent in all aspects of safeguarding

- Implement and monitor recommendations in intercollegiate document (year 1 Safeguarding Children; year 1 –2 Safeguarding Adults)
- To increase organisational ability to take ownership of safeguarding (year 1 – 3)
- To increase the numbers of staff and managers involved in Safeguarding Supervision (year 1 Safeguarding Children; year 2 – 3 Safeguarding Adults)
- To increase the numbers of managers trained in supporting staff (year 1 Safeguarding Children; year 3 Safeguarding Adults)
- Staff dealing with safeguarding cases access safeguarding/clinical supervision in line with LCH supervision policy (year 1 – 3)
- Learning from incidents, complaints, serious case reviews, domestic homicide reviews and safeguarding adult reviews will used to influence practice and bring about change, improving patient experience whilst promoting quality, honesty and safety throughout the organisation (year 1 – 3)
- All staff will attend safeguarding training as outlined in the intercollegiate document, statutory and mandatory training grid, Prevent strategy and SUDIC training plan with priority targeting of those staff most directly involved in Safeguarding Practice. (year 1 – 3)

Work-stream Three – Improve health outcomes for children looked after and care leavers

- There will be a creative range of services which keep CLA and Care Leavers safe in Leeds (year 1 – 3)
- Assessment and follow-up will be evidence based and outcome focused (year 1 – 3)
- Irrespective of service area care delivery will be consistent (year 1)
- All care leavers will receive a comprehensive assessment and transition plan (year 1 – 2)

Work-stream Four – Regard for duty of candour

- All staff are aware of information sharing agreements and boundaries of confidentiality (year 1)
- All safeguarding concerns will be taken seriously and dealt with using a transparent and consistent approach (year 1 – 3)

Work-stream Five – Recognised as effective and valuable Partners

- Attendance at strategy meetings and safeguarding case conferences will be prioritised (year 1 – 3)
- Work in partnership to improve SUDIC and bereavement pathways (year 1 – 3)
- Contribute to the work of the safeguarding Boards and subgroups (year 1 – 3)
- Establish a single point of contact representing the health economy within the front door arrangements at Westgate (year 1 – 2)
- In partnership with other LSCB contributors implement the multi-agency CSE strategy (year 1 – 3)
- All staff will contribute to the Prevent agenda (year 1 key staff groups; year 2 – 3 all staff)

Work-stream Six – 'Think family, Work family'

- Staff working with Children, young people and adults have a better understanding of Domestic violence and abuse through training, lunch & learn sessions and learning from DHRs, SCR, LLRs, SARs etc. (year 1 – 3)
- Victims of Domestic Violence get support earlier (year 1)
- All information sharing will be through integrated software (year 2 – 3)

Each of the work-streams sets out a number of objectives that have been developed by representatives from across the three business units and operational groups, via a facilitated workshop.

The key objectives for the next three years will be delivered through a series of strategic and operational actions contained in the annual safeguarding work plans; progress against the annual work plan will be monitored by the Safeguarding Committee.

5.0 Monitoring of effectiveness

The safeguarding strategy will be monitored by the Safeguarding Committee, which reports to LCH Quality Committee. The Safeguarding Committee will produce an annual report for LCH board and commissioners.

6.0 Resources

In order to implement the three year strategy key people have been identified to take a lead role for each of the actions. Whilst emphasis is placed on delivering the objectives the implementation of the vision is everybody's business irrespective of their role within the organisation and commitment across all business units – Adults, Children Specialist and Corporate is essential to the delivery of this strategy. The resource implications engendered by the strategy cannot be met by any single service or team – Safeguarding is everybody's business.
The scope and remit of safeguarding is increasing to take on a broader agenda including Prevent, Child Sexual Exploitation, modern day slavery, human trafficking, Domestic Homicide Reviews, Care Leavers and Dementia so there is a need keep resources,

priorities and goal setting under continuous review to be able deliver against these complex and demanding work-streams.

The number of services to which the Safeguarding Team provides training, support, guidance and supervision will increase and become more complex, as LCH successfully tenders for new business; in the light of these changes, the impact on and priorities of the Safeguarding Team must be considered, in order to maintain the capacity of the team to be responsive to service needs.

The Trust continues to support the growth and development of an integrated safeguarding team which ensures the leadership and capacity to manage this agenda.

7.0 Training

Training is delivered through a variety of methods, including e-learning, classroom teaching and bespoke sessions for frontline teams and services and with due regard to intercollegiate guidance on staff competences. Where possible training is undertaken by a combined approach covering adult and children's safeguarding; the content of all courses delivered face-to-face now includes information on Prevent, Domestic Violence and 'Think family, Work family'.

The safeguarding training flowcharts (available via the LCH intranet) are reviewed annually; the flowcharts and training programmes are amended accordingly, to reflect any local, regional or national changes.

A target of 90% compliance is set against adult and children's safeguarding, and MCA. Compliance is monitored and reported on a quarterly basis through business unit's performance meetings. Safeguarding and MCA training compliance is also reported externally to CCGs, LSCB and SAB.

Where staff are non-compliant a process has been established to remind individuals of their contractual obligations. Feedback from practitioners is acted upon and consideration given to removing any barriers to support them to gain compliance.

8.0 Risks & horizon scanning

The safeguarding agenda is constantly changing to reflect national, regional and local developments, learning and statute or case law; this strategy and annual work-plans will need to be flexible to respond to any changes in a timely manner.

Locally, the development of the Safeguarding Hub at Westgate presents a resourcing pressure to the team; we are currently stretching staffing originally intended to support the Duty and Advice function to input to the Domestic Violence and Abuse daily meetings. As the Domestic Violence and Abuse function grows, both as a result of the effectiveness of the daily meetings and the planned reduction in use of MARAC processes, this approach will become unsustainable without additional staffing.

Nationally, the broad scope of the Goddard Inquiry has the potential to skew the safeguarding agenda, first as demands are placed on health service providers to respond to specific allegations of historic abuse within institutions or organisations and subsequently as practice guidance is developed to prevent any repetition of those abuses.

Potential also exists for criminal prosecutions and civil actions through the Courts to arise from the inquiry; these could have significant fiscal impact on any organisation drawn into the legal arena.

The Safeguarding Adults agenda is likely to undergo rapid growth and development within the timeframe of this strategy as the full implications of the Care Act (2014) are embedded along with local and national systems and processes to govern and support practice e.g. imminent publication of *"Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document"*.

9.0 Conclusion

Safeguarding is everybody's business; doing nothing is not an option.

Safeguarding practice develops through proper use of reflection, supervision, incident reporting, serious incident investigation and sadly, through close scrutiny of practice in relation to incidents where serious injury or death has occurred.

We are committed and open to any opportunity for learning and to listening carefully to service users, to ensure safeguarding is personal.

This strategy sets out the key safeguarding priorities and areas of development within Leeds Community Healthcare over the next three years, while acknowledging the crucial importance of inter-agency collaboration and close co-operation with our service users, commissioners and inspectorates to ensure we safeguard the population of Leeds through the delivery of high quality, effective healthcare.

Appendix 1

DEFINITIONS

Abuse

Abuse is a form of maltreatment. Anyone may abuse or neglect a child, young person or adult at risk by inflicting harm or failing to act to prevent harm. (Working together 2015). Abuse is the violation of an individual's human or civil rights by any other person/s and involves the misuse of power by one person over another. (Safeguarding Adults). ADASS, 2005)

Abuse can be unintentional or deliberate and can result from either actions or inactions.

Abuse can take many different forms and is often considered under the following headings:

Physical	Sexual	Emotional
Financial	Organisational	Modern slavery
Domestic violence	Neglect	Self-neglect
Discriminatory		

Adult at Risk

Where a local authority has reasonable cause to suspect that an adult (aged 18 years or more) in its area (whether or not ordinarily resident there)

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

The local authority must make (or cause to be made) enquiries to enable it to decide whether any action should be taken and, if so, what and by whom.
The decision to carry out a safeguarding enquiry **does not** depend on the person's eligibility for services.

Concerns

This refers to any suspicion, allegation, or other concern relating to the safety or wellbeing of an adult who may be experiencing or at risk of abuse. Individuals do not need 'proof' in order to raise concerns under the safeguarding adults' procedures.

Mental Capacity

Mental capacity is the ability to understand, retain and weigh up information in order to make a decision and to communicate the choice they have made. When an adults' ability to make a particular decision is reduced, they can be at increased risk of abuse, including neglect.

Mental Capacity Act

The Mental Capacity Act (MCA) 2005 provides a statutory framework to empower and protect people who may require help to make decision or may be unable to make decisions for themselves.

The Mental Capacity Act is accompanied by a 'Code of Practice' which provides practical guidance and everyone who works with people who may lack capacity has a duty to work within and have 'due regard' to the Code.

Safeguarding Children and Young People

Working Together 2015 definition:

- Protection of children from maltreatment
- Preventing impairment of children's health or development
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care and
- Taking action to enable all children to have the best life chances.

Safeguarding work can include;
Prevention – actions which identify and reduce the risk of abuse, and
Protection – actions to protect someone who is experiencing abuse

Appendix 2

Equality Analysis (EA) – Relevance Screening Form

<table>
<tr><td>1. Name of the document</td><td colspan="4">Safeguarding Strategy
2015-2018</td></tr>
<tr><td>2. What are the main aims and objectives of the document</td><td colspan="4">This strategy sets the direction of travel, and identifies a range of objectives for staff working for LCH around the safeguarding agenda. The objectives are based on The CQC fundamental standards

It also aims to support the delivery of LCH Strategic Objectives which are:
• To provide high quality, safe services, continuously improving the patient experience and measuring our success in outcomes;
• To work in partnership with service users, communities and to deliver service solutions, particularly around integrated care and care closer to home principles;
• To engage and empower our workforce; ensuring we recruit, retain and develop the best staff;
• To become a viable and sustainable organization, with the ability to invest in the community, and with a relentless focus on value for money.
There is an accompanying work plan prioritizing actions from the strategy.</td></tr>
<tr><td rowspan="2">3. Is this a key strategic document?</td><td colspan="2">Yes</td><td colspan="2">No</td></tr>
<tr><td colspan="2"></td><td colspan="2">X</td></tr>
<tr><td rowspan="2">4. What impact will this document have on the public or staff?</td><td>High</td><td>Medium</td><td>Low</td><td>Don’t know</td></tr>
<tr><td></td><td></td><td>X</td><td></td></tr>
</table>

Explain:
Preventing and responding to abuse is essential to achieving optimum standards of health, safety and wellbeing and is integral to all care delivery.

The protection from abuse and neglect is fundamental to care provision and integral to service delivery. LCH recognises the economic challenges facing health care providers and the need to deliver high quality person-centred care with the need to focus on innovation, productivity and prevention. All this cannot be achieved single handed and safeguarding is most effective when delivered through effective multiagency working and public engagement.

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM
2015-16
(105)

Report to: Trust Board

Date of meeting: 5 February 2016

Report title:
Working with people – organisational development strategy update

Responsible Director:
Director of Workforce

Report author:
Head of Organisational Development

Previously considered by:
Senior Management Team

EXECUTIVE SUMMARY

The Board last received a formal update on the Working with People strategy in July 2015. In January 2016 the Board held a workshop for consideration of the issues with well-led non-CQC domain. This informal time together enabled updates on progress on various strands and identifying of key areas for further action.

As previously agreed the Trust has used the overarching Working with People framework to capture the staff engagement response to the staff survey and staff morale.

This report concentrates on the key points and illustrates there have been two main underpinning actions that create strong foundations for the further implementation of the Trust's plans. These are: the behaviour framework development, which has been welcomed and is starting to embed and recruitment and retention initiatives, leading to both an actual and perceived increase in capacity, which is starting to lead to improvement in other metrics such as appraisal and staff engagement.

Progress has been made on several fronts, with the next priorities for work described with timescales in to 2016/17.

RECOMMENDATIONS

The Board is recommended to:

- Receive the updated information
- Anticipate a report on the latest staff survey outcomes in March 16

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community & with a relentless focus on value for money
Links to principal risks:	▪ 3.1 a motivated and engaged workforce ▪ 3.2 effective joint working with Staffside colleagues ▪ 3.3 to secure workforce supply through workforce planning ▪ 3.8 workforce capacity to cope with change
NHS Constitution:	This report supports all of the principles in the Constitution by ensuring the Trust remains a viable and sustainable organisation by transforming its services.
CQC Outcomes:	This report is relevant to all CQC Essential Standards. Through appraisal the Trust can ensure quality is maintained and all quality standards achieved.
Equality and diversity:	Equality Analysis has been completed and will influence our specific initiatives within the OD plan.
Sustainability Implications:	N/A
Publication Under Freedom of Information Act:	This paper is available Freedom of Information Act

1.0 PURPOSE OF THIS REPORT

The purpose of this paper is to provide an update on implementation of our organisational development strategies, now titled 'Working with People', and to share progress on the various action plans on staff engagement, which have been pursued within the Trust.

2.0 BACKGROUND

There have been two main underpinning actions that have been required to create a strong foundation to enable good progress:

2.1 Development of a behavioural framework

The Magnificent 7 behavioural framework under the title 'How we Work' has been launched in October 2015, and has become the way that we reference our action plans to deliver the overall OD strategy. It has been welcomed by staff, is underpinning many of our leadership activities now and will form a core part of the new appraisal system. It forms the heart of our new leadership approach.

2.2 Action to improve patient care and staff capacity through recruitment and retention

The concerning capacity risks and challenge to care through not having sufficient staff, has been met by a concerted recruitment and retention response. The incrementally positive outcome on recruitment has been reported regularly through to Business Committee and the Board, with rising numbers of new recruits to posts, and some very recent levelling off in staff turnover. The Trust is not complacent however about these achievements in a volatile situation of workforce supply.

3.0 CURRENT POSITION

3.1 The People Engagement Plan

As set out in July 2015 there are a number of strands of work which inform and have figured in our people engagement approach.

Updates on these strands in summary are as follows:

- The staff survey results: the response rate for 2015-16 has risen to 51% compared to 34% in 2014-15. The actual content has yet to be reported, and will be presented to the Board in March 2016.

- Friends and Family staff test: the results and comments have continued to be shared and used by managers within business units and directorates, and discussed at SMT.

- Road shows / listening events: a series of road shows to launch the ‘Magnificent 7’ and involve staff have been run with 1 in 10 staff attending led by the CEO and Senior team with the Chair attending all events.

- Significant engagement activities have been undertaken with new starters within the Trust, including the preceptorship programme for newly qualified nursing students, and welcome events for other new starters. The CEO speaks and leads at all induction events.

- The Medical engagement survey outcome of managers, doctors and dentists has been acted upon in particular ‘hotspots’ and work continues to look at the development of doctors and dentists and close partnership working with managers.

- Key performance indicators including staff sickness and absence, appraisal rates and engagement with Statutory and Mandatory training have remained under review, and show early signs of improving as workforce capacity increases.

- Ad hoc work has been undertaken as required, such as in response to whistleblowing or consultation on staff shift patterns and where there have been lessons to learn and consider across the Trust these have been shared and spread.

- Work in response to consider the issues raised by examination of the workforce race equality standards (WRES). A network of BME staff of grade 6 and above is meeting in March.

3.2 Staff Survey

Whilst the response rate for the 2015-16 staff survey is known to us as mentioned above, the detail of content is not yet known.

The themes we have been working on since the last survey are:

- Looking to improve consistency of management and communication – Team Brief group of 65 senior leaders meeting regularly (now to be called Leaders Network) weekly blog from the CEO which is widely read, regular engagement of senior staff service visits and attendance at team meetings, developing clinical forums, piloted Pulse surveys and follow-up in Specialist Business unit and feedback leading to supported action. Communication is everybody’s business and the culture of listen and involve the front line staff in everything we do is becoming embedded.

- Looking to reduce change fatigue – helped by service review outcomes bedding in, and considering impact of the span of control in teams on staff support. During the year we ensured that the extra stretch targets that needed to be achieved were not passed to the front line staff who remained protected from further change.

- Looking to involve staff in decision making so that actions follow listening activities – sustaining staff side relations, how to launch Magnificent 7, invitation to a network for BME staff, broad membership and activity by 50 Voices, and context of involvement actions within business units

- Workload and pressure points considered and tools of support are provided – workload management project and roll-out of EPR. Issues of span of control being monitored

- To seek to develop a greater sense of positive sign-up to the future strategy of the Trust, rather than cynicism – renewed commitment to core vision and values and consistent and frequent conversation about the future for community services in BLOG and roadshows with the revised strategy and business plan formulated in this context .

- To enhance celebration and enjoyment so that staffs' work is recognised and success is celebrated – annual awards and positive features on Elsie and in Community Talk. Specialist business unit celebration event, other business unit staff engagement forums

3.3 Establishment of 50 Voices and results to date:

The initial 50 Voices group has met three times since August 15. The membership of the 50 Voices is now ready change to a further group, and the achievements of this group have been set out as follows:

- 'How we Work' and behaviours commentary and launch

- Issues on retention of staff

- Bringing frontline voices directly to the senior team

- A sense of engagement which means that the current group are reluctant to pass on to a successor group

3.4 Recruitment and Retention

Recruitment and retention challenges have continued throughout this year with a relatively high number of vacancies being carried, which have been covered either by agency staff or additional workload for our in-house teams.

A recruitment project in response, and new focus with different approaches, has resulted in 594 new starters (since January 15), and the recruitment time for nursing staff has been reduced by 22%, by speeding up processes including the Disclosure and Barring service and other processes.

The initiatives on recruitment have led to more applicants for a post overall, more views on social media websites and a deliberate effort to use staff who have recently started to promote the benefits and opportunities, particularly with other students. The CLASS team have created an innovative partnership to use Health and Social Care students from Leeds Beckett University, and Bank support workers. Data regarding recruitment progress over the year has been regularly shared at Business Committee, and was shared at the Board workshop on the 8th January.

Priorities for retention work are listed under next steps.

3.5 Clinical and Professional Leadership

Progress has also been made with clinical and professional leadership. The Trust has sustained engagement with Medical and Dental staff through the engagement survey and follow up activity, and we are now engaging nursing and therapy staff in ideas for their professional development, through the process of consultation on an AHP and Nursing strategy for professional development. We are particularly working at the end of this year and beginning of 16/17 about ways of making clinical careers rewarding in the Trust as opportunities for roles at more senior levels lessen. There has been enthusiastic uptake of this work.

The Manager and Leadership Development Programme have been delivered since April 2015 and has contributed a range of topics. Service Improvement, innovation and development resources have been used in bespoke support to business units such as supporting complex change and integration in neighbourhoods, and working with leadership teams who have identified needs. Work is focussed on areas of greatest need and concern.

Significant preparation and workshops for staff affected by the new registered nurse revalidation process have also been delivered form August 15.

3.6 Health coaching

Health coaching is an evidence-based approach to develop skill sets in staff which encourages/activates the patient towards agreed goals. This philosophy and approach has been well embraced in order to improve patient outcomes. 7 People have been trained as in-house trainers with 80 – 100 people trained as health coaches to use this in their day-to-day work. The Trust continues to be committed to health coaching and will sustain the investment of time needed to equip our staff.

The Trust also has a coaching strategy which involves coaching as a management support, either offered to individuals (based on 5 sessions with in-house coaches trained to ILM 5 standard), or as team coaching whereby team leaders are encouraged to work in a coaching way with their own team. This has been well spread across clinical and corporate departments.

3.7 Learning and Development - continuous approach

The Trust's Learning and Development Group has developed and expanded its membership, such that libraries, service improvement, organisational development, those responsible for Statutory and Mandatory training, those responsible for clinical and professional development and the development to support Bands 1 – 4, are now working in synergy. A mapping exercise has been undertaken to identify the various actions that the Trust has in place against different elements of the "employee life cycle". The Learning and Development Group is now accountable through the Clinical Effectives Group to the Quality Committee.

Work has also commenced in December 15 on devising an AHP and nursing professional development strategy, which is due to be finalised in March 16.

3.8 Board member input

As well as the regular input from the Chair and NEDs as Committee members, the Board workshop on the 8th January 2016 also spent time considering the key topics of:

- What is a catalyst for making cultural change faster? This brought in challenge and ideas on learning from other organisations which will now be explored further.

- What are the issues about span of control and leadership accountability? This is linked to the shared understanding of core line management expectations.

- How do we spread investment in leadership rather than management? This is a key priority area for 2016/17.

- How do we attract and retain staff including those nearing retirement age, from generation X and Y, and 'Millennials' or BME communities? Again a focus for 16/17.

4.0 NEXT STEPS

The following priorities have been identified for our next steps:

4.1 Our retention strategy and retention plan activities have been categorised into:

- Leadership behaviours (linked to How we work but also identifying talent and creating project opportunities)

- Employment terms / benefits (including attracting or retaining those in different generational groups

- Learning and development offers (based on consultation work described above)

This is monitored by the Recruitment steering group which reports to SMT and then to the Business Committee.

4.2 We have set an objective of improving the Staff Friends and Family results on the Trust as a place for treatment and a place to work, and to reduce staff absence and turnover. These metrics are routinely reported through Business Committee.

4.3 Our staff communication and engagement approach is being enhanced by developing a revised internal communications strategy (ready by June 16) and further iteration of the 50 voices group (to include and consideration of whether this methodology could effectively be expanded as say 30 voices per Business unit). This will be discussed at the next meeting of this group in March 16.

4.4 Progress against the July 2015 staff survey action plan will be brought forward in March 16 after an SMT review. The target set is for more survey results to benchmark in a positive position, compared to the previous year. There will be issues emerging from the 2016/17 survey results which require a refocus for action. This may also helpfully be guided by the new BME invited network with regard to any issues of race equality.

4.5 Appraisal completion at 95% has been one of our key metrics where we have been seeking better performance. Improvement is gradually and sustainably being achieved, and from April 16 the design of the system will reflect the How we Work behavioural framework .This will lead to roll out of a mandatory training for all managers, to familiarise them with the core behaviours and revised appraisal arrangements starting in April 16, as part of the manager and lead development programme. Delivery will last for as long as is required to cover all managers (which may be at least 6 months.)

5.0 RECOMMENDATIONS

5.1 The Board is recommended to:

- Receive the updated information and the focus of the work for 16/17
- Anticipate a report on the latest staff survey outcomes in March 16 which may further change the priorities for next financial year.

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015-16 (106)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Board effectiveness review
Responsible Director: Chief Executive **Report author:** Company Secretary
Previously considered by:

EXECUTIVE SUMMARY

At all levels in the NHS, boards are encouraged to periodically review their own performance in order to build on strengths and to identify areas where there is room for further development in order to draw out the full benefits of the NHS unitary Board model.

The purpose of this report is to provide a summary of the outcomes from a recent exercise to review the effectiveness of the non-executive and executive contribution to the Board and the wider Trust.

The paper provides information gathered from a Board effectiveness diagnostic exercise and the results from recent Board effectiveness workshops. The outcomes of the review have focused on four themes as areas in which the Board should aspire to optimum effectiveness, the four themes being:

- Demonstrating values and behaviours in the conduct of business (internal and external)
- Strong and effective relationships between committees and Board
- Effective leadership, decision-making and full accountability for delivery
- Balancing strategic and operational matters; maintaining a strategic perspective amidst operational delivery

The papers also sets out a number of conclusions aimed at enhancing Board effectiveness.

RECOMMENDATIONS

The Board is recommended to:

- Note the outcomes of the Board effectiveness review and the associated actions

Links to strategic objectives:	This report supports the Trust's strategic objective: To become a viable and sustainable organisation with the ability to invest in the community and with a relentless focus on value for money
Links to principal risks:	Risk to achieving the strategic objectives: Failure to provide high quality services resulting from failure to maintain compliance with regulatory standards. Failure to maintain a viable and sustainable organisation arising from failure to meet its statutory and regulatory duties.
NHS Constitution	This report supports all of the principles, values, rights and pledges detailed within the NHS Constitution.
CQC Outcomes:	This report supports the Trust to meet its obligations across all of the CQC's domains
Equality and diversity:	An equality analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act.

Leeds Community Healthcare NHS Trust
Reviewing Board effectiveness

1.0 Purpose of the report

1.1 The purpose of this report is to provide a summary of the outcomes from a recent exercise to review the effectiveness of the non-executive and executive contribution to the Board and the wider Trust.

1.2 The sections below provide anonymised information gathered from a Board effectiveness diagnostic exercise, the results from recent Board effectiveness workshops and a number of conclusions aimed at enhancing Board effectiveness.

2.0 Background

2.1 By way of context, the purpose of NHS Boards is to govern effectively and in doing so to build patient, public and stakeholder confidence that health and health care is in safe hands *(The Healthy NHS Board 2013).* In meeting this purpose the Board has three key roles, to:

- Formulate strategy
- Ensure accountability by holding the organisation to account for the delivery of strategy and through seeking assurance that systems of controls are robust and reliable
- Shape a strong culture for the Board and the organisation

2.2 Towards the end of 2015, the Chair determined that there would be value in reflecting on the effectiveness of the non-executive and executive contribution to the Board and the wider Trust and to consider how Board colleagues could further develop as a team to:

- Ensure strong and effective leadership at Board level
- Develop a culture of full and proper personal accountability
- Maintain a strategic perspective
- Ensure the Trust identifies the necessary operational changes to meet the financial challenge
- Ensure improved and sustainable quality
- Balance risk and opportunity
- Work in a partnership environment

2.3 In order to determine the level of effectiveness and to identify means by which the Trust could build on strengths and develop areas where there was room for improvement, the Chair concluded a three-staged approach which is explored in detail in the sections which follow:

- Gathering of views from Board members by way of a questionnaire (section three)
- A series of focussed workshops (section four)
- Identification of actions to enhance effectiveness (section five)

3.0 Questionnaire: themed summary of responses from Board members

3.1 A questionnaire was developed to elicit views. Responses in the questionnaires remained anonymous and were only used to distil themes to facilitate discussion. The questionnaire comprised 20 statements grouped under the headings of *leadership and accountability* and *strategy development and operational delivery* and asked for ratings on a scale of 1 (strongly disagree) to 5 (strongly agree); plus narrative comment on opportunities for change.

3.2 In terms of the range of responses to the questionnaire statements, it was noticeable that non-executive Board members expressed a greater range of views ie a number statements attracted a range of scores from disagree (2) to strongly agree (5). There was greater consistency amongst the executive directors ie most respondees provided scores very similar to their executive colleagues for any one question, indicating a clear common understanding as to the strengths and weaknesses of the Board.

3.3 The remainder of section three describes some high level summary statements drawn from the questionnaire responses; both quantitative scoring and narrative responses.

3.4 Strong and effective leadership at Board and amongst committees

3.4.1 All respondents scored this area positively.

3.4.2 All Board members recognised that there was a good level of appropriate skills and expertise around the Board table. However, there was some reflection on whether the alignment of skills and expertise was appropriately matched to the priorities of the Trust and executive members felt that the expertise of non-executives was not always capitalised on to the best effect.

3.4.3 Committee leadership was determined to have developed well although the Quality Committee was seen as warranting further development.

3.4.4 Respondents felt there was generally good, transparent, open and engaging debate and that this was a strong feature of the Board. There were some observations related to whether discussion was sufficiently focussed on the most strategic as opposed to operational issues and whether conclusions from debate translated in actions.

3.4.5 Wider participation in Board meetings was seen as a desirable feature if the potential benefits of contributions from the whole Board membership were to be realised. Individual Board members commenting outside of their own area of expertise was seen as positive and would be evidence of a ‘unitary board’ in practice.

3.5 Effective decision-making and accountability for delivery

3.5.1 Respondents commented on the robustness of information to inform decision-making. There was acknowledgement of some improvement in this area; but Board members (particularly non-executive colleagues) also indicated that there was often too much data, without enough focussed analysis. Recent moves to make greater use of benchmarking and forecasting were welcomed.

3.5.2 Clarity as to the outcomes from discussions, the identification of actions and the indication of the accountable lead director was seen as an area for continuing development. Both non-executive and executives sought constructive approaches to 'holding the executive to account' for delivery whilst recognising the unitary nature of the Board.

3.6 Values and behaviours

3.6.1 Statements relating to the demonstration of the Trust's values and behaviours were scored consistently highly by respondents. There was also a strong belief, expressed by executives, that the Board actively 'championed' the work of the Trust both externally and internally. The non-executive cohort felt that there was more that they could do in this area which was welcomed.

3.7 Focus on quality and safety

3.7.1 In relation to quality and safety aspects and meeting the needs of patients and communities, all respondents felt this was good and an improving area. Respondents felt that there were good discussions based on quality but with a tendency to focus on achieving a quality target rather than the experience of quality.

3.8 Strategy development and alignment

3.8.1 All Board members indicated that the Trust had further work to do in the context of a rapidly changing external environment - both nationally and locally - in reviewing the Trust's overall strategy. Most respondents felt that the vision and strategy would benefit from greater clarity and sharper articulation in these challenging times to enable wider communication and understanding both within the organisation and across the wider health and social care economy.

3.8.2 There was some consideration given by Board members about the alignment of strategies and whether enabling strategies were aligned well enough to service strategy and whether the capacity and capability to deliver strategic aspirations was in place within the challenging financial constraints.

3.8.3 Board members indicated, however that individuals brought appropriate expertise, perspective and challenge to strategy development; the wide range of skills and expertise brought to the Trust by non-executives was seen as an asset. The introduction of workshops as an opportunity for greater engagement in strategy development was welcomed.

3.9 Operational delivery

3.9.1 The block of statements related to the balance between strategic development and operational delivery were viewed the least positively.

3.9.2 Risk-based performance management discussions were seen as having a greater focus on operational risks (solution-based) rather than strategic risks and there was less opportunity to use information to influence future planning which was at the detriment of discussion about opportunity, innovation, growth etc

3.9.3 Respondents felt that they were generally aware that operational plans linked to the Trust's overall strategy, but greater rigour and more realistic, clear plans and outcomes should be the aim. The implementation of the organisational development (people) strategy was cited as a critical component of assuring that the challenges of operational delivery could be met.

3.9.4 The meeting of in-year quality and financial challenges was generally, seen as a strength; quality and financial challenges were known and addressed. Some respondents identified the need to maintain a focus on evidence-based assurances matched to operational delivery.

3.10 Balance between strategic and operational matters at Board

3.10.1 The need to strike the right balance between consideration of strategic direction and day to day operational management at Board meetings and amongst Board members attracted the lowest overall score.

3.10.2 All respondents felt there was too little time spent on strategic issues with Board meetings and discussions focussing on operational or tactical detail without enough 'forward focus'. The move to fewer Board meetings mixed with workshops was welcomed and Committees were seen as a balancing mechanism to Board discussions. There had been a bigger focus on strategy over the previous three workshops which too had been welcomed.

4.0 Board effectiveness workshops

4.1 Three Board effectiveness workshops have been held amongst Board members. The first two workshops (November and December 2015) allowed for non-executive only and executive only consideration to take place. The third workshop was held on Friday 15 January 2016 and enabled all Board members to come together and to:

- Review results form Board effectiveness questionnaire exercise
- Reflect on the views expressed in the questionnaire results
- Reflect on the implications for the Board and the organisation
- Consider the Board's strengths and how these should be built upon
- Consider areas for development and associated actions

4.2 In order to facilitate discussion during the workshop, four themes had been identified that were seen as areas in which the Board should aspire to optimum effectiveness, the four themes being:

- Demonstrating values and behaviours in the conduct of business (internal and external)
- Strong and effective relationships between committees and Board
- Effective leadership, decision-making and full accountability for delivery
- Balancing strategic and operational matters; maintaining a strategic perspective amidst operational delivery

4.3 The summative feedback from the theme-based discussions is detailed in the remainder of section four.

4.4 Values and behaviours

4.4.1 Workshop participants reinforced the perception that the Board upheld and demonstrated the values and behaviours of the Trust and that opportunities should be sought to identify and promote good examples of values-driven behaviour.

4.4.2 Board members concluded that championing the work of the Trust was more effective internally than externally. There was support for a more assertive external communications approach to build confidence and reputation and a greater outward-facing profile for the Trust in the local community.

4.5 Relationships between committees and the Board

4.5.1 Workshop participants reported that this was an evolving position and whilst all Board members were aware of the main issues a common understanding of the role and functions of committees and Boards to achieve best effective was still required.

4.5.2 One group in particular focused on the level and nature of assurance gained by Board members from committee and Board discussions and whether members were clear which types of evidence provided the necessary assurance.

4.5.3 On a more practical note, some Board members reported that they felt that that the same debate was often held at more than one committee and at Board too.

4.5.4 It was felt that where a function was delegated to a committee to discharge on behalf of the Board, members who were not represented on that committee needed to have confidence in that committee to deal with the delegated matter.

4.5.5 The Chair proposed that committees should ensure succinct, factual reports with clear identification of key messages and points for consideration or escalation coupled with a statement about the level of assurance generated by the items discussed. He also proposed that, at Board meetings, he would contain discussion on committee assurance reports to those matters raised by colleagues who were not in attendance at the committee concerned.

4.5.6 In this way, the committees will fulfil a role distinct from that of the Board. The Board will, in turn, meet its obligation to hold the organisation to account for the delivery of strategy by examining the Trust's performance in terms of considering the strategic implications (risks and opportunities) to quality, safety, sustainability and regulatory requirements (eg CQC). More in depth scrutiny being reserved for areas where assurance is poor.

4.6 Leadership and accountability

4.6.1 Discussions on this topic exposed the matter of how an effective challenge function can be carried out by non-executives in the context of a unitary board. There was debate about the respective roles of non-executives and executives and further consideration of the key seven behaviours in the Trust's 'how we work' framework.

4.6.2 There was discussion about the 'team' function of the Board and how the Trust should ensure that the collective capacity and capabilities are utilised to the full ie 'the whole being greater than the sum of the parts'

4.6.3 In determining priorities, the matter of focussing on core, non-negotiable issues was recognised and the need to respond to the demand of regulators and the external environment. Board members saw the tension between ambition to drive strategic change and the need to secure operational delivery but concluded that they needed to continue to actively consider this balance.

4.7 Strategic development and operational delivery

4.7.1 All Board members recognised that the balance between strategic considerations and the focus on operational delivery amongst Board members and at Board meetings needed to be addressed; with the Board insufficiently focused on strategy.

4.7.2 There was unanimous support for refreshing the Trust's vision and service strategy. The Chief Executive indicated that, whilst the Trust needed to be secure in terms of its own strategic direction (from both a transformational and sustainability perspective), this needed to be in the context of the health and social economy's requirement to produce a five year place-based sustainable transformation plan by June 2016.

4.7.3 The Chair proposed that the Senior Management Team should determine the approach to be taken.

4.7.4 A number of more practical suggestions emerged from the workshop including: re-ordering of Board business; periodic longer (30 minutes) discussions on strategic topics (eg business strategy); ensuring Board papers indicate the unique (strategic) consideration required of the Board; covering papers to demonstrate impact on strategic objectives and regulatory requirements (eg CQC).

5.0 Workshop outcomes: areas for development

5.1 This section takes the conclusions from the questionnaire responses and workshop deliberations and identifies a number of actions.

Action	By whom	By when
Identify and promote examples of values-driven behaviours in practice	All	Ongoing
Establish informal and flexible relationships with NEDs both for ongoing matters and items of significance	EDs	Ongoing
Develop a team development workshop for Board members after appointment of two new non-executive directors	SE	TBA
Develop a more assertive, outward-facing communications and stakeholders engagement approach	TS	June 2016
Map committee and Board functions and revise terms of reference as appropriate (following review of standing orders)	VM	April 2016
Revise committee and Board covering paper to require paper authors to identify: main points for consideration; impact (risks and opportunities) on strategic objectives; impact on any regulatory requirements (eg CQC); indicative level of assurance	VM	April 2016
Sharpen up committee assurance reports to include evidence-based assurance statements	Committee chairs	Ongoing
Contain discussion at Board to strategic considerations; restrict repetition of committee business unless assurance is poor	Chair	Ongoing
Identify core, non-negotiable objectives and tasks for the Trust for inclusion in operational plan and as basis	TS	April 2016
Determine approach to vision and service strategy revision: timescale; engagement; external facilitation	TS	April 2016
Revise vision and service strategy in context of Leeds STP	EF	June 2016
Validate alignment of enabling strategies (workforce, estates, IM&T, quality, stakeholder engagement) with revised service strategy	EF	August 2016
Close the gap between data and analysis through clarity of data and reporting requirements arising from non-negotiables and strategic objectives	BM	October 2016

6.0 Recommendations

6.1 Board members are asked to:

- Note the outcomes of the Board effectiveness review and the associated actions

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015-16 (107)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Board Assurance Framework
Responsible Director: Chief Executive **Report author:** Company Secretary
Previously considered by: Senior Management Team

EXECUTIVE SUMMARY

This report presents a risk-assessed, high level summary of the full Board Assurance Framework (BAF) and indicates the significant risks that impact on the potential achievement of the Trust's strategic objectives.

The Board last received the BAF in full in August 2015. The attached summary version (dated 25 January 2016) provides an update of strategic risks, risk scores and review dates following review by members of the Senior Management Team (SMT).

The process for future updating of the BAF will include a review of risks by the committees to which the risk is assigned, the output of which will be periodic recommendations to the Board on changes to risk scores and levels of adequacy of controls and assurances.

In addition, as this report demonstrates, there will be a periodic, deeper review of assurances to support a number of risks recorded in the BAF. This paper focuses on the risks to the Trust's strategic objective relating to engaging and empowering the workforce and ensuring the trust recruits, retains and develops the best staff

RECOMMENDATIONS

The Board is asked to:

- Note the current BAF
- Note the in depth review of risks arising from the Trust's strategic objective related to engaging and empowering the workforce and ensuring the trust recruits, retains and develops the best staff and consider further ways in which the Board wish to gain assurance on workforce topics
- Note proposed BAF enhancements

Links to strategic objectives:	This report supports all of the Trust's strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home principles • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community and with a relentless focus on value for money
Links to principal risks:	The BAF summarises all of the risks to the Trust's strategic objectives.
NHS Constitution:	There are no decisions in this report that require regard to the NHS Constitution.
CQC Outcomes:	None.
Equality and diversity:	An equality analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	None.
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act.

1.0 Purpose of the report

1.1 This report presents a risk-assessed, high level summary of the full Board Assurance Framework (BAF) (see appendix 1) and indicates the significant risks that impact on the potential achievement of the Trust's strategic objectives.

1.2 In addition, this paper takes a deeper review of the principal risks arising from one of the Trust's strategic objectives, namely:

- Strategic objective 3: To engage and empower our workforce, ensuring we recruit, retain and develop the best staff

2.0 Background

2.1 The 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 objectives as set out in the Trust's five year integrated business plan, its annual plan and the strategic priorities of business units
- Principal risks that might prevent the Trust from meeting its strategic objectives; their causes and effects
- Controls and assurance mechanisms in place to manage risk and so support the delivery of objectives
- Actions to remedy gaps in controls or assurances

2.2 The Trust's four strategic objectives are reflected in the current, full version of the BAF and as such drive the definition of risks, risk causes and impacts, controls and assurances.

2.3 The BAF identifies the principal risks which could prevent the Trust achieving its strategic objectives. Because of the nature of these significant risks, the risks will not change materially over the course of one year; key controls and assurances are more liable to change.

2.4 The articulation of strategic risks in the BAF continues to help drive the business of the Board and the Board's committees to which the principal risks are assigned.

3.0 Current position

3.1 The Senior Management Team (SMT) has undertaken a role in reviewing the BAF including:

- Confirming those risks which remain valid
- Confirming all current and target risk scores
- Assigning all risks to relevant committees
- Reviewing controls and assurances
- Amending and updating actions to address gaps in controls and assurances and dates for review

3.2 All risks reported previously remain valid and are retained on the BAF.

3.3 Following previous discussions at the Board and amongst Senior Management Team members, it has been concluded to undertake a more in depth review of a portion of the BAF at each Board meeting to facilitate a more extensive understanding of risks to the Trust's strategic objectives.

3.4 On this occasion, this paper probes more deeply into the three principal risks linked to the Trust's workforce objectives.

4.0 In depth review: Lack of internal workforce capacity and engagement to secure quality and drive transformational change

4.1 Set out below is a summary of the assurances related to two areas of risk recorded in the BAF; the assurances that evidence active management of the risk are set out in section 4.2

Strategic objective	*To engage and empower our workforce, ensuring we recruit, retain and develop the best staff*
Principal risk	*Failure to engage and empower workforce*
Cause	*Lack of internal capacity to secure quality and drive transformational change*
Impact	*Low staff morale; reduction in quality; service change and improvement plans not delivered*
Risk score	*Initial: consequence major (4) likelihood likely (4) =* ***extreme (16)***
	Current: consequence major (4) likelihood possible (3) = ***high (12)***
	Target: consequence major (4) likelihood unlikely (2) = ***high (8)***
Cause	*Lack of staff involvement and engagement in the organisation*
Impact	*Failure to achieve strategic objectives; low staff morale*
Risk score	*Initial: consequence moderate (3) likelihood likely (4) =* ***high(12)***
	Current: consequence moderate (3) likelihood likely (4) = ***high (12)***
	Target: consequence moderate (3) likelihood unlikely (2) = ***moderate (6)***
Responsible director	*Director of Workforce*

4.2 Assurances

4.2.1 External and regulatory

- Full participation in Leeds Transformation Board and Leeds Health and Wellbeing Board to consider the Leeds workforce in totality and joint approaches to recruitment and retention
- Individual officers maintain regular and effective links with opposite numbers in partner organisations whether at an operational or strategic level in relation to the workforce implications of transformational change including leadership of the city-wide workforce workstream
- Full participation in city-wide workforce planning and organisational development activity
- Wide engagement with academic providers about current and future workforce needs and education programmes
- Direct engagement with cohorts of students

- Engagement with Yorkshire and Humber, Health Education England in reviewing educational placements and future investments
- Engagement in Leeds-wide Clinical Senate activity and care pathway re-design work
- Scrutiny by CQC as part of inspection processes; CQC's well-led domain focuses on workforce factors for which the Trust was assessed as 'good' as part of the CQC's inspection of the Trust in 2015
- NHS Trust Development Authority (TDA) feedback and involvement for example in recruitment to senior posts (eg Head of Communications)

4.2.2 Audit

- During 2014/15, the internal auditors (Baker Tilly) undertook a number of audits on topics including: statutory and mandatory training and use of administrative bank and agency staff
- The 2015/16 internal audits (to be conducted by TIAA Ltd), include an audit of recruitment processes, sickness absence management, the use of bank and agency staff (non-administrative), middle management training and communications

4.2.3 Board assurances

- Board approved an organisational development strategy in June 2014
- Board receives six monthly updates on progress with implementation of organisational development strategy
- Board workshop in January 2016 focussed on the Trust's long term strategy in relation to people management and in particular examples of benefits that have resulted from recent initiatives
- Endorsement, at Board level, of new behavioural framework 'how we work' setting out seven preferred behaviours to be modelled within the Trust and used to recruit, develop and appraise staff
- Board receives monthly integrated performance reports showing workforce metrics which could be adversely affected by service change
- Board receives, through the Chief Executive's report, regular updates on recruitment and retention issues
- Board receives reports within the integrated performance report at each meeting on 'safer staffing' levels and achievement against targets, in addition, an in depth 'safer staffing' report is received by the Board twice each year; safer staffing detail is posted on the Trust's external website
- Board receives updates on the Trust's deployment, performance and management of bank and agency staff and costs; a full report on new agency control standards was received in December 2015
- Board has received an update on implementation of a suite of equality and diversity goals including data showing the representation of certain groups within the workforce (December 2015)
- Staff survey for 2015 attracted a 51% response rate; Board receives staff survey results in March each year with an action plan reported in July; active use made of data arising from benchmarking survey staff results with those of other trusts
- Chief Executive's report contains periodic reports on staff engagement actions including listening events, roadshows and discussions with '50 Voices' group

- Board receives a report on progress across a range of transformational projects from the Programme Management Board on two occasions each year
- Trust's corporate risk register has included risks associated with recruitment and retention and the implications for achieving transformational change; subject to full discussion at Board

4.2.4 Committee assurances

- As part of its annual cycle of business, the Business Committee undertook a substantial, in depth review of workforce issues, including staff engagement, in July 2015
- Business Committee receives reports at each meeting on metrics that could indicate, poor performance and diminishing quality eg recruitment, retention, staff turnover, agency staff deployment, sickness absence, appraisal rates and take up of training (particularly statutory and mandatory)
- Business Committee has received regular reports on the Trust's recruitment and retention activity and outcomes (April, September, October 2015 and January 2016)
- Business Committee has maintained oversight of the Trust's approach to and performance of agency staff
- Business Committee discussions correlate workforce performance indicators with service activity indicators through neighbourhood reports and a 'heat map' (showing performance on a service line basis)
- Business Committee debates workforce related risks (scored as high) to consider mitigating actions that could impact on service quality and transformation
- Business Committee has had a "deep dive" approach to looking at the neighbourhood teams during the past year as an area of particular recruitment, retention and morale concern; this has taken the form of in depth reports on particular individual teams and wide ranging discussions on the issues affecting teams
- Business and commercial developments report is received by each Business Committee meeting sets out risks and opportunities to maintaining current or securing new business; workforce implications of business growth or loss would be drawn out
- Business Committee has received the detailed status of results from the staff, friends and family test through the integrated performance report
- Quality Committee receives the quality impact assessment reports of service reviews; over the months, service reviews have included significant workforce implications the adverse impact of which could result in reduced quality of care
- Quality Committee receives reports on whistleblowing incidences as a minimum on a twice yearly basis; issues of note are escalated for consideration by the Board
- Issues of staff engagement and staff morale regularly form part of the conversations and reflections with individual services when presenting at Committees on key issues such as reduction in pressure ulcer rates

4.2.5 Other positive assurances

- Programme Management Board meets monthly and oversees a range of service review projects; deliberations include the significant workforce consequences of service transformation
- Programme management office has had additional human resources and trades union time allocated to work on projects with extensive workforce implications
- Joint Negotiation and Consultation Forum and a separate Medical and Dental Forum meets every six weeks and addresses workforce related elements of service change; this is complemented by informal and ad hoc meeting with trades union representatives
- Significant staff engagement is a major feature of all service reviews and business development initiatives
- Corporate induction attended by 580 staff within two months of start date; the Chief Executive speaks at all induction sessions when possible setting out the vision, values and behaviours framework of the Trust
- First cohort of the 50 Voices initiative (drawing together staff from across locations, disciplines and grades) has finished the first six months of working with the senior team; the second 50 have been chosen from the nearly 200 people who applied to be part of the group
- All of the executive team spend time out on the front line with staff; the core of the visits being to look at staff morale, engagement and recruitment and retention issues
- Board members, during the course of service visits, actively seek the feedback of staff on the extent to which staff feel engaged in the business of the Trust
- Approaches to internal (staff) communications coordinated by the communications team working with the workforce directorate
- Wide range of communications initiatives to support engagement, including: team brief, community talk etc
- Survey Monkey tool used to gain and share feedback by team, service or special topic through the intranet site ELSIE

5.0 In depth review: Ineffective workforce planning leading to unsustainable workforce plans

5.1 Set out below is a summary of one of the risks recorded in the BAF. Section 5.2 describes the assurances that evidence active management of the risk.

Strategic objective	*To engage and empower our workforce, ensuring we recruit, retain and develop the best staff*
Principal risk	*Failure to engage and empower workforce*
Cause	*Ineffective workforce planning leading to unsustainable workforce plans*
Impact	*Service transformation and cost improvement plans not delivered*
Risk score	*Initial: consequence major (4) likelihood possible (3) = **high (12)***
	*Current: consequence major (4) likelihood possible (3) = **high (12)***
	*Target: consequence major (4) likelihood unlikely (2) = **high (8)***
Responsible director	*Director of Workforce*

5.2 Assurances

5.2.1 External and regulatory

- Individual officers maintain regular and effective links with opposite numbers in partner organisations whether at an operational or strategic level in relation to the workforce requirements (demand and supply)
- Full participation in the city-wide workforce planning activity
- Wide engagement with academic providers in Yorkshire and Humber area for planning purposes and to support placement capacity
- Engagement in Local Academic Health Partnership
- Engagement in West Yorkshire Partnership Council of Health Education England
- Submission to NHS TDA and clinical commissioning groups twice-yearly of workforce plans aligned to finance
- Submission of monthly workforce data collection to NHS TDA
- Submission to commissioners of an adults services' workforce plan
- Recruitment activity has included participation at recruitment fairs (eg RCN Careers Fair) and open 'cohort' recruitment

5.2.2 Board assurances

- Board workshop in January 2016 focussed on the Trust's long term strategy in relation to people management and in particular examples of benefits that have resulted from recent initiatives to enhance recruitment and retention to meet workforce plan requirements
- Board receives monthly integrated performance reports showing workforce metrics particularly staff in post against planned levels and staff turnover
- Finance reports to the Board on progress in achieving the cost improvement programme evidences implementation of workforce plans arising from service reviews

5.2.3 Committee assurances

- Business Committee undertook an in depth session at its meeting in July 2015 which examined the future workforce requirements of the Trust, the capacity and capability of the existing workforce to meet these requirements and the adverse impact of high staff turnover
- Business Committee receives reports at each meeting on metrics that could impact on the Trust's ability to meet its workforce plans eg recruitment, retention, staff turnover, agency staff deployment etc
- Business Committee has commissioned additional reports in order to scrutinise workforce measures where the reported performance has given cause for concern eg recruitment and retention
- Audit Committee has also sought additional assurances on specific topics eg sickness absence management

5.2.4 Other positive assurances

- Senior Management Team has exercised additional oversight on certain areas of performance eg authorisation of vacancies, reasons for poor retention, use and costs of agency staff
- Recruitment and Retention Steering Group reports directly to SMT

- Rolling programmes of recruitment and 'cohort' recruitment exercises have sought to ensure an optimum level of recruitment
- Initiatives to modernise working practices have evolved from service reviews including the introduction of new more flexible roles
- Learning and Development Group mapping current and required skills and competences and developing potential new roles
- Apprenticeship schemes available within the Trust
- Participation in city-wide health and social care apprenticeship pilot arrangements
- Developed a memorandum of understanding across NHS organisations and Leeds City Council regarding a 'passport' approach to statutory and mandatory training and competency

6.0 Future developments

6.1 There is a continuing plan to ensure the BAF is actively managed and provides the required assurance to the Audit Committee and the Board. Further enhancements include:

- A small number of controls and assurances will benefit from greater definition
- The Board will consider scheduling time during a Board workshop to review and update the structure and content of the BAF prior to formal (annual) approval; this could be linked to and be seen as an output of the Trust's business planning process
- A schedule of assurances will be maintained and produced as a report for the Board detailing the progress of assurances received in line with the review dates set for each group of risks
- The Company Secretary will work with the Chair, committee chairs and Chief Executive to populate and maintain Board and committee work plans, taking account of risks identified within the BAF and the identified controls and assurances

7.0 Recommendations

7.1 The Board is asked to:

- Note the current BAF
- Note the in depth review of risks arising from the Trust's strategic objective related to engaging and empowering the workforce and ensuring the trust recruits, retains and develops the best staff and consider further ways in which the Board wish to gain assurance on workforce topics
- Note proposed BAF enhancements

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2015-16 (107)

Leeds Community Healthcare NHS Trust

Board Assurance Framework: summary

Board meeting: 5 February 2016

Leeds Community Healthcare NHS Trust
Board Assurance Framework October 2015: Summary
Version 6
Dated 25 January 2016

Appendix 1

Agenda item 2015/16 (107)

ID	Principal risks	Assessment of risk						Responsible director								Governance						Audit				Regulator	
		initial risk score	Current Net Risk Score No Score ⟷ No Change	Target (Maximum Risk Threshold)	RisK Target Gap	Adequacy of Control (work in progress)	Review date	Chief Executive	Director of Finance and Resources	Director of Operations	Medical Director	Director of Nursing	Director of Integration	Director of Workforce	Director of Strategy and Planning	Business Committee	Quality Committee	Audit Committee	Remuneration Committee	Senior Management Team	Trust Board	Clinical Audit	Internal Audit	External Audit	Professional Body	NHS TDA	CQC
Strategic objective 1: To provide a high quality, safe services, continually improving the patient experience and measuring our success in outcomes																											
Principal risk 1: Failure to provide high quality, safe services																											
205	Ineffective systems and processes for assessing the quality of service delivery and compliance with regulatory standards	16	8	8	0		Jun-16					●					●						●			●	●
590	Failure to implement and embed lessons learned from internal and external recommendations (Francis, CQC, Winterbourne etc.)	12	8	4	4		Jun-16				●						●						●			●	●
Strategic objective 2: To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home principles																											
Principal risk 2: Failure to deliver intregrated care and care closer to home																											
209	Relationship with stakeholders including commissioners not well managed	12	8	4	4		Aug-16	●													●					●	
211	Inability to provide integrated care for patients due to poor partnership arrangements	12	8	4	4		Aug-16			●										●						●	
361	Public and patients are not effectively engaged in Trust decisions	9	6	3	3		Aug-16								●		●										
Strategic objective 3: To engage and empower our workforce, ensuring we recruit, retain and develop the best staff																											
Principal risk 3: Failure to engage and empower workforce																											
360	Lack of internal capacity to secure quality and drive transformational change	16	12	8	4		Oct-16							●						●						●	
218	Lack of staff involvement and engagement in the organisation	12	12	6	6		Oct-16	●													●					●	
223	Risk to service sustainability due to ineffective workforce planning	12	12	8	4		Oct-16							●						●						●	
Strategic objective 4: To become a viable and sustainable organisation with the ability to invest in the community																											
Principal risk 4: Failure to maintain a viable and sustainable organisation																											
234	Loss of business or decommissioning of services	16	12	4	8		Apr-16		●							●										●	
312	National Efficiency requirements cannot be delivered recurrently	16	12	4	8		Apr-16		●							●										●	
227	Income and Expenditure levels are not managed to achieve target surplus recurrently	16	12	4	8		Apr-16		●							●										●	
591	Finances not managed to achieve minimum acceptable Continuity of Services Risk Rating (CSRR)	16	4	4	0		Apr-16		●							●										●	
199	Trust does not meet its statutory and regulatory duties: (a) failure to report position to the TDA (b) failure to meet the requirements of the Civil Contingency and Climate Change Act	20	5	5	0		Apr-16		●							●										●	●
516	Failure to achieve Foundation Trust status	15	10	5	5		Apr-16								●					●						●	
592	Commissioners decide that the community trust model is no longer supported	15	10	5	5		Apr-16								●					●						●	
224	High levels of sickness absence impacts on quality of care and staff morale and is a net cost to the organisation	16	16	8	8		Apr-16							●		●							●			●	
720	Non delivery of the full benefits and potential of the Adult Health & Social Care Integrated Programme	12	12	8	4		Apr-16						●							●			●				-

Leeds Community Healthcare NHS
NHS Trust

ITEM
2015-16
(108)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: Corporate risk register
Responsible Director: Chief Executive **Report author:** Risk Manager
Previously considered by: Not applicable

Executive summary

The Trust has a Board approved risk management strategy and a range of risk management approaches which provide a framework for the systematic management of risk. This includes processes to identify and assess risks and to control, mitigate and reduce risks that would otherwise impede the Trust in meeting its objectives. This report is part of the governance processes supporting risk management in that it provides assurance about the effectiveness of the risk management processes and that adequate controls are in place to manage the Trust's most significant risks and covers:

- All risks currently scoring 15 or above as shown on the attached spreadsheet and which form the Trust's corporate risk register; as received by SMT monthly and the Board on a bi-monthly basis
- Description of risk movement for those clinical and non-clinical risks at 15 or above: new risks and risks with increased or decreased scores
- A section detailing risks scoring 12; whilst these do not meet the definition for inclusion in the corporate risk register they have been detailed as they evidence those matters of high risk and scrutinised closely by SMT
- A section summarising those risks scoring 8 or above that are reported in full to the Quality Committee and Business Committee at each meeting
- Planned developments to enhance the reporting and managing of risk including an update to the Trust's risk management strategy and procedure.

After the application of controls and mitigation measures there are two risks with a current score of 15 (extreme) or above across the Trust, which are shown on the corporate risk register (CRR) and listed below.

- Risk 224: reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust
- Risk 813: compliance with information governance (IG) training requirement (new)

Recommendations

The Board is recommended to:

- Note the contents of the register and movements within the risk profile
- Note the improvements made and future developments
- Approve the proposal that revisions to the risk management strategy and procedure be approved by the Audit Committee for ratification by the Board

Links to strategic objectives:	The risk register provides assurance that risks to the Trust's strategic objectives are identified and managed, namely: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home principles • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community and with a relentless focus on value for money
Links to principal risks:	Where applicable, the risk register provides links with the principal risks within the Board Assurance Framework (BAF).
NHS Constitution:	This report and the risk register attached supports all of the principles, values, rights and pledges detailed within the NHS Constitution.
CQC Standards:	The risk register ensures the Trust manages risks effectively by putting effective systems and processes in place These measures supports the Trust to meet its obligations across all of the CQC's domains and also meets the requirements of the National Health Litigation Authority (NHSLA) risk management.
Equality and diversity:	The risk management strategy has, been assessed using the Equality Impact Assessment (EIA) toolkit, to ensure consideration has been given to the actual or potential impacts on staff, certain communities or population groups.
Sustainability Implications:	Where applicable, risks with sustainability implications are detailed, in the risk register.
Publication Under Freedom of Information Act:	This paper has been, made available under the Freedom of Information Act.

1.0 Purpose of the report

1.1 The report provides the Board with an overview of the Trust's risks currently scoring 15 or above after the application of controls and mitigation measures. There are two risks on the corporate risk register attached to this paper, which is reported at SMT monthly, and on a bi-monthly basis to the Board. The paper also provides a description of risk movement since the last register was presented to the Board on 4 December 2015.

1.2 The paper also provides a section detailing risks scoring 12; whilst these do not meet the definition for inclusion in the corporate risk register they have been detailed as they evidence those matters of high risk and scrutinised closely by SMT. In addition, there is a short summary of those risks scoring 8 or above whether clinical or non-clinical and which are reported in full at the Quality Committee or Business Committee at each meeting (10 occasions each year).

1.3 The paper also describes a strengthened approach to risk management and planned developments to enhance the future reporting and management of risk including a proposed approach for updating the Trust's risk management strategy and procedure.

2.0 Background

2.1 Trusts require robust systems and processes to manage risk. As with all processes, these should be simple to understand, use and maintain but provide a secure mechanism in order to ensure the required level of assurance.

2.2 Risks showing a current risk score of 15 (extreme) or above are reported to the Trust's Board at each meeting. Prior to Board scrutiny, Senior Management Team (SMT) considers and moderates the risks at 15 (extreme) and above. In exceptional circumstances, a director may request inclusion of any risk onto the register received by the Board.

2.3 In order that there is continuous oversight of risks across the spectrum of severity, consideration of risk factors by SMT is not contained to extreme risks. Senior managers are sighted on services where the quality of care or service and financial 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.

2.4 Risks recording a current high or extreme score (8 or above) and designated as clinical risks are reported to the Quality Committee for scrutiny. The Business Committee discharges a role in respect of non-clinical (operational, corporate and headquarters functions) risks with a current score of 8 or above. A summary of these risks (8 or above) is included in the reports for SMT and the Board.

3.0 Summary of current corporate risks scoring 15 or above

3.1 There are two risks with a current score of 15 (extreme) or above on the Trust corporate risk register as at 7 January 2016. Both risks score 16 (major/likely) and are as follows:

Table 1 Extreme risks (scoring over 15)

Risk 224	**Non-clinical**	**Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust (non-clinical)**
Risk 813 (new)	**Non-clinical**	**Compliance with information governance (IG) training requirement**

4.0 Changes to the corporate risk register

4.1 The Board last reviewed a register of 15 or above risks at its meeting on 4 December 2015.

4.2 A report of all risks recorded with a current risk score (ie after the application of controls and mitigations) of 15 or above was extracted from Datix on 7 January 2016 (attached). The report showed:

- One new risk
- Refinement and updating of risk descriptions, controls and actions
- No closure of risks
- Three deescalated risks (a fourth risk has been more recently deescalated see section 6.1)

5.0 New or escalated corporate risks

5.1 Since the last report generated in November 2015, there has been one new risk recorded at 15 or above.

- ***Risk 813: Compliance with information governance (IG) training requirement.*** As a result of poor compliance with IG training requirements, there is a risk of incurring a significant fine from the Information Commissioner's Office which would have a financial and reputational impact. There is also a risk of an information governance breach, which could cause distress to patients and reputational damage to the Trust. An action plan has been developed to mitigate this risk. Actions taken include reminders being sent to staff to complete IG training and to advise that the training is now an annual requirement. The workforce information team have identified and notified staff with less than 12 months' compliance, and enrolled these staff on an IG refresher course. The current risk score is **16 (extreme).**

5.2 There are no escalated risks.

6.0 Closures, consolidation and de-escalation of corporate risks

6.1 Since the November 2015 report, there has been no closures or consolidation of risks previously recorded at 15 or above. Four risks have been deescalated:

- ***Risk 644 increased waiting times arising from increased demand, complexity of referrals and capacity in child and adolescent mental health services (CAMHS)*** was deescalated from 16 (extreme) to 9 (high) on 20 January 2016. This was after the cut-off date for the Datix extraction, however as this was previously a significant risk, a decision was made to include this recent amendment in the Board report. The reason for de-escalation is that additional waiting list management resource has been deployed and patients on the waiting list have been prioritised and seen according to need.

- ***Risk 705 Reduced level of care arising from recruitment issues in district nursing services*** was deescalated from 16 (extreme) to 12 (high). This risk was discussed by the senior management team in January 2016 and it was agreed that the recruitment situation had improved.

- ***Risk 716 Reduced level of care arising from recruitment issues in twilight services*** was deescalated from 16 (extreme) to 12 (high). As with risk 705, the recruitment situation has improved. This risk may no longer be relevant as 'twilight' services now form part of the neighbourhood team, rather than existing as a separate service. This risk may be merged with risk 705.

- ***Risk 798: Caseload management in children's dietetics*** was deescalated from 16 (extreme) to 12 (high). The reason for de-escalation is that locum capacity is now in post for a short period of time to help manage the demand. Weekly allocation meetings have commenced from January 2016 to optimise dietetic resource to manage the waiting list and prioritise review of patients with greatest need. Recruitment is underway to substantive vacancies.

7.0 Summary of risks scoring 12 (high)

7.1 High clinical risks (scoring 12)

7.1.2 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by SMT is not contained to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12.

Table 2 High clinical risks (scoring 12)

Risk description	Risk score		
	Initial	Current	Target
Increased risk of falls in adult inpatient and community services	16	12	6
Impact on service delivery of implementing integration programme	16	12	6
Risk of reduced level of care due to recruitment difficulties in neighbourhood teams	12	12	12
Risk of reduced level of care due to recruitment difficulties in twilight services	20	12	12

Table 2 High clinical risks (scoring 12) (contd)

Risk description	Risk score		
	Initial	Current	Target
(Non-reportable) waiting lists exceeding 18 weeks in certain adult services; diabetes, continence and neighbourhood teams	15	12	4
Under-delivery of wound prevention and management service impacting on patient care and increased risk of pressure ulcer incidence	16	12	4
Information-sharing limitations between paediatricians for children with complex medical needs	12	12	6
Risk of bed closures at Hannah House due to staff shortages and inability to maintain required staffing levels	15	12	2
Risk of non-delivery of childhood immunisation programme (BCG)	16	12	4
Insufficient capacity of speech and language therapy available to triage and treat demand in adult learning disabilities	20	12	4
Insufficient resource to meet demand for health services at Wetherby YOI arising from increased prison population and complexity of needs	16	12	3
Clinical risk to people in prison due to increasing use of NPS (legal highs)	12	12	8
Changes in prison regimes (Transforming Youth Custody) reducing young people's access to health care and increasing waiting times	8	12	4
Reduction in number of experienced clinicians in children's dietetics service	16	12	2
Lack of forensic medical examiners' availability to cover SARC and police custody	15	12	6

7.2 High non-clinical risks (scoring 12)

7.2.1 Continuous oversight of risks across the spectrum of severity is applied to non-clinical risk areas too. SMT considers services where service and/or financial sustainability is at risk where these aspects of the Trust's business is reflected in risks recorded as 'high' and scored at 12.

Table 3 High non-clinical risks (scoring 12)

Risk description	Risk score		
	Initial	Current	Target
Risk of failure of IT support and additional costs due to current provider (Yorkshire and Humber CSU) not retained on NHS procurement framework and consequent migration to alternative provider	12	12	4
Effect of loss of prisons' contract resulting in requirement for additional reduction in corporate services functions and costs	12	12	1
Failure to achieve level 2 standard against the information governance toolkit	12	12	4
Lack of awareness of service line performance; performance reports do not sufficiently describe or escalate performance at granular level	12	12	4
Potential risk that equipment is not fit for purpose and may present a risk due to non-commissioned pre-planned maintenance	16	12	4
Functionality of nurse call alarm system at Little Woodhouse Hall	20	12	5
Risk of non-delivery of benefits from implementation of electronic patient record system	16	12	6
Failure to meet national improving access to psychological therapies targets due to lack of referrals and additional marketing	16	12	8
Risk of reduced level of care and loss of experienced staff as a result of staff retention in current employment market	16	12	6

8.0 Summary of all risks currently scoring 8 or above

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

8.2 Presently the Trust's risk register comprises 54 risks at risk score 8 or above assigned to the Trust's three business units and all directorates providing corporate and headquarters functions.

8.3 Clinical risks scoring 8 or above

8.3.1 The chart below shows the number of clinical risks (29) logged on the Trust's risk management database (Datix) as at 7 January 2016.

Table 4 Clinical risks by business unit

Business unit	Risk score 8-12 High	Risk score 15+ Extreme	Totals by Unit
Adults	11	0	**11**
Children's	5	0	**5**
Specialist	13	0	**13**
Totals by risk severity	**29**	**0**	**29**

8.3.2 None of clinical risks on the risk register are defined as a significant risk (extreme) with current score of 15 or above (i.e. after the application of controls and mitigations).

8.3.4 There are three new clinical risks scored as a high risk (8-12):

- ***Risk 802 Waiting times in adult business unit services exceed 18 weeks.*** The current risk score is 12 (high).
- ***Risk 805 Delivery of specialist wound prevention and management advice.*** The current risk score is 12 (high).
- ***Risk 809 Risk of high staff turnover in prison service.*** Current risk score is 9 (high)

8.3.5. No clinical risks have been escalated since November 2015.

8.4 Non-clinical risks scoring 8 or above

8.4.1 There are 25 non-clinical risks by directorates providing operational, corporate and headquarters functions as at 7 January 2016 (shown below).

Table 5 Non-clinical risks by directorate

Directorate	Risk score 8-12 High	Risk score 15+ Extreme	Totals by Unit
Finance and resources	5	0	**5**
Medical	1	0	**1**
Operations	13	0	**13**
Quality & professional development	1	0	**1**
Strategy and planning	1	0	**1**
Workforce	2	2	**4**
Totals by risk severity	**23**	**2**	**25**

8.4.2 Two of the total number of non-clinical risks on the risk register are defined as significant risks (extreme) with current scores of 15 or above (i.e. after the application of controls and mitigations) and are included in the corporate risk register (Risks 224 and 813, see paragraph 3.1 and table 1).

8.4.3 There are eight new non-clinical risks scored as a high risk (8-12):

- ***Risk 803 Non-delivery of contracted face-to-face activity levels 2015/16***. The current risk score is 9 (high)
- ***Risk 804 Failure to deliver preferred place of death contractual target for 2015/16.*** Current risk score is 9 (high)
- ***Risk 807 Short-term lack of capacity in adult business unit leadership.*** Current risk score is 9 (high)
- ***Risk 808 Delivery of financial balance including cost improvement plans (CIPs) 2015/16 in Adult Business Unit.*** The current risk score is 8 (high)
- ***Risk 810 Effect of loss of prison tender on corporate services.*** The current risk score is 12 (high)
- ***Risk 811 Risks to retention of staff.*** The current risk score is 12 (high)
- ***Risk 814 Risk to Trust's reputation for failure to achieve an overall Level 2 standard of the information governance toolkit by 31 March 2016.*** The current risk score is 12 (high)
- ***Risk 816: Board and management not sufficiently aware of service line performance.*** The current risk score is 12 (high)

8.4.4 No risks have a revised (higher) current risk score.

9.0 Risk profile - all risks

9.1 There are 39 open clinical risks on the Trust's risk register and 33 open non-clinical risks. The table shows how risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

Table 6 Risk profile across the Trust

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	1	0	0	0	1
4 - Major	2	4	18	2	0	26
3 -Moderate	3	6	19	8	0	36
2 - Minor	0	3	3	1	1	8
1 - Negligible	0	0	0	0	1	1
Total	5	14	40	11	2	72

9.2 There has been no significant movement within the Trust's risk profile since the previous report therefore in-depth analysis has not been provided in this report. Further analysis will be included periodically in the Business and Quality Committee reports (in March, July and November 2016). This analysis will be reflected in the subsequent reports to SMT and Trust Board.

10.0 Risk management training

10.1 A number of bespoke risk management training sessions have been arranged for frontline services for early 2016. The training sessions include spotting hazards, assessing risks, situational awareness, effectiveness of controls, and how the Trust uses its risk register.

10.2 Risk management is now included on the Trust's induction programme as of January 2016. This briefly introduces the risk management framework and signposts staff to further training opportunities.

11.0 Risk management newsletter

11.1 *Risky Business*, the Trust's new risk management newsletter was distributed in December 2015. This quarterly newsletter keeps staff up to date with lessons that can be learned from incidents and complaints, the latest information about risk management, training courses available and examples of good practice across the Trust.

12.0 Risk Review Group

12.1 The Risk Review Group met for the first time in November 2015. Newly recorded risks were discussed and updates were provided on existing risks by members of the group. Risks that have remained on the risk register for more than three years were reviewed to ensure the group felt that they were still current and relevant risks. The revised Risk Management Strategy and Procedure was received by the group, which made some suggestions for further improvements.

12.2 The group discussed suggestions for additional items for future meetings. A review of the risk categories and subcategories on Datix was suggested. It was also suggested that this group could be used as a sounding board for risk information that will be published on the Trust's intranet site (Elsie).

12.3 The group draws is membership from a small number of essential individuals together cover the majority of risks on the Trust risk register.

13.0 Risk Management Strategy and Procedure

13.1 The draft revised Risk Management Strategy and Procedure was reviewed by the Audit Committee in December 2015. The Committee's deliberations included a discussion on whether the document was more akin to a policy rather than a strategy. A review of similar documents produced by other trusts would indicate that most 'strategies' closely resembled 'policies' and most were subject to Board approval.

13.2 In relation to Board approval, the Audit Committee suggested that, if material changes eg risk thresholds and the level of scrutiny applied by committees to risk issues were not significant, then the Audit Committee could provide approval of the revised document on a delegated basis for subsequent ratification by the Board.

14.0 Board assurance framework and risk management: internal audit

14.1 The Trust's internal auditors, TIAA Limited, are to undertake an audit exercise including elements of risk management in the last quarter of 2015/16. The results of which will be advised to the Board once available.

15.0 Recommendations

15.1 The Board is recommended to:

- Note the contents of the register and movements within the risk profile
- Note improvement actions
- Approve the proposal that revisions to the risk management strategy and procedure be approved by the Audit Committee for ratification by the Board

AGENDA ITEM

2015-16

(108)

Corporate Risk Register December 2015

Date of Meeting: 5 February 2016

Lead Directorate: Workforce											
Portfolio: Corporate & HQ functions											
224	Ann Hobson	Sue Ellis	01/01/2012	Title: Prevalence of staff sickness: Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust	Regular monthly reporting by individual team to managers.Monthly discussion of absence by teams at business unit performance meetings.Monthly discussion of absence by Business unit at operational performance meetings, SMT, Business Committee and Board.Health and wellbeing team in place to support managers. Greater scrutiny within business units re compliance with return to work interviews.	Limited	There is now greater scrutiny within business units re compliance with return to work interviews. (updated 01/12/2015)	Extreme (16)	Extreme (16)	High (16)	29/01/2016
813 New	Ann Hobson	Sue Ellis	15/12/2015	Title: Compliance with information governance (IG) training requirement. As a result of poor compliance with IG training requirements, there is a risk of incurring a fine from the Information Commissioner's Office which would have a financial and reputational impact. There is also a risk of an information governance breach which could cause distress to patients and reputational damage.	Reminders have being sent to staff to complete their IG training and to advise them that the training is now an annual requirement. Workforce Information team have identified staff with less than 12 month's compliance, notified them and enrolled these staff on IG refresher course.	Limited	Following the meeting on 3 November 2015, an action plan has been created. The IG manager is currently assessing all framework agencies IG training content. Some have been found to be non-compliant. Induction checklist now shows IG training is required on day one. (updated 31/12/2015)	Extreme (16)	Extreme (16)	Low (3)	31/01/2016

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015-16 (109)

Report to: Trust Board
Date of meeting: 5 February 2016
Report title: TDA Monthly Report on Board Statements and Monitor Licence Conditions
Responsible Director: Director of Strategy & Planning **Report author:** Business Planning Manager
Previously considered by: None

EXECUTIVE SUMMARY

The Board is asked to review and approve the report to the NHS Trust Development Authority (TDA) for November and December 2015 on Monitor's Board Statements and the TDA subset of Monitor's Provider Licence Conditions.

The Trust remains

- compliant with all Board Statements (see Appendix 1)
- non-compliant with Monitor Licence Condition G8: in relation to making patient eligibility and selection criteria readily available. Work progressed in Q3, as planned, on the refresh of the Trust's website which includes improving service information. The refresh is due to be completed by the end of Quarter 4 2015/16. The Head of Communications is also progressing work to investigate the scope for improving information about services on NHS Choices website.

If there is no change to the current FT regime the Trust would need to be fully compliant by the time it is authorised as a FT.

RECOMMENDATIONS

The Board is recommended to review and approve:

- the assessment of full compliance with the TDA Board Statements
- the assessment of non-compliance with Condition G8: Patient eligibility and selection criteria and note that progress made in Q3 2015/16.

Links to strategic objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community & with a relentless focus on value for money
Links to principal risks:	Non-compliance with Foundation Trust requirements.
NHS Constitution:	There are no decisions in this report that require regard to the NHS Constitution
CQC Outcomes:	The paper indirectly supports all CQC outcomes e.g. via work related to development of the Quality Governance Assurance Framework
Equality and diversity:	An Equality Analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	No sustainability implications have been identified
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act

Appendix 1: Clarification and Assurance re Board Statements

Since April 2013 the Trust has reported compliance with all Board Statements.

Board Statement 1

The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients

Clarification of what's required

The TDA Accountability Framework describes the TDA's oversight model which sets out how Trusts will be assessed and held to account for delivering their Annual Plan. The model reflects Monitor's Risk Assessment Framework (replaced Monitor's Compliance Framework in October 2013). The model includes monthly and quarterly / annual reporting against quality and workforce metrics as well as CQC and other 3rd party reports. The monthly metrics include RTT, outcomes, patient experience and staff satisfaction.

How assurance is provided to the Board

- Assurance provided through Quality Committee that core CQC standards are being met, safety is being actively managed e.g. SI report and any exceptions are reported to Board via Quality Committee minutes.
- The Integrated Performance Report is aligned with the TDA Accountability Framework
- Integrated Performance Report provides assurance that quality metrics are being monitored and actively managed: includes serious incidents, complaints and patient and staff satisfaction feedback. Assurance through BAF and risk reporting system that strategic and quality risks are being actively managed
- Internal Audit reports provide assurance about key quality governance processes and systems; outcomes are reported via Audit Committee minutes
- External data sources e.g. National Patient Safety Agency and the Care Quality Commission, provide further assurance of culture and compliance and are reported to the Board through Quality Committee minutes.
- Quality Committee Terms of Reference have been revised to reflect its focus on reviewing IPR quality performance metrics

Board Statement 2

The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements

How assurance is provided to the Board

- As above
- Quality Risk Profile reviewed by Quality Committee: frequency to be reviewed

Board Statement 3

The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements

How assurance is provided to the Board

- Assurance that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements is provided through Quality Committee on the Annual Organisational Audit return and action plan and direct reports to the Board through the Medical Director's annual report

Board Statement 4

The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time

How assurance is provided to the Board

- Annually the going concern concept is considered as part of the annual accounting process and assurance is sought and tested by External Audit. In this the Board and Auditors should consider the trading position and the cash position for the Trust to assess how well it can continue to meet its obligations. This is clearly part of the information which is considered by Board when setting the financial strategy and operational financial plans for the Trust in ensuring the finances underpin the delivery of the IBP. These assumptions are then considered by External Auditors who use their judgement to provide independent assurance for all stakeholders. Their conclusions are presented to the Audit Committee at the time of the annual accounts.
- The Board approved LTFM demonstrates financial performance for historic, current year and forecast for the next 5 years demonstrating the overall forecast financial performance from the key financial risk perspectives as defined by Monitor. The LTFM is updated periodically.
- LTFM is stress tested and long term viability is reviewed along with potential mitigating actions which should addresses internal and external risks to the financial position
- Ongoing assurance provided to the Board through the Finance report in the Integrated Performance Report, including reporting against Monitor's Continuity of Services Risk Rating

Board Statement 5

The board will ensure that the trust remains at all times compliant with regard to the NHS Constitution.

Clarification of what's required

The key elements of the NHS Constitution are:

For patients

- Access to services within waiting time
- Equality of access
- High standards of care
- Clean safe environment
- Treated with dignity and respect
- Only receive treatment consented to
- Informed and involved about care
- Privacy and confidentiality
- Access to health records
- Right to complain

For staff

- Clear roles and responsibilities
- Access to training and personal development
- Be engaged and involved in decisions
- Informed

How assurance is provided to the Board

- The organisations' policy framework has been developed in line with the NHS Constitution. Monitoring of compliance with policy is provided to the Board and its sub committees, including reporting against the Integrated Performance Report
- All Board and sub-committee cover sheets require statement indicating alignment with NHS Constitution

For patients

- Integrated Performance Report focus on key Quality indicators for the 5 CQC quality domains including waiting times, complaints and patient satisfaction and experience
- Quality Committee review of equality strategy and equality impact assessments of any project or service development
- Quality report
- Quality Committee review of involvement and engagement
- Involvement Strategy
- Information Governance Toolkit (confidentiality / access to records)

For staff

- Reporting on Staff survey and action plan
- Integrated Performance Report workforce performance indicators

Board Statement 6

All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner

Clarification of what's required

Clear understanding of the risks faced by the organisation; how these are identified; mitigated and managed

How assurance is provided to the Board

- Assurance provided through risk reporting to Quality Committee, Business Committee and to the Board including the Annual Governance Statement
- BAF reviewed by the Board quarterly
- Assurance provided through Quality Governance Framework self-assessment, Board Governance Framework self-assessment and NHSLA accreditation process
- External and internal audit reports
- Audit Committee Standing item is the review of internal and external audit recommendations and progress against actions
- The Risk Management Strategy and risk review processes have been revised to strengthen the robustness of risk management and reporting including addressing issues identified through Internal Audit.
- Quality Committee Terms of Reference revised in 2014 to reflect its focus on reviewing clinical and quality risks. Business and financial risks are reviewed by Business Committee

Board Statement 7

The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks

How assurance is provided to the Board

- The Board Assurance Framework has been developed by the Directors and reflects the principal risks to the delivery of the Integrated Business Plan
- The Chief Executives monthly report to the Board highlights any emerging political, economic, social and technological risks for consideration
- The Audit Committee considers the alignment between the Internal Audit Programme and the Board Assurance Framework and those areas of higher risk are prioritised
- The Board receives assurances that the recommendations following audits are completed via the minutes of the Audit Committee
- Where required, independent external reviews may be commissioned to provide additional assurance regarding the quality of care and these are reported to Board via the relevant sub-committee
- The Risk Management Strategy and risk review processes have been revised to strengthen the robustness of risk management and reporting including addressing issues identified through Internal Audit.
- Quality Committee Terms of Reference revised in 2014 to reflect its focus on reviewing clinical and quality risks. Business and financial risks are reviewed by Business Committee

Board Statement 8

The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily

How assurance is provided to the Board

- The Board Assurance Framework has been developed by the Directors and reflects the principal risks to the delivery of the Integrated Business Plan
- In line with the Risk Management Strategy operational risks are reviewed at the most appropriate level within the organisation and those most significant are reported to Board monthly
- Audit recommendations are monitored by the Audit Committee until completion and these are reported to the Board via the minutes of the Audit Committee
- The Terms of Reference for the Board Committees are reviewed on an annual basis to ensure that they enable oversight of the delivery of the annual operating plan and each Committee establishes a work programme in line with its terms of reference
- The Integrated Performance Report (IPR) is developed to enable Board oversight of quality, financial, regulatory and contractual targets as defined within the plan. IPR metrics are reviewed annually and approved by Board
- The Risk Management Strategy is reviewed annually and has been revised to strengthen the robustness of risk management and reporting including addressing issues identified through Internal Audit. There has subsequently been further strengthening of risk review processes.
- Quality Committee Terms of Reference have been revised to reflect its focus on reviewing clinical and quality risks. Business and financial risks are reviewed by Business Committee

Board Statement 9

An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury

Clarification of what's required

Annual Governance Statement replaced the Statement of Internal Control. It is a description of how we manage risk in the organisation, the key risks faced and any breaches / reports to the information commissioner

How assurance is provided to the Board

- External assurance given by external auditors
- Assurance through the Chief Executive's monthly Highlight Report
- Annual Governance Statement compliant with DH and HM Treasury guidance
- Risk report
- BAF
- SI report

Board Statement 10

The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant TDA quality and governance indicators; and a commitment to comply with all known targets going forwards

Clarification of what's required

As indicated for 1 above, the TDA Accountability Framework describes the TDA's oversight model which sets out how Trusts will be assessed and held to account for delivering their Annual Plan; it includes metrics, including RTT, outcomes, patient experience and staff satisfaction.

How assurance is provided to the Board

- Assurance provided through Quality Committee that core CQC standards are being met and safety is being actively managed e.g. Incident reporting
- Integrated Performance Report provides assurance that quality metrics are being monitored and actively managed and are aligned with the TDA Accountability Framework metrics.
- Assurance through BAF and risk reporting system that strategic and quality risks are being actively managed
- External Assurances received via regulator reports from the CQC and HMP Inspectorate and compliance with NHSLA level 1 assessment standards
- Quality Committee Terms of Reference have been revised to reflect its focus on reviewing IPR quality performance metrics

Board Statement 11

The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit

Clarification of what's required

The Information Governance Toolkit is a self assessment tool to help health and social care organisations achieve compliance with the international standard for security ISO7799. The DoH requires all NHS Trusts to achieve level 2 for the Information Governance Toolkit; it is also a Monitor requirement. The process is based on submission of an annual and interim self-assessments

How assurance is provided to the Board

The Trust is compliant having submitted its annual self-assessment at Level 2 in March 2015 following complete and successful implementation of the action plan.

Board Statement 12

The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies

How assurance is provided to the Board

- Members of the Board are invited to declare any interests in the agenda at every Board and Committee meeting as a standing agenda item
- Directors are required to complete an annual declaration of interest to ensure their information remains up to date
- The Board approved Code of Conduct Policy has been circulated to all staff and a complete Register of Interests is reported twice a year to the Board
- Board positions are developed and advertised in line with the TDA requirements and the recruitment process builds in the necessary checks for "fit and proper persons"
- Terms of Office for Board members are monitored and future plans developed accordingly

Board Statement 13

The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability

How assurance is provided to the Board

- Board positions are developed and advertised in line with the TDA requirements and the recruitment process builds in the necessary checks for "fit and proper persons"
- An independent assessment of Board Effectiveness was completed in 2011 (Deloittes) and by the TDA in 2012
- 360 degree assessment of Non-Executive Directors and Chair provide clear areas for development and these are built into the Board Development Programme
- In line with the Standing Orders the Chief Executive determines the structure of the Executive Team in order to enable the delivery of the plan and any changes to the structure and portfolios are reported to the Nomination and Remuneration Committee and through its minutes to Board.
- The Board schedules bi-monthly workshops focussed on Board development
- The Board Development Plan to be approved by the Board to ensure that there is clear sign up to it.

Board Statement 14

The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan

How assurance is provided to the Board

- As for 13 above

Leeds Community Healthcare NHS Trust

Trust Board public workplan 2015-16
Version 5 PORTRAIT
Dated 21 January 2016

Agenda item
2015-16
110

Topic	Frequency	Lead officer	2 October 2015	4 December 2015	5 February 2016	31 March 2016	2 June 2016	5 August 2016
Preliminary business								
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X
Patient story	every meeting	DSP	X	X	X	X	X	X
Quality and delivery								
Chief Executive's report	every meeting	CE	X	X	X	X	X	X
Intregrated performance report	every meeting	EDFR	X	X	X	X	X	X
Programme management board report	2 x year	EDO			X			X
Operational plan including capital programme	2 x year	DSP		X		X		
Performance management framework	annual	EDFR				X		
Care Quality Commission inspection	as required	EMD		X				
Quality account	annual	EDN					X	
Staff survey annual report	annual	DW				X		
Safer staffing report	2 x year	EDN			X			X
Infection prevention control annual report	annual	EDN	X					
Emergency preparedness and resilence report and major incident plan	annual	DSP	X					
Complaints and incidents report	2 x year	EDN		X			X	
Safeguarding annual report	annual	EDN	X					
Strategy								
Service strategy (integrated business plan)	annual	DSP					X	
Quality strategy	annual	EDN			X			
Safeguarding strategy	annual	EDN			X			
Public engagement strategy	annual	DSP		X	X			
Equality and diversity strategy	annual	EDN		X				
OD strategy	2 x year	DW			X			X
Research and development strategy	annual	EMD						X
Risk management strategy	annual	CS			Referred to Audit Committee			
Sustainable development management plan	annual	EDFR	X					
Other strategic developments: **- Service relocations** **- Health and justice services** **- Intregrated neighbourhood teams and out of hospital provision** **- Child and adolescent mental health services** **- Continuing care nursing services and personal health budgets**		DSP EDO EDO EDO EDO		x	x	x	x	x
Governance								
Well-led framework	3 x year	DSP			X		X	
Medical Director's report: doctors' revalidation	annual	EMD						X
Nurse revalidation	annual	EDN						X
Annual report	annual	EDFR					X	
Annual accounts	annual	EDFR					X	
Letter of representation	annual	EDFR					X	
Audit opinion	annual	EDFR					X	
Audit Committee annual report	annual	CS					X	
Standing orders/standing financial instructions review	annual	CS				X		
Annual governance statement	annual	CS				X		
Going concern statement	annual	EDFR				X		
Committee terms of reference	annual	CS					X	
Board and sub-committee effectiveness	annual	CS					X	
Register of sealings	annual	CS					X	
Declarations of interest/fit and proper persons test/gifts and hospitality	annual	CS					X	
Information governance annual declaration	annual	EDFR				X		
Board development programme	annual	CS				X		
Board workplan	every meeting	CS	X	X	X	X	X	X
Board assurance framework	every meeting	CS	X	X	X	X	X	X
Corporate risk register	every meeting	CS	X	X	X	X	X	X
NHS TDA monthly compliance statement	every meeting	DSP	X	X	X	X	X	X
Decisions for ratification	as required	CS						
Reports								
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board, Children's Trust Board	every meeting	CS	X	X	X	X	X	X

Key

CE	**Chief Executive**
EDFR	**Executive Director of Finance and Resources**
EDN	**Executive Director of Nursing**
EDO	**Executive Director of Operations**
DSP	**Director of Strategy & Planning**
EMD	**Executive Medical Director**
DI	**Director of Integration**
DW	**Director of Workforce**
CELs	**Committees' Executive Leads**
CS	**Company Secretary**

= received
= deferred to another meeting
= not required

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Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2015/16 (111a)

Audit Committee

Boardroom, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
Friday 23 October 2015
9.00am – 11.30am

Present:	Jane Madeley (JM)	Chair
	Professor Ieuan Ellis (IE)	Non-Executive Director
	Robert Lloyd (RL)	Non-Executive Director
In Attendance	Bryan Machin	Executive Director of Finance and Resources
	Vanessa Manning	Company Secretary
	Steve Terleckis	Assistant Manager, (KPMG)
	Jenny Robinson	Director of Audit (TIAA Limited)
	Don Pritchett	Local Counter Fraud Specialist (TIAA Limited)
	Ian Wallace	Audit Director (TIAA Limited)
	Darren Rigg	Head of Information Governance (for item 31a)
	Richard Slough	Head of Informatics (for item 31a)
Apologies:	Jackie Rae	External Audit Manager (KPMG)
	Trevor Rees	External Audit Partner (KPMG)
Minutes:	Tricia Hannon	Interim Assistant Board Secretary

Item	Discussion Points	Action
	Welcome and introductions The Chair welcomed attending members and introduced Steve Terleckis, Assistant Manager (KPMG).	
2015-16 (27a)	**Apologies** Apologies were received from Trevor Rees, External Audit Partner (KPMG), and Jackie Rae, External Audit Manager (KPMG).	
2015-16 (27b)	**Declarations of interest** There were no declarations of interest.	
2015-16 (27c)	**Minutes of the previous meeting 24 July 2015** The minutes of the meeting held on 24 July 2015 were reviewed and accepted as an accurate record. **Outcome**: The Committee approved the minutes of the previous meeting held on Friday 24 July 2015.	
2015-16 (27d)	**Matters arising and action log** There were no matters arising or actions due for completion. Attention was drawn to actions 18c (internal audit assurance report), and 18d (internal audit status report). The Director of Audit advised that actions 18c and 18d had been completed.	

	Internal Audit	
2015-16 (28a)	**Summary internal controls assurance report** The Director of Audit introduced the report. She advised that two audits (healthcare centres establishment review and sickness and absence audits) had been completed. *Healthcare centres review* The Director of Audit drew the Committee's attention to the management action plan within the report and areas of note. The Audit Director raised two points: the issue of medical supplies by health centres, which had been progressed by the Executive Director of Nursing and the maintenance contracts for estates which are being progressed by an in-depth piece of work. The Committee noted that the audit reported a lack of a comprehensive report on estates issues to the Senior Management Team. The Executive Director of Finance and Resources outlined the governance arrangements for estates management and explained this included a number of bodies (with responsibility for estates) working together. The Executive Director of Finance and Resources said that the Business Committee had addressed this area. The Executive Director of Finance and Resources confirmed that the scope of the audit had only involved a review of two premises. In reply to the Chair, the Audit Director confirmed that the key findings were set out in detail within the full report. It was agreed that more detail would be provided to the Committee on key findings. **Action:** More detail on key findings from audits to be included in future Internal Auditor's report. *Sickness absence* The management action plan was discussed in detail. The Director of Audit provided assurances and that various aspects to the report were being addressed. The main points are around the use of the sickness absence notification form, access to ESR and self-certifications; and managers' span of control in order to monitor and manage sickness absence appropriately. A Non-Executive Director (IE) referred to the high number of recommendations in the report and requested that there be further discussion at a future Audit Committee meeting. He also referred to the key findings in the sickness absence executive summary and the 22 sample cases where seven individuals (32%) had recorded sickness absence in excess of 100 days sickness absence over 48 months. He asked about assurance levels and if a more robust action plan should be in place. The timescales, scope and improvement actions made by internal audit were noted by a Non-Executive Director (RL). He also felt the management responses in the report were not robust enough nor provided sufficient assurance and suggested that a wider piece of work be carried out.	**Audit Director**

	A Non-Executive Director (IE) agreed that insufficiently robust recommendations were being made and suggested a re-audit in six month's time. A Non-Executive Director (RL) added that sickness absence was a major area of concern for the Trust and that he was not assured by management's responses as contained in the report. A Non-Executive Director (RL) said he had spoken to the Chair of the Business Committee and had had recent conversations with the Director of Workforce and a report was to be presented to the November 2015 Business Committee meeting. The audit recommendations will be included in that report. The Chair of the Committee said she did not feel assured by the piece of work outlined in the report and the 'reasonable' opinion. The Chair proposed that the Director of Workforce be invited to the 11 December 2015 Audit Committee meeting, after which, it would be decided whether to re-audit. **Action:** The Director of Workforce to receive feedback from the Audit Committee and be invited to the 11 December 2015 Audit Committee meeting. *Audit plan progress* Reference was made to the delay in the scheduling of the internal communications audit. This is due to the delay in the starting date of the new Head of Communications. In view of this audit being delayed until later in the year, the Chair of the Committee suggested bringing other audit dates forward. This was confirmed by the Audit Director who agreed to liaise with the Executive Director of Finance and Resources and Company Secretary to schedule new dates. For example, the dates already scheduled for April 2016 to be rephased to February 2016. The Director of Audit advised it was the intention to bring seven audits to each Audit Committee meeting. **Action:** The internal audit dates to be reviewed and brought forward as appropriate. The Chair of the Committee brought to the Committee's attention the lateness of the internal audit report. The Executive Director of Finance and Resources clarified that this was as a result of the delay in completing the management action plan for the sickness absence audit. The briefings on developments in governance, risk and control were introduced by the Director of Audit as being for information. In reply to the Chair of the Committee, the Executive Director of Finance and Resources explained that the Senior Management Team received weekly briefings on newly published legislation, guidance and publications along similar lines to that prepared for the Audit Committee by both internal and external auditors. Any actions arising from the briefings are acted on appropriately by the Trust. **Outcome:** The summary internal controls assurance report and its contents were noted.	**Company Secretary** **Director of Audit**

2015-16 (28b)	**Status report on the implementation of internal audit recommendations** The Executive Director of Finance and Resources presented the report which set out the position as reported by the responsible manager for all internal audit recommendations that had an agreed implementation date by 30 September 2015. The status report showed the total number of recommendations, completed recommendations, those not due for completion and overdue actions. A Non-Executive Director (IE) referred to the recommendations to undertake specific items, he suggested further information be provided if items are completed or ongoing and declared as 'business as usual'. The Executive Director of Finance and Resources acknowledged the suggested changes to be made on future reports to provide greater assurance. Following the update to the item on estates management, the implementation date of 1 March 2015 was queried by a Non-Executive Director (RL). It was confirmed by the Executive Director of Finance and Resources that this was the correct date and he advised that the bulk of the estates work has already been completed. The item on South Leeds Independence Centre (SLIC) was highlighted by a Non-Executive Director (RL) who asked about the SLIC management board requesting a fundamental review of all governance documents as outlined. An update was provided by the Executive Director of Finance and Resources on the current contractual position and the change in commissioner responsibility. A Non-Executive Director (RL) asked about the expected completion date for the agreement of new governance arrangements. There is no confirmed date; but completion was expected within three months. A further query arose from a Non-Executive Director (RL) who asked if SLIC patients were at a disadvantage clinically as a result of the delays and if there were any associated risks. It was clarified by the Executive Director of Finance and Resources there is no risk to the Trust and that SLIC continues to provide safe and effective services. With reference to the item on asset management, a Non-Executive Director (IE) referred to the ongoing asset tagging work and suggested this item be removed from the grid as it had been deemed to be a low risk. This was agreed by the Executive Director of Finance and Resources. Reference was made by the Chair of the Committee on the status of the quality governance assurance framework which had been replaced by the well-led framework. She requested that the content in the report be updated to include timescales and future references in reports to be made to the well-led framework. The Company Secretary advised that this item is being progressed at the 4 December 2015 Trust Board meeting. **Outcome:** The Committee received and noted the status of the report.	
2015-16 (29)	**External Audit** **External audit technical update** The paper was presented by the External Audit Assistant Manager. He drew the Committee's attention to one specific item within the report concerning the appointment of external auditor panels, processes and the timescales involved.	

	Guidance had been published by the Healthcare Financial Management Association (HFMA) and the Department of Health for NHS bodies who are required to appoint auditors for the financial year 2017/18. As these auditor appointments are required to be in place by 31 December 2016, the Trust will need to have its auditor panel in place early 2016 in order to commence the appropriate appointment processes. **Action:** The Executive Director of Finance and Resources to commence the required processes for external auditor appointments in order to meet the stipulated deadlines. The Chair of the Committee drew attention to the internal audit top 10 key risks which were to be reflected in next year's internal audit plan. It was confirmed by the Audit Director these key risks have been noted for inclusion in the plan. A Non-Executive Director (IE) asked how the Senior Management Team could obtain a sense of actions or priorities arising from this Committee. It was clarified by the Executive Director of Finance and Resources and the Company Secretary that the Senior Management Team are advised of key issues arising from the Board's committees. Following publication of new rules introduced from September 2015 by the NHS Trust Development Authority (TDA) and Monitor concerning agency expenditure, a Non-Executive Director (RL) drew attention to the new annual ceiling target being set for each trust for 2015/16 and the next financial year. It was advised by the Executive Director of Finance and Resources that agency expenditure had decreased significantly over the last two months. **Outcome:** The Committee received and noted the report.	**Executive Director of Finance and Resources**
2015-16 (30a)	**Counter fraud and security management** **Counter fraud progress report** The Local Counter Fraud Manager introduced the progress report; work undertaken being in line with NHS Protect standards and a work plan agreed with the Executive Director of Finance and Resources. The report summarises the work undertaken from 5 July 2015 to 5 October 2015. The Local Counter Fraud Manager brought to the Committee's attention the number of staff receiving counter fraud training, either through induction or other training, and that this had risen from 333 to 400 staff. Reference was made to current investigations and a case currently under review concerning sale of computer equipment formerly owned by the Trust. Investigations are ongoing with a meeting being held in due course with the seller in which the Executive Director of Finance and Resources will also be in attendance. The Chair of the Committee asked that a robust approach is taken during this investigation. Further confidential updates were provided to the Committee on several other investigations not involving counter fraud but recorded as incidents. In reply to a Non-Executive Director (RL) querying how counter fraud is promoted to staff, it was confirmed that the counter fraud service and the Local Counter Fraud Specialist's details were widely promoted through the Trust's website, training sessions and awareness posters.	

	Outcome: The counter fraud progress report was received and its contents noted.	
2015-16 (30b)	**Bribery Act 2010: risk assessment and top level statement** The Local Counter Fraud Manager introduced the paper and provided a summary of the Bribery Act 2010 and the Trust's compliance. A list of compliances and risk assessments has also been completed. The Local Counter Fraud Specialist said the Trust is considered as a low risk organisation. The Chair of the Committee asked if records of potential fraud were kept. The Local Counter Fraud Specialist made the Committee aware of the tracking manual used to record incidents including fraud details. A Non-Executive Director (IE) felt the organisation maybe assessed as a low risk, but would be a higher risk if there was greater dealings with pharmaceutical companies. The Local Counter Fraud Specialist made the Committee aware of the specialist training for clinicians who had involvement with pharmaceutical companies. The Committee endorsed the Bribery Act 2010 information, risk assessment and top level statement. It was also agreed to include information on the specific risk areas. **Action:** Information concerning the Bribery Act 2010, risk assessment, specific risk areas and the top level statement to be included in the Local Counter Fraud report with the information uploaded onto the Trust's website. **Outcome:** The Committee received and noted the contents of the report.	**Local Counter Fraud Specialist**
2015-16 (31a)	**Governance** **Information governance review** Darren Rigg, Head of Information Governance and Richard Slough, Head of Informatics, attended for this agenda item. The report informed the Committee of the work being undertaken on the Information Governance (IG) toolkit. The report provided an assessment of progress in IG work and summarises the IG toolkit submission and compliance. The majority of scores are expected at level 2 but one requirement, relating to training, will only be completed at level 1 resulting in an overall projected level 1 rating as at 31 March 2016. The current position on training numbers for IG training across the Trust needs to be improved from the submitted score of 67%, reported in 2015, to 95% for all staff, including agency and locums. The Head of Informatics said the new target for training from 1 April 2015 to 31 March 2016 was believed to be unachievable; the target should be achieved in 2016/17. Additional proactive work in order to meet the target is to be undertaken. The Committee was provided with an update on the data breach which had occurred in August 2014. As a result of the breach, the organisation had recently been requested by the Information Commissioner's Office to sign an undertaking. The undertaking will specify that all staff, including agency and locum staff, will be required to undertake IG training within a twelve month	

	period. The previous IG training requirement had been once every three years. The resource and financial implications were highlighted. The Committee was advised that the risk of not complying with the undertaking could potentially result in a financial penalty for the Trust. The Trust's responsible officer is the Chief Executive. A Non-Executive Director (RL) noted the potential significant exposure of non-compliance for the Trust. A Non-Executive Director (IE) asked whether the 95% target would take into account staff on long term sickness absence or maternity leave. The recent changes in agency staff rules were noted and it was the immediate line manager and agencies responsibility to ensure agency staff receive appropriate training. Awareness to complete training was promoted through team meetings, newsletters and the intranet. This should not only be for information governance training but all future statutory and mandatory training. The Chair of the Committee asked at what stage had the Trust been notified of the new IG training timescales. This was confirmed by the Head of Information Governance as being April/May 2015. A Non-Executive Director (RL) referred to (resource requirements) and the implications of failure in not meeting the targets. The Head of Information Governance and Head of Informatics advised of the training implications of training over 3000 staff annually and the impact this would have on resources. The methods by which IG training could be completed were discussed and confirmed as either face to face or on line processes. The timescales for completing face to face training for over 3000 staff was not felt to be viable and the preferred option would be through e-learning which takes approximately 30 minutes completion time. It was confirmed that a national IG training e-learning model is in place. Effective processes for promoting on line training to staff would be required. The Executive Director of Finance and Resources said the organisation needs to look at the best way forward to carry out training, in order to meet the timescales and targets. A Non-Executive Director (IE) said the organisation needs to review not just the IG training requirements but the whole training approach. The IG training is classified as statutory and mandatory training and can be carried out as part of staff induction. As there are over 3000 current staff who are required to undertake the training, there is an urgency to take immediate action. An action plan with deadlines and timescales to be set, conversations to take place with the Director of Workforce and the training team. The item to be brought back to the 11 December 2015 Audit Committee meeting.	

	The Chair of the Committee asked that, prior to the undertaking being signed, the Audit Committee review the formal letter and timescales once received from the Information Commissioner's Office. **Action:** The Director of Workforce to be advised of outcomes from discussions from this meeting. The item to be brought back to the 11 December 2015 Audit Committee meeting. **Action:** The Audit Committee to review the formal letter and timescales once received from the Information Commissioner's Office. **Outcome:** The Committee noted the contents of the report.	**Company Secretary** **Executive Director of Finance and Resources**
2015-16 (31b)	**Non-compliance with standing orders and standard financial instructions** The Executive Director of Finance and Resources advised there were no items of non-compliance to report.	
	Financial focus	
2015-16 (32a)	**Tender and quotations waiver report** The Executive Director of Finance and Resources introduced the report. The report presented an extract of the 2015/16 register of waivers which had been completed since the last Audit Committee meeting held on 24 July 2015. The report provided assurance on the procurement processes with the Trust. Several of the entries around continuation of contracts for service were queried in terms of whether they should be included on the register. The Executive Director of Finance and Resources advised that assistance had been sought from the internal auditors for clarity on those items. A Non-Executive Director (RL) referred to the previous discussion held in the meeting with reference to the Bribery Act 2010 and drew attention to the risk around quotations not being required for purchases under £20,000 but quotations to be obtained for spend between £20,000 and £50,000. It was noted there is one item on the register under £20,000 at a value of £13,720. The Chair of the Committee asked that requisition approval routes with correct levels of approval are made and for the Committee to receive full assurances for those waivers in future reports. **Action:** The Executive Director of Finance and Resources to further liaise with the Director of Audit on waiver register entries. **Outcome:** The Committee received and noted the report on tender and quotations waivers.	**Executive Director of Finance and Resources**
2015-16 (32b)	**Losses, claims and special payments report** The report and register was presented by the Executive Director of Finance and Resources. The report covered payments made from July 2015 to September 2015 covering four items to a value of £493.00. The report provided assurance to the Committee on the use of public funds and safeguarding of assets. The Chair of the Committee referred to the two South Leeds Independence Centre (SLIC) entries concerning loss of personal property and asked if the Executive Director of Nursing is aware of these two entries on the register.	

	Action: The Executive Director of Nursing to be advised of these entries by the Company Secretary. **Outcome:** The losses, claims and special payments report containing four items was received by the Committee.	**Company Secretary**
2015-16 (33)	**Audit Committee work plan** The paper and draft revised work plan was presented by the Company Secretary. The July 2015 Trust Board meeting had approved the outcome of a review of the frequency of Board and committee meetings. It was reported that new proposed committee annual work plans which incorporate these changes are currently being developed. These work plans will support the new frequency of meetings to ensure an appropriate and timely flow of business. The newly revised Audit Committee work plan will be regularly updated and included in the papers for future Audit Committee meetings. The Chair of the Committee asked if the items on the work plan were unchanged as in the previous work plan. The Company Secretary advised of one new included topic on the work plan which is legal activity and expenditure. The Chair of the Committee queried the annual governance statement and the going concern statement items and, as they are both draft statements, if they should be progressed at two meetings (February and April). It was clarified by the Company Secretary both draft statements, once agreed by the Audit Committee would be progressed to the Trust Board for final approval. The Director of Audit requested the Head of Audit opinion and the annual audit plan is a twice yearly frequency in February and April. The draft reports to be progressed to the Audit Committee meetings in February and April 2016. **Action:** Amendments, in line with discussions and agreement made by the Committee, to be made to the work plan. **Outcome:** The Committee noted the report and new Audit Committee work plan.	**Company Secretary**
2015-16 (34)	**Matters for the Board and other sub-committees** The following items were identified as matters for inclusion in the Committee Chair's assurance report for consideration by Board members. • Sickness absence management processes • 2016/17 external auditor appointment and processes • Bribery Act 2010, risk assessments and top level statement • Information governance toolkit annual self-assessment and training compliance.	
2015-16 (35)	**Any other business** There was no further business transacted.	
	<u>Date and time of next meeting</u> Friday 11 December 2015, 9.00am – 11.30am, Boardroom, Stockdale House.	

Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM
2015/16
(111b)

Quality Committee
Monday 23 November 2015
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Neil Franklin	Trust Chair (Items 60 – 63b)
	Prof Ieuan Ellis	Non-Executive Director
	Marcia Perry	Executive Director of Nursing
	Thea Stein	Chief Executive
In Attendance	Sam Prince	Executive Director of Operations
	Caroline McNamara	Clinical Lead for Adult Services
	Maureen Drake	Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience
	Karen Worton-Smith	Clinical Lead for Children's Services
	Richard Chillery	Clinical Lead for Specialist Services and Vulnerable Groups
	Florence McDonagh	Associate Medical Director (Item 74e)
	Caroline Schonrock	Business Planning Manager (Items 71 - 73d)
	Vanessa Manning	Company Secretary
	Elaine Goodwin	Professional Lead for Nursing (Items 72 – 81)
	Lynne Leech	Lead for Quality (Item 72)
	Nikki Stubbs	Clinical Pathway Lead, North 1 Neighbourhood Team (Item 72)
	Jacqui Tunnard	Neighbourhood Team Co-ordinator, Meanwood (Item 72)
	Philippa Roberts	Community Staff Nurse (Item 72)
	Sharon West	District Nurse Team Leader, Yeadon Health Centre (Item 72)
	Sarah Haygarth	Lead for Quality, West 2 Neighbourhood Team (Item 72)
Minutes	Lisa Rollitt	Personal Assistant to the Executive Medical Director
Apologies	Dr Amanda Thomas	Executive Medical Director

Item No	Discussion Item	Actions
Welcome and introductions		
2015-16 (71a)	**Welcome and Apologies** The Chair opened the meeting. Apologies were received from Dr Amanda Thomas.	
(71b)	**Declarations of Interest** There were no declarations of interest received.	
(71c)	**Minutes of meeting held on 26 October 2015** The minutes of the meeting were reviewed for accuracy and agreed.	
(71d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log.	

	2015-16(43b): Serious incident report: Clinical Governance Manager to review incidents and timescales for actions It was agreed to close the incident as it would be picked up in the Experience, Incident and Learning Group. 2015-16(51a)(iv): Integrated performance report (quality issues): Clinical Lead for Adult Services to share the information from the Safety Congress to the experience, incident and learning group The timescale was revised to January 2016. 2015-16(51c): QGAF self-assessment: migration to well-led framework: Foundation Trust Programme Manager to prepare a proposal to be approved at SMT that the Quality Committee will receive individual papers which link to quality areas of the Well-Led Framework as part of the oversight process The timescale was revised to January 2016. 2015-16(52b): Pressure ulcer report: Professional Lead for AHP and Head of Patient Experience to investigate the figures in relation to unstageable pressure ulcers increasing to Category 3 or 4 reported in the IPR It was agreed to close the action as it would be reported in the Director of Nursing report. 2015-16(56d): Mortality Surveillance Group minutes: 17 July 2015: Executive Medical Director and Executive Director of Nursing to establish a process to address the recording and sign off of death with DoLS and discuss how DoLS will sit within the Safeguarding Committee remit The Executive Director of Nursing confirmed a process had been agreed and would be disseminated. It was agreed that the action was complete.	
2015-16 (72)	**Service spotlight: Adults** Team members from Meanwood and Yeadon Health Centres joined the meeting and everyone introduced themselves. The Executive Director of Nursing explained the reasons for having a service spotlight and confirmed that this month, the subject would be pressure ulcer incidents. Each team gave an overview of their work, thoughts, progress and challenges in relation to pressure ulcer incidents from 1 September 2015 to 31 October 2015. A Non-Executive Director (IE) stated that there were a number of factors identified that could be correlated into the reasons for the number of pressure ulcer incidents and asked if there were any emerging trends which would indicate that those factors were impacting on the figures reported. The Clinical Pathway Lead, North 1 Neighbourhood Team stated that the increased awareness had resulted in an increase in the number of incidents reported more readily and frequently. The Chief Executive stated that she was aware of the pressure on the teams and asked if there was anything which could be done to help with this. It was identified that more cameras needed to be available to staff. The Chief Executive stated that this was an issue that had been identified and options were being reviewed. It was noted that electronic referrals were not being used in all areas. There were still areas where referrals are sent by fax. **Action: Executive Director of Operations to check which sites are using electronic referrals with a view to ensuring all sites are using the facility.**	

	The Trust Chair queried what was specifically required in terms of the leadership from Band 6 staff. The Clinical Pathway Lead, North 1 Neighbourhood Team stated that the aim was for all Band 6 staff to know every complex patient on their caseload and ensure that they had visited each of these patients. Given the amount of patients, it was felt that this was not achievable. The Trust Chair acknowledged the workload issues but stated that Band 6 staff were supported by community nurses who completed the visits, and questioned if the leadership role was more about how they used their team to ensure they were sighted on issues of risk rather than personal intervention. The Clinical Lead for Adult Services stated that it was a complex situation which was not in the Trust's control, as patients were being brought into the service with pressure ulcers. In addition, it was noted that there was an increasing proportion of patients who wished to stay at home to receive end of life care. It was acknowledged that a more rigorous discharge plan process from acute trusts was needed and that the correct equipment should be in place. The Chair referred to caseload management and handover process and queried if both teams across the city were working in the same way. It was asked if there was a requirement for any further support. It was noted that there were methods of prioritising caseloads in place and that the process was still in the design phase. The Clinical Pathway Lead, North 1 Neighbourhood Team stated that it would be ideal to have a wound prevention management nurse in post which would release capacity in current caseloads. The Chair thanked the teams for their attendance. The teams from Meanwood and Yeadon left the meeting and the Chair asked the committee to reflect on the item. The Trust Chair stated that development was required. It was noted that although the service spotlight item needed to be conducted constructively, it was important that services were held accountable. The Chief Executive agreed but felt it was important to ensure that there was a balance and that the Committee should ask the teams how they felt issues could be improved. It was noted for future items that a paper in advance of the meeting would be beneficial. **Action: Executive Director of Nursing and Chair to provide written feedback to the teams.**	**SP** **MP**
Quality Governance		
2015-16 (73a)	**Integrated performance report (quality issues)** A full report was provided but it was agreed that the focus would be on the safety, caring and effectiveness domains. The Executive Director of Nursing referred to the percentage of Venous Thromboembolism (VTE) assessments and highlighted that the issue with the timeliness of assessments had been picked up with outstanding assessments being completed within 24 hours. A standard operating procedure had been implemented. The Chair referred to VTEs and queried the figures stated on the cover sheet and the figures stated further in the report, which were different. It was noted that the discrepancy was due to the timeliness of the data submission in the report and the Executive Director of Nursing confirmed that the figures stated on the cover sheet	

	were correct. The issue of discrepancy would be addressed in future reports.	
(73b)	**Director of Nursing: quality and safety report** The Executive Director of Nursing presented the report and highlighted the information presented under incidents, medication, duty of candour, safety thermometer, pressure ulcers, infection prevention, friends and family test, revalidation and safeguarding. It was agreed that the report was very comprehensive and the clinical perspective was appreciated, however too much information was included and it was important to acknowledge that there was not an expectation that all issues would be discussed at Quality Committee. This would be reflected in future reports. The Trust Chair asked the Executive Director of Nursing to consider how to identify the areas of weakness, performance and risk that would need to be addressed by the Board. The Executive Director of Operations stated that the report was also reviewed at the Senior Operations meetings where issues would be discussed in more detail. The Clinical Lead for Adult Services referred to the safety thermometer and stated that the response rate would be improved if the sample size was increased and that action had been taken to increase the number of patients sampled. The Chair referred to pressure ulcers and asked if there was further work needed in relation to caseload management and handovers. The Executive Director of Nursing confirmed she was satisfied that work was progressing to assist the issue; she confirmed that a new policy was being drafted for consideration at Quality Committee in March 2016.	
(73c)	**Quality account** The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience presented the paper and identified two outstanding priorities of concern as protecting patients from harm and staff wellbeing. The Chief Executive stated that a paper was to be presented at Business Committee on 25 November 2015 with regard to health and wellbeing interventions. It was noted that the number of staff currently off work with stress was not higher than expected but was similar throughout the health service. The Chair asked for assurance on progress with regards to outcomes and learning lessons. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience confirmed that progress was on target. The Trust Chair referred to the Well-Led item and stated that the Board would expect to see a link between delivery and outcomes next year. The Chair referred to the delay in uploading complaints information onto the Trust website, and asked the Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience if she was confident that the Trust had the means to complete this task. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience updated the Committee on the resource in place within the complaints department and assured that this task would be completed within timescale.	

	The Committee was content with the timeline presented with progress against priorities to be brought to Quality Committee in January 2016. **Action: The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience to present progress against priorities and priorities for quality improvement in 2016/17 to Quality Committee in January 2016**	**MD**
(73d)	**Quality improvement plan** The Business Planning Manager presented the paper and highlighted that the CQC re-inspection would not take place before April 2016 unless their assessment of risk was escalated. The focus of the inspection would be on the aspects of greatest risk. The Business Planning Manager confirmed that all actions relating to the Community Intermediate Care Unit (CICU) for the period that it would be managed by Leeds Teaching Hospitals NHS Trust (LTHT) had been removed from the plan. The Chair referred to the request for an extension of timescale on action 10: Community Dental Service infection prevention training, and queried why the extension to 23 December 2015 was required. The Business Planning Manager explained the reason for the request. The Chair referred to the request for an extension of timescale on action 25D: Trust-wide: improvement of appraisal rates, and stated that this would be discussed at the Business Committee. The Committee accepted the extension requests and noted the progress.	
Safety		
2015-16 (74a)	**Serious incidents report** The Executive Director of Nursing presented the report and stated that there were ten serious incidents reported in October 2015, all were within the Adult Business Unit. The Committee sought more detailed assurance from the executives that there was confidence that extensions to dates would be met. The report continued to provide only limited assurance that the Trust was operating effective systems and processes in relation to serious incidents' management. The Chair stated that there was a discrepancy in the progress and timescale data. The Executive Director of Nursing would investigate the data to address the discrepancy issues. **Action: Executive Director of Nursing to investigate the progress and timescale data to address discrepancy issues**	**MP**
(74b)	**Serious incidents themed report** The Executive Director of Nursing presented the report and highlighted that there were 48 incidents meeting the serious incident criteria during the period from 1 April 2015 to 30 September 2015. 77.1% of the serious incidents related to category three pressure ulcers. The Trust Chair referred to falls resulting in a Fractured Neck of Femur at South Leeds Independence Centre (SLIC) where it was highlighted that the standard operating procedure had not been followed, and asked about the actions arising from this. The Clinical Lead for Adult Services stated that the Falls Reference Group had recommended that within 12 hours of admission, a formalised risk assessment would be completed and this had been implemented. The Executive Director of Nursing	

	stated that a staffing model for SLIC had been agreed with the Commissioners. A Non-Executive Director (IE) stated that when he had visited SLIC, he noted that there were no therapy staff on duty after 15.30 and queried how that would impact on completing the risk assessment within 12 hours of admission. The Clinical Lead for Adult Services stated that she was working with the Executive Director of Nursing to review how therapy time was dedicated in SLIC. The Committee had limited assurance as there was a significant work plan in place but commended the report for the inclusion of good practice and areas for improvement.	
(74c)	**Incidents: learning** The Executive Director of Nursing presented the report and stated that the Executive Medical Director had led a significant programme of work to cleanse the backlog of open incidents. The key finding was the need for the Learning from Incidents and Experience Group which had been established under the Executive Director of Nursing. In addition, the three clinical leads would be sent a monthly report on incidents to enable improved review, action and trend analysis. The Committee noted the positive reporting culture in the Trust. The Trust Chair asked for clarity on who would be responsible for the delivery of the actions identified. The Executive Director of Nursing confirmed that she is working with the Clinical Lead for Adult Services to identify capacity in each team and to assess how the triumvirate review open incidents on a weekly basis. **Action: Executive Director of Nursing to provide an update including a matrix of ownership in the Director of Nursing report to the Committee in January 2016.**	**MP**
(74d)	**Risk register: clinical risks** The Company Secretary presented the paper. The Committee noted that there were 31 clinical risks (including three new risks) with a current score of 8 or above across the business units and corporate services as at 9 November 2015. The new risks were in relation to non-delivery of the childhood immunisation programme, children's dietetics services and diabetes services backlog waiting list for podiatry. The Committee noted that further discussion regarding the new risks was scheduled for the next Senior Operations meeting. The Chair referred to risk management training and stated that he was surprised that this was not part of the Trust Induction. The Company Secretary confirmed that this had been reinstated from January 2016. The Trust Chair referred to ID 705: Difficulties recruiting to district nursing posts; and queried how many of the 47 newly recruited nurses had been retained. The Chief Executive stated that Director of Workforce was aware of the individuals who had not been retained and wished to assure the Committee of the level of monitoring being undertaken. The Chair referred to ID 751: Estates, and asked if the risk in CICU was allocated to LTHT. It was confirmed that this was correct and the risk would be suspended from the Trust's register. The Chair referred to ID 797: Risk of health visiting service level agreement not being delivered due to clerical support capacity; and asked from where the risk had arisen. The Executive Director of Operations attributed the risk to the introduction of the	

	Electronic Patient Record (EPR) and the requirement for clinical staff to undertake more clerical tasks. A response to the risk was under review. The Trust Chair referred to ID 644: CAMHS waiting list: system efficiencies in development; and asked if this was being progressed. The Executive Director of Operations confirmed that the issue was being progressed with actions around better referrals and caseload. It was recognised that a culture shift was required for clinicians to manage their workloads with a view to better productivity. The Committee felt that current systems and processes for managing risks provided limited assurance and recommended that an update be provided after the Senior Operations meeting.	
(74e)	**Medical Child Protection report** An Associate Medical Director (FM) presented the paper. The committee agreed to close the reporting process to the Quality Committee.	
Clinical Effectiveness		
2015-16 (75a)	**Outcome measures** The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience presented the paper which provided an overview of work to date on the development of service level outcome measures and identified the next stages of development. It was noted that each business unit had nominated three service areas who would commence with taking the work forward in January 2016 with an initial dashboard and report to Quality Committee in April 2016. It was recognised that there was further work to be completed in terms of capacity, prioritisation and developing links with the research strategy and academic partners. The Chair stated that due to capacity, this piece of work would never be rapid. It was noted that clarity was required of what could be achieved in the next six months, plus six months following and what the services were reporting. A Non-Executive Director (IE) stated that the vision should encompass Leeds, not just the Trust and that there was a lot of resource and expertise within the city. **Action: Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience to provide an update at the Committee in January 2016 with an initial dashboard available from April 2016**	**MD**
(75b)	**Patient group directions** The Committee ratified all the patient group directions presented.	
Patient experience		
2015-16 (76a)	**Complaints thematic analysis** The Executive Director of Nursing presented the paper which highlighted that during the period from April to September 2015, the Trust received 128 complaints and 231 concerns. The Committee noted that the top three categories of complaints related to clinical treatment, appointments and staff attitude. The report was broken down by business unit enabling the Committee to drill down.	

	The programme of work in training was noted and it was agreed that the Complaints Manager would implement an investigator pack to ensure learning from outcomes could be shared and reported upon, and complaints and concerns would be picked up as part of the Managers and Leads Development Programme. The report was felt to provide significant assurance that satisfactory processes were in place. **Action: Trust Chair to review a random sample of complaints with the Executive Director of Nursing**	**MP**
External reports		
2015-16 (77)	There were no reports received.	
Policies, reports, minutes for approval and noting		
2015-16 (78a)	**Service review quality impact assessment: Falls** The paper was received for information.	
(78b)	**Board members' service visits** The paper was received for information. A Non-Executive Director (IE) queried how feedback would be received on the progress of actions. **Action: Chief Executive, Executive Medical Director and Executive Director of Nursing to review mechanism to feedback progress on actions**	**TS**
(78c)	**Clinical policies approved at CCP panel** There were no clinical policies to approve.	
(78d)	**Health, Safety and Experience Governance Group minutes: 30 October 2015** The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience presented the paper. There were no further comments.	
(78e)	**Clinical Effectiveness Group minutes: 29 October 2015** The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience presented the paper. There were no further comments.	
Quality Committee work plan		
2015-16 (79a)	**Items from work plan not on agenda** Nothing to report.	
(79b)	**Future work plan** The work plan was included for information. The Chair referred to the Well-Led Framework and queried the timeliness of the Quality key performance indicators (KPIs). The Company Secretary stated that the indicators would be signed off in in March 2016 as part of the business planning process.	
2015-16 (80)	**Matters for the Board and other committees** It was agreed that the Chair and the Executive Director of Nursing would summarise the matters for the Board.	

2015-16 (81)	**Any Other Business** There was no other business.	
	<u>Dates and Times of Next Meetings (09:30 – 12:30)</u> **Monday 25 January 2016 (confirmed)** **Monday 22 February 2016 (confirmed)** **Monday 21 March 2016 (confirmed)** **Monday 25 April 2016 (confirmed)** **Monday 23 May 2016 (confirmed)** **Monday 20 June 2016 (confirmed)** **Monday 25 July 2016 (confirmed)** **Monday 26 September 2016 (confirmed)** **Monday 24 October 2016 (confirmed)** **Monday 21 November 2016 (confirmed)**	

Leeds Community Healthcare NHS
NHS Trust

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 25 November 2015 (9.00 – 12.00 noon)

Agenda Item 2015/16 (111c)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Robert Lloyd	Non-Executive Director (RL)
	Tony Dearden	Non-Executive Director (TD)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sue Ellis	Director of Workforce
Attendance:	Sam Prince	Executive Director of Operations
	Vanessa Manning	Company Secretary
	Emma Fraser	Director of Strategy & Planning
	Arifa Chakera	Transformation Programme Manager
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2015/16 **(62)**	a) **Apologies**: None recorded b) **Declarations of Interest**: None recorded. c) **Minutes of last meeting:** The minutes of meeting dated 28 October 2015 were approved by the Committee subject to amendments on pages 1 and 3 as follows: <u>Item 2015/16 (44)</u> – **IPR (medication incidents in prisons)** The Executive Director of Operations assured the Committee that the *pharmacy team in the prison* service was now fully staffed. Item 2015/16 (54d) **- Non-reportable waiting times** The Executive Director of Operations highlighted the areas to consider. She said currently there were two breaches *of reportable waiting times* in month and assured the Committee that these did not present any clinical concerns. d) **Matters arising and review of actions:** • <u>Item 2015/16 (53a)</u> – *Estates strategy review* The Executive Director of Finance & Resources reported that the plan is to review the estates strategy in May 2016 in line with the citywide estates strategy being developed. He said it was a requirement of Clinical Commissioning Group (CCG) to have the estates strategy for primary and community estates at first draft stage. • <u>Item 2015/16 (54a)</u> – *Analysis of turnover in corporate services* The Director of Workforce reported that turnover for last 12 months was 20% in corporate services. She said turnover was high in finance and quality and professional development departments, and majority of those leavers were voluntary resignations. • <u>Item 2015/16 (54d)</u> – *Non reportable waiting list* The Executive Director of Operations was asked to report back on the actions taken at the next meeting in January 2016.	BM SP

2015/16 **(63)**	**Performance Reports** **a) Integrated Performance Report (IPR)** The Executive Director of Finance & Resources introduced the IPR and referred to the key performance concerns. The report had been reviewed at the Quality Committee on 23 November 2015. A Non-Executive Director (TD) highlighted issues considered at the meeting in pressure ulcers and venous thromboembolism risk assessments. **The Chair noted the following:** • Concerns in the safe cohort that only four measures out of sixteen were indicating to forecast achievable target at end of year. • Concerns with fluctuating figures showing against the child measurement indicator. • A number of charts and graphs in the well-led section were without year to date figure or end of year projections. • The friends and family test had no year to date target figure. • Complaints responses were missing data. • Good progress in over 18 weeks non-reportable activities. • Sickness absence; management not delivering formal/informal stage meetings and not undertaking consistently return to work interviews. • The monitoring of black minority and ethnic people in leadership and key roles in the Trust was welcomed. The Director of Workforce responded to say that some of those were quarterly measures and would not be populated until April 2016. A Non-Executive Director (TD) said that a high number of reds were related to pressure ulcers which had been scrutinised by Quality Committee. The Executive Director of Operations added that the child measurement data would get better as the schools progressed through the academic year, and assured the Committee that there were no particular concerns at this time. The Chief Executive said that she was assured by the Executive Director of Nursing that it would take up to six months to see a real difference in figures for pressure ulcers. A plan was in place and work was continually monitored by the Quality Committee. In response to a Non-Executive Director's (RL) question about resource constraints impeding the improvement of pressure ulcer incidence, the Chief Executive said that the senior management team was looking at costings of providing new mobile phones to front line nurses. She said there was evidence suggesting that nurses needed to have better mobile phones with cameras to take pictures of wounds and to have the ability to link that picture back to wound management team specialists. The Executive Director of Operations said that the frustration was not cost but better uses of resource ensuring patients were seen on a regular basis as part of caseload management. The Executive Director of Operations said that the area she was most concerned about was waiting times in Child and Adolescent Mental Health Service (CAMHS). She said since the last meeting a task force had been set up as reported in the narrative. A dash board is reviewed regularly by SMT. The Executive Director of Operations said that the data presented had now broken down with each team showing in detail the current level of demand, referrals and waiting patients. She said although the service was in a better position but there are still concerns about productivity levels. An activity target had been set for each practitioner and is carefully monitored. The Executive Director of Operations felt that the service can manage the waits within the resource allocation.	

	The Executive Director of Finance & Resources noted that steps were being taken to improve the waiting times. Further discussions would take place outside the meeting between the Executive Director of Finance & Resources and the Executive Director of Operations.	BM
	A Non-Executive Director (RL) queried the narrative in the IPR stating that four patients had been waiting for more than 40 weeks for treatment. The Executive Director of Operations agreed to find out the reasons. She said that enquiries were being undertaken to make sure everybody who was waiting still wanted to be seen in the service.	SP
	Staff appraisal performance showed deterioration since September 2015 and it remained below target. The Director of Workforce said that SMT would give consideration to how far out of date the appraisals were and will provide a more incisive feedback at the next meeting in January 2016. The Executive Director of Operations reported that at the performance panel meeting on 24 November 2015 an action was agreed that if the situation did not improve by December 2015 she would be asking to see every service manager and clinical lead.	SE
	The Director of Workforce asked the Committee to note the workforce equality target. The proposal was to concentrate on bands 1 to 4 in the first instance.	
	The Chair summarised the discussion and said the conversation around safety reflected issues with pressure ulcers and be noted a comprehensive plan of action was in place. The Committee also reflected on the time line and considered bringing that forward.	
	The Committee was assured that there was fundamental cause for concern in the waiting times, and noted input from the Executive Director of Finance & Resources, the Executive Director of Operations and a Non-Executive Director (RL) about data accuracy, monitoring and a focus on the most challenging areas.	
	b) Financial position 2015/16 The Executive Director of Finance & Resources reported that the financial position had improved and that he was forecasting that the stretch target would be achieved. It had been identified that Leeds Teaching Hospitals Trust had over charged Leeds Community Healthcare for pathology tests associated with the integrated sexual health service which would make a significant difference to the forecast yearend figure.	
	A paper was tabled to show the actual expenditure in the last three months compared with the forecast outturn. The Executive Director of Finance & Resources was pleased to say that the action taken at end of last three months had had an impact on reducing non-pay expenditure in those areas where it was intended to work.	
	c) Planned activity review The Executive Director of Finance & Resources presented a brief paper for the Business Committee to understand the Trust's plans for reviewing activity variances from plan. The paper detailed the ongoing work concerning district nursing and intermediate care activity variances. The analysis in the paper provided the background material for members, comprising the analysis that had been shared with the CCG. The analysis of district nursing activity remained inconclusive and work continues.	

	The Executive Director of Finance & Resources said that an internal audit was currently being undertaken, looking at activity recording. The work of the audit was expected to conclude over the next few weeks. A report will be presented to the Business Committee when the work is complete.	BM
	d) Neighbourhoods' report The report highlighted the capacity position across the adult neighbourhood teams in October 2015. The Executive Director of Operations drew attention to the unallocated vacancy line in the report and said as new staff were being taken on they were allocated to individual teams. The funded establishment set for the new neighbourhood teams had to be changed to match budgets. Further clarity would be provided at the next meeting in January 2016.	SP
	e) Neighbourhoods in depth report – Wetherby, Beeston and Morley It was reported that Beeston is a team which had faced considerable difficulties in terms of vacancy and sickness absence at leadership level. The Executive Director of Operations said that the situation had now improved with reduced sickness and better demand and capacity management. She referred to the action plan in the report and said the plan had made the service more stable in recent months. The Wetherby team had additional investment from Commissioners to focus on the elderly population which had reduced caseload sizes. The Executive Director of Operations said that this team was low in terms of resource but still achieved against most of the indicators. The Executive Director of Operations reported that the Morley team was 80% down on capacity due to sickness absence and unfilled vacancies. The team repeatedly sought extra capacity from other areas. A Non-Executive Director (TD) commented on discussions at Quality Committee relating to pressure ulcers. He said that the Business Committee paper confirmed his view that there are clearly differences in the handover methodology the teams are using, and a significant variance on caseload management approach. The Executive Director of Operations said that teams are working together to agree on the best way of handing over in terms of caseload size, clinical judgement, risk tolerance and leadership. A Non-Executive Director (TD) noted that Woodsley neighbourhood team had relatively high sickness absence, high number of agency and low fill rate. The Executive Director of Operations said that she was spending some time with the team on 26 November 2015 and can provide an update at the next meeting in January 2016.	SP
	The Chair said that the view of the Committee is that most of the actions are falling behind. He said this does not provide the assurance that the Committee requires. The Chief Executive assured the Committee that this work was active operationally and was being considered by the Executives. It was agreed that the Executive Director of Operations and the Chief Executive would meet and deicide on the best way it would be reported to the Committee in January 2016. It was highlighted that the Committee received limited assurance in terms of progress in this area of delivery.	TS

	f) Retention initiatives The Director of Workforce provided a verbal update following on from the retention paper presented at the last meeting, comments were received that it had far too many actions. The action plan will now focus on the key actions. Retention had now been entered on to the risk register and would be presented to the Trust Board meeting on 4 December 2015. **g) Sickness absence** The paper detailed the initiatives since the establishment of health and wellbeing steering group and health and wellbeing support team in September 2013. There was a request by the Business Committee whether the initiatives could provide a return on the investment. The Director of Workforce said the paper describes initiatives but had difficulties in capturing the return on investment. The Chair noted that the paper described reducing staff sickness absence and making cultural organisational changes but he said the year to date sickness absence rate was 5.3% and in the past month it had risen to 6.2%. A Non-Executive Director (RL) said that the paper was very much input driven and did not describe outputs or outcomes. The Director of Workforce said that the recent internal audit report highlighted some of the issues raised in the meeting today and therefore she would be concentrating on getting the steps of the process tighter and consider other factors outside the meeting. The Chair said that it was the responsibility of the Committee to say whether it had received assurance on this programme of activity delivering for the organisation's needs. He indicated that the current report only provided limited assurance. The Chief Executive said most Community Trusts experience sickness levels similar to Leeds Community Healthcare NHS Trust. She said a Board workshop in January 2016 is scheduled to focus on workforce topics including staff sickness. A Non-Executive Director (RL) said that it might be valuable to look at membership of the health and wellbeing group. He said the operations contribution was very low and suggested leaders who have the accountability for delivering objectives for sickness and turnover should be included.	
2015/16 **(64)**	**Business and commercial development –** Please see private minutes	
2015/16 **(65)**	**Business cases –** Please see private minutes a) Workforce Management (e-rostering) Procurement b) IT support services update c) Leeds MindMate – single point of access (SPA)	
2015/16 **(66)**	**Operational plan 2015/16** – midyear update The midyear review and priorities for the remainder of the year was presented by the Director of Strategy & Planning, the focus of which had been scrutinised throughout the year.	

	The Committee was asked to comment on some of the key time scales around the planning process for next year. The Chair said that reflecting on the rest of this year he would like to see a focussed approach on sickness absence and staff appraisal.	
2015/16 **(67)**	**Financial management -** Reference costs 2014/15 The Executive Director of Finance & Resources introduced the reference cost paper. The results had not formally been published for the Trust's index of 98 for 2014/15. The Trust was 2% cheaper on average in comparison to other providers. The main driver of the reduction in the overall index for 2014/15 had been the national inclusion of intermediate care teams. A Non-Executive Director (RL) said the reference costs were very informative and he was pleased to note that the Trust met the target. He asked about the prison services and how that would impact on the Trust and how that would feed into plans for next year. The Executive Director of Finance & Resources said that the loss of prison service would improve the overall reference costs position. He said the wider consideration would be the loss of corporate overheads contribution. The plan was to use reference costs information and to consider how to target resource utilisation in the organisation as a whole and how to target future CIPs. A Non-Executive Director (RL) asked that reference costs be mentioned at the business planning meeting on 4 December 2015. An update would be provided at a subsequent meeting on reference costs following activity review.	BM
2015/16 **(68)**	**Risk register -** Non-clinical risks register 8+ The Company Secretary presented the risk register. This month showed one extreme risk of over 15 which would migrate into the Board report; this related to staff sickness absence. In the non-clinical risks for Business Committee there were three new risks reported this month. The paper also recorded a significant cleanse of under 8 risks on the register. The Executive Director of Finance & Resources clarified the risk registered against 794 relating to lack of suitable estate for neighbourhood teams. He said work was continuing to look to accommodate clinical staff where accommodation was needed in clinical buildings. An estates project was underway. A paper on estates and neighbourhood approach would be provided in January 2016 meeting. The Executive Director of Operations and the Executive Director of Finance & Resources agreed to amalgamate estates issues into the neighbourhood report for January 2016 meeting.	SP
2015/16 **(69)**	**In depth review** – project management office (PMO) The Chair welcomed the Transformation Programme Manager who delivered a PowerPoint presentation to provide an overview of the project office, summary snap shot of projects undertaken over the last two years and future work plan. The programme management office was set up in 2013/14 to support existing cost improvement projects. In 2014 the service reviews had started and the	

	focus was to look at financial efficiencies. In 2014/15 the PMO covered project management training, corporate reviews, working with finance colleagues to develop business cases and also continued to support service reviews. The Executive Director of Operations said that there are clear priorities for the PMO covering key objectives which are considered and agreed by the senior management team. A project is usually aligned to a responsible Executive Director and a project sponsor. The Chair thanked the Transformation Programme Manager for the presentation.	
2015/16 **(70)**	**Business Committee work plan** **a) Items from work plan not on agenda** **b) Future work plan** The Committee acknowledged the work plan.	
2015/16 **(71)**	**Matters for the Board and other Committees** The Chair reflected on today's discussion as follows: • The Business Committee would work alongside Quality Committee to bring the timeline down from six months to earlier resolution on pressure ulcers. • Waiting lists – the Committee received assurance on a number of aspects of the waiting list and around CAMHS issues. Some measures were being considered that might help to progress better. • Neighbourhood teams – the Committee recognised work that was developing positively but still had limited assurance on outcome. • Sickness absence and health and wellbeing – there was reservations about outcomes and benefits. • Finance information was received about efficiency measures which had had a significant impact on expenditure. • Business cases – private discussion for approval.	
2015/16 **(72)**	**Any other business** The Executive Director of Finance & Resources will be asking the Committee before the next meeting by email to approve a capital spend on one item for speech and language therapy in line with the investment policy. The equipment totalled £136k which was outside the limit of SMT.	

Leeds Safeguarding Children Board

Agenda item 2015/16 (111d)

LSCB Board Meeting
19 November 2015

Mark Peel	LSCB Independent Chair
Sal Tariq	LCC, Chief Officer, CSWS
Superintendent Sam Millar	West Yorkshire Police, Superintendent
Jo Harding	Leeds West CCG, Director of Nursing and Quality
Marcia Perry	LCH, Executive Director of Nursing
Rebecca Gilmour	Leeds YOS, Manager
Cllr Roger Harington	Deputy Executive Member for Children's Services
Rob McCartney	LCC, Head of Housing
Dee Reid	LCC, Head of Communication
Sharda Parthasarathi	NSPCC, Head of Service
Gill Marchant	Leeds South & East CCGs, Deputy Head of Safeguarding Children & Adults
Claire Linley	LTHT, Deputy Chief Nurse (for Suzanne Hinchcliffe)
Karen Rodger	NHS England, Senior Nurse
Andy Percival	Leeds Secondary Heads Group (for Andy Goulty)
Andrew Chandler	National Probation Service, Head of Leeds LDU/Cluster
Peter Harris	Primary Headteacher's Forum
Steve Boorman	Legal Advisor to the LSCB
Bridget Emery	Office of DPH, Chief Officer Strategy & Commissioning
Anthony Deery	Leeds and York Partnership NHS Foundation Trust, Director of Nursing
Shona McFarlane	Adult Social Care, Chief Officer Access & Care Delivery
Mariya Naylor	Yorkshire Place 2 Be/Third Sector Reference Group Chair
Amandip Johal	CAFCASS, Service Manager
Sandra Chatters	WYCRC, Head of Service for Leeds
Phil Coneron	LSCB Business Unit, LSCB Manager
Karen Shinn	LSCB Business Unit, LSCB Manager
Lucy Chadwick	LSCB Business Unit, Communications and Engagement Officer
Professor Adam Crawford	Pro-Dean for Research and Innovation, University of Leeds (re Item 2)
Nadeem Siddique	Safer Leeds (re Item 3)
Gail Faulkner	Children's Social Work Service, Head of Service (re Item 4)
Raminder Aujla	Integrated Safeguarding Unit (re Item 5)
Maggie Colman	Integrated Safeguarding Unit (re Item 7)
Jeni Roussounis	LSCB Business Unit, Training and Development Officer (observer)
Gill Parkinson	Children's Services, Integrated Safeguarding Unit (observer)
Heather Vevers	LSCB Business Unit, Senior Support Officer (minutes)

Apologies for Absence

Nigel Richardson	LCC, Director of Children's Services
Steve Walker	LCC, Deputy Director, Safeguarding, Specialist and Targeted Services

Sharon Yellin	Office of DPH, CDOP Chair
Amanda Thomas	Leeds CCG, Designated Doctor
Andy Goulty	Leeds Secondary Heads Group
Hilary Paxton	Adult Safeguarding Board, Adult Social Care
Dave Basker	LCC, Children's Services, Head of Integrated Safeguarding Unit
Maureen Kelly	Leeds CCG, Assistant Director of Nursing
Andrea Cowans	Leeds City College, Head of Safeguarding
Marcella Goligher	Wetherby YOI, Governor
Cllr Lucinda Yeadon	Executive Lead Member for Children's Services
Simon Costigan	Environment & Neighbourhoods, Chief Officer, Strategic Housing
Victoria Allen	Lay Member
Shareen Khan	Lay Member

Item	Description	Action
1	Introductions/apologies/new members	
1.1	1.1.1 Mark Peel formally introduced himself as Independent Chair. Mark welcomed everyone to the Board meeting and apologies were noted. 1.1.2 Gill Marchant (NHS Leeds South & East CCGs) was welcomed as a new Board member.	
2	Partnerships in the Delivery of Policing and Safeguarding Children	
2.1	2.1.1 Following on from his presentation at the Board meeting held on 2 April 2015, Professor Adam Crawford talked to the draft report "Partnerships in the Delivery of Policing and Safeguarding Children". 2.1.2 A team of researchers at the University of Leeds have been working in conjunction with West Yorkshire Police and the Office of the Police and Crime Commissioner for West Yorkshire, on a case study of the benefits and challenges of partnership working 2.1.3 Professor Crawford noted that the case study was based on: • Face-to-face interviews • Focus groups with frontline staff from Social Care, the Police, Health, Youth Offending Service and the Third Sector • The fieldwork was largely conducted between May and August 2015. 2.1.4 Professor Crawford highlighted: • The positive developments around leadership and shared visions • That there are challenges around managerial level developments/shared visions being disseminated to front line staff • The Front Door is an important example of effective multi-agency work • Staff across all services expressed concerns regarding how budget cuts would impact on future multi-agency relationships • Issues raised regarding Police engagement with safeguarding are to be taken forward. 2.1.5 Board members to forward any comments to Professor Crawford by 26 November 15.	
2.2	2.2.1 Superintendent Sam Millar noted that she had not had sight of the report prior to receiving the papers for the meeting. Superintendent Millar stated that the report does not represent the partnership from a Police perspective. 2.2.2 Mark Peel noted that considerations need to be made regarding the dissemination of information from the management tier to front line staff.	

Agreed/Actions

Action: Superintendent Millar to feedback the concerns that were identified to Professor Crawford. — Supt Millar

3 Prevent Strategy Update

3.1 3.1.1 Nadeem Siddique provided an update on the Prevent Strategy and informed the Board that:

- Prevent work has significantly intensified in Leeds over the past year
- The government has placed the Prevent Strategy on a statutory footing, which requires a range of specified agencies to give due regard to the need to prevent people from being drawn into terrorism.

3.1.2 Nadeem highlighted the following key achievements and progress:

- Delivery of the Home Office approved Prevent training package to schools across the city, with the aim of increasing knowledge of the factors that might make a young person vulnerable to radicalisation
- The model Child Protection Policy, which is sent to all schools on an annual basis, has been updated to incorporated the Prevent Duty
- A safeguarding policy- 'Safeguarding children and young people from the threat of violent extremism' has been approved by the LSCB Policy and Procedures Sub-group
- Prevent briefings have been delivered to Primary and Secondary Head Teachers
- 'British Values' briefing sessions have been developed and delivered to teachers
- Advice about online radicalisation has been sent out to all schools
- Prevent has also formed part of the School Governor briefing sessions
- A Prevent page has been established on the Leeds Education Hub, with access to policy documents, advice and guidance notes
- A Prevent self-assessment checklist has been developed for schools to measure their progress against the implementation of the Prevent Duty
- Prevent training has been delivered to all School Improvement Advisors and the Council's Health and Wellbeing Team, Integrated Processes Team, and Duty & Advice Team
- A range of Prevent training sessions have been delivered as part of the LSCB Light Bites and also as stand-alone sessions
- On 19 October 15 the Government announced a new counter extremism strategy, which complements the Prevent strategy
- Louise Casey is undertaking a review into the cohesiveness of communities in the UK
- There is a concern that people may be reluctant to make referrals.

3.2 3.2.1 Dee Reid queried where Leeds sits in relation to referrals made to other core cities. Nadeem advised that there have been a steady rate of referrals and, as a result of 7/7, Leeds has been proactive in this area for a number of years.

3.2.2 Mark Peel noted that the Board should consider how support, in addition to training, is provided in educational settings.

Agreed/Actions

Action: The Education reference group feed back to the LSCB the impact implementing the Prevent Strategy has on Education Sector resources. — ERG

4 Leeds Safeguarding Hub Update

4.1 4.1.1 Gail Faulkner provided an update on the Front Door Safeguarding Hub and noted that:

- Ofsted inspectors found the arrangements to be robust and that they contribute to the confidence of safeguarding arrangements in Leeds
- The overarching arrangements at the Front Door are called the Front Door Safeguarding Hub (FDSH) and consist of:
  - The Multi Agency Duty & Advice Team, who talk to professionals re child protection concerns
  - Police colleagues who deal with domestic violence concerning children
  - Customer Service Contact Officers who talk to the general public regarding child protection concerns
- The FDSH deal with 16–18k calls per month
- It is gratifying to see partners working well together in Leeds
- The Integrated Processes Team was integrated into the FDSH in spring 2015. This has presented challenges in terms of staffing and has impacted on the recording of Early Help Assessments
- Leeds Community Health Trust has employed and allocated a full time worker to join the FDSH
- Daily MARACs have been taking place since April 2015, representing a ground breaking multi-agency response to domestic abuse.

4.1.2 In conclusion the report states that:

- The current Duty & Advice arrangements have continued to provide a professional and safe advice service which responds to concerns about vulnerable children
- There is a need to further develop and promote local conversations to increase the confidence and knowledge at cluster level
- The FDSH has begun to undertake risk assessment and planning for high risk domestic abuse.

4.1.3 The recommendations of the report are:

- This report and its contents are endorsed by the Board
- Board members consider the implications for their agency, in relation to participation in the arrangements.

4.2 4.2.1 Mark Peel acknowledged that there is a real partnership in Leeds based on the evident conversations between agencies.

4.2.2 Bridget Emery informed the Board that funding for the Front Door has been agreed at CLT, with Neil Evans taking the lead on this. Bridget noted that there is backing from commissioned services within the Third Sector.

4.2.3 Sal Tariq reminded Board members how far the process has come from the 2009 Ofsted report.

4.2.4 Jo Harding noted that, with recent changes in senior leadership, she would be happy to discuss future opportunities with Gail.

Agreed/Actions

Agreed: The Board accepted the recommendations of the report

Action: Board members consider the implications for their agency, in relation to participation in the arrangements. LSCB

5 Education and Early Start Annual Report 2014/15

5.1 5.1.1 Raminder Aujla talked to the 'Education and Early Years Start Safeguarding Team Annual Report' for 2014/15 on behalf of Dave Basker, noting that:

- The Education and Early Years Safeguarding Team (EEYST) sits within the Integrated Safeguarding Unit (ISU) of Children's Services
- The primary function of the ISU is to provide quality assurance of practice re safeguarding and planning for children
- The EEYST remit is to:
    - Provide Quality assurance of safeguarding practice within early years settings, including Section 11 audits to early years providers
    - Coordinate Section 175/157 assurance throughout Leeds educational establishments
        - 100% compliance has been received from all schools, free schools and colleges
    - Undertake Internal Management Reports in the event of a serious child care incident
    - Ensure Leeds Children's Services fulfil their statutory duty with regards to identifying children of compulsory school age who are not receiving an appropriate education
    - Represent Education Providers at MARAC meetings
    - Provide training and specialist advice for schools and education services
        - This has included the team visiting schools and asking pupils what they would like to be covered in the training which their teachers receive; bullying was highlighted by 45% of pupils
- Outstanding Ofsted judgments for behaviour and safety are 12% higher than the latest Ofsted statistics released in March 2015. Overall, Leeds schools are performing better than the national average in this area
- 77% of Leeds schools have supervision sessions in place
- Areas requiring further development in relation to safeguarding practice are:
    - Governor training
    - PSHE and whole school contribution to the preventative curriculum.

5.2 5.2.1 Maryia Naylor queried whether the supervision sessions are quality assured. Raminder advised that the model policy, sent to all schools, outlines who should be providing the sessions. Raminder noted that schools are asked to confirm compliance.

5.2.2 Mark Peel noted that Leeds compares very well to other local authorities but that children looked after is an area that should continue to have appropriate focus..

Agreed/Actions

Action: That the ERG consider how supervision is offered within education especially to both Head Teachers and wider school staff that manage safeguarding issues — ERG

6 Serious Case Reviews (Confidential Session)

6.1 Decision to Undertake SCR (Child Z)

6.1.1 Mark Peel informed the Board that he signed off the decision to undertake an SCR re Child Z on 18 November 15. Mark acknowledged the delay in the decision, but stated that it needed to be peer reviewed in order for the right decision to be made. The scoping report highlighted agency involvement with the child and family, leading Mark to conclude that a SCR should be undertaken.

6.1.2 Supt Sam Millar noted that undertaking a SCR on Child Z is the right course of action. As an operational Police Officer Supt Millar stressed the importance of learning lessons from this case in terms of future preventative measures.

6.1.3 Karen Shinn informed the Board that the necessary paperwork is being completed to inform the National Panel.

6.2 Progress SCRs & LLLRs

Progress SCRs and LLLRs were noted.

6.3 Progress implementation SCR action plans

Progress implementation SCR action plans were noted.

7 Family Drug and Alcohol Court

7.1 7.1.1 Maggie Colman, FDAC (Family Drug and Alcohol Court) Project Manager, talked to the 'West Yorkshire Family Drug and Alcohol Court Information for Professionals' document.

7.1.2 Maggie informed the Board that FDAC was piloted in central London between January 2008 and March 2012 and was evaluated by Brunel University, who produced a report in 2012. Highlights of the report were:

- More parents overcame their problems by the end of the proceedings
- 40% of FDAC mothers were no longer misusing substances, compared to 25% of the comparison mothers
- 25% of FDAC fathers were no longer misusing substances, compared to 5% of the comparison fathers
- More children are returned to their parents at the end of proceedings

7.1.3 Maggie noted that:

- The majority of parents have said that they feel they were given a proper opportunity to be part of and to engage with the process
- There were fewer contested hearings
- In 2008 cases were taking up a year to go to court
- Legislation now requires cases to go to court within 26 weeks
- The long term savings to society, in terms of the reduction of the impact of substance misuse, are considerable
- All five West Yorkshire local authorities are working together with the support of the national unit and will contribute towards continued research with Brunel University
- The child remains at the centre of this model
- Leeds will select 24 cases to be part of FDAC
- Leeds will look to include cases of a preventative measure, therefore looking at repeat removals
- The FDAC process differs from normal proceeding whereby parents attend court every two weeks in the presence of a Judge, without Lawyers. Lawyers will attend 3 hearings

- FDAC goes live in Leeds on 25 November 15.

7.1.4 Mark Peel noted that this is an exciting project for Leeds to be involved with and stated that, as referred to in the documentation, "strengthening relationships" and "child centred lifestyle" are key.

7.1.5 Steve Boorman asked Board members to consider how their agencies can help to support the project.

Agreed/Actions

Action: Board members to contact Steve Boorman/Sal Tariq to discuss how their agencies can help to support the project. LSCB

8 Safeguarding in Secure Settings Annual Review

8.1 8.1.1 Rebecca Gilmour talked to the 'Safeguarding in Secure Settings Annual Review 2014-15' and noted that:

- The Secure Settings Sub-group have been meeting since September 2014
- The Sub-group's initial remit was to address the issue of restraints in the secure estate
- The Sub-group now has a broader remit, including self-harm and violence
- The Sub-group's focus is on HMYOI Wetherby, Adel Beck Secure Children's Home and the police custody suite at Elland Road
- The Sub-group continues to work on promoting relationships with partners to increase the profile of vulnerable teenagers
- Wetherby YOI have faced a number of challenges over the past year in terms of an increase in their numbers due to closures of other facilities across the country
- The Sub-group have been reassured by the openness of colleagues at Wetherby and the initiatives which have been set up to address issues, such as violent behaviour
- She (Rebecca) has been attending quarterly safeguarding meetings at Wetherby and has been assured that the right safeguarding questions are being asked
- Smaller numbers of young people are entering custody
- Adel Beck have been presented with a number of challenges which include a change of building/staffing. The unit now also accommodates females.

8.1.2 Challenges for the following year include:

- Learning from practice in other areas, perhaps by participating in a national working group
- Continuing to learn from each other and keeping ourselves properly informed about the issues when there are likely to be increasing capacity issues for each of us
- Further clarifying and strengthening the data set and reporting processes
- Further developing the work around the child friendly police custody aspirations
- Further developing restorative processes within each setting
- Developing a means of keeping interested parties across the region informed about our progress
- Completing the self-assessment audit tool developed by the NSPCC and Association of Independent chairs of LSCBs and developing and implementing an action plan based on the findings.

8.1.3 Bridget Emery queried whether Housing Options need to consider doing anything differently re young people who are released from secure settings. Rebecca advised that transitions are carefully monitored and that all Leeds young people have plans in place. The biggest issue is regarding the period of notice young people have in terms of their release accommodation.

9 CSE Audit Findings

9.1 9.1.1 Phil Coneron talked to the 'CSE multi-agency round table case audit findings':

Methodology:

- Cases were identified from the ISU central CSE data base and assessed as low, medium or high risk
- Eight audits were undertaken and chaired by a CSE Strategic Sub-group member
- Lengthy round table multi-agency discussions
- Inclusive of front line practitioners
- A clear quality assurance framework was in place.

Operational Audit Findings:

- Four of the cases were judges as 'good'
- The complexity of working with children and young people experiencing CSE
- There has been a marked improvement re: how CSE is managed in Leeds and how much better children and young people are supported.
- There was clarity around vulnerability and risk
- The cases sit outside of 'traditional intra-familial' child protection framework and intervention
- The overarching finding was the complexity of the young person's situation, which were wider than CSE
- It was noted that young people can form complex relationships with their perpetrators
- Cases managed by social care resulted in a clearer plan with better outcomes.
- Parents and carers often had their own issues and some did not recognise CSE as an issue
- Considerations around managing cases included:
    - Lacking SMART planning
    - 'Stuck' cases
    - Management oversight or supervision
    - Contingency plans.

Strategic Audit Findings:

- Dealing with vulnerable adolescents with complex issues
- Transitions - pathways into adult life
- Importance of 'Think Family Work Family'
- 'Stuck' cases - ways of moving forward were discussed
- Thresholds versus Conversations
- Focus /capacity /resources/long term solutions.

Next steps:

- To map operational audit findings to the relevant strands of the CSE strategy and then challenge the key leads on these strands
- Share findings via a series of learning events
- Feed findings into other LSCB sub groups to widen the discussion
- Share strategic findings with the LSCB and wider partnerships
- To repeat the audit in 2016.

9.1.2 SWOT Analysis:

The Board considered vulnerable adolescents and transition in two groups and developed a SWOT analysis:

1) Vulnerable adolescents- How does the partnership seek to address the challenges posed by

adolescents who are highly vulnerable to multiple risk factors outside the family environment and for whom the likelihood of achieving positive outcomes is compromised?
Please see Appendix 1

2) Transition- Given that those subjected to CSE have a range of pre-existing vulnerabilities and are likely to need ongoing support to sustain improvements how do strategic boards and services manage issues of transition for those with vulnerability?
Please see appendix 1

9.1.3 Mark Peel highlighted that professionals need to ensure that early conversations with the right people at the right time need to continue and re-enforced in with families where there is sometimes a degree of denial.

Agreed/Actions
Actions:

- Sub Groups to consider the wider issues of vulnerable teenagers in Leeds
- To support the development of an LSCB themed focussed piece of work

LSCB Sub groups

- To challenge key agencies and the CSE Sub Group of areas the audit identified as needing improvement

PMSG

- Continue to promote the Think Family Work Family way of working

LSCB

- To promote closer strategic relationships with Safer Leeds and Adults Safeguarding Board to address themes identified through the CSE Audit

PMSG

10 Children in Police Custody

10.1 10.1.1 Supt Sam Millar informed the Board that Innovation Fund will finance an Inspector post within Safer Leeds to look at PACE accommodation for children in custody.
10.1.2 Supt Millar asked Board members to consider the paper 'Children in Police Custody – the Future Direction in Leeds?', which will be tabled for a future meeting.

Action: Board members to give due consideration to the paper. LSCB

11 Review and Re-commissioning of Housing Related Support

11.1 Bridget Emery informed the Board that the report 'Commissioning a new model for the delivery of supporting people service' was agreed at the LCC Executive Board. The report was tabled for today's meeting so that Board members would have the opportunity to review it.

Actions: Board members to review the paper and provide suggestions/comments to Bridget Emery within 1 month of this meeting. LSCB

12 Minutes of previous meeting 24 September 15

12.1 The minutes of the meeting on 24th September 2015 were agreed.

13 Draft minutes of Executive Group meeting 15 October 15

13.1 The draft minutes of the Executive Group were noted.

14 AOB

14.1 Domestic Violence Campaign

Bridget Emery informed the Board of a domestic violence campaign "Get Comfortable Talking About Domestic Violence", launching on 25 November 15. There will be a number of installations around the city with the aim of generating conversations about domestic violence.

14.2 Student LSCB

Lucy Chadwick informed the Board that the new cohort of students have asked Board members to consider whether there are any pieces of work they would like the students to become involved with.

Appendix 1 LSCB SWOT Analysis

Strengths Vulnerable Adolescents

- Care leavers
- Secure settings
- Front door
- Clusters, targeted services
- Think family
- Early conversations
- Think Family/ Work Family approach
- Cluster arrangements
- CSE strategy and action plan
- Training of professionals
- Awareness raising WY wide campaigns
- Partnership working and commitment to it

Opportunities Vulnerable Adolescents

- Safe Team
- Child friendly custody
- EDT review
- Skilled workforce
- Think Family
- Flagship etc
- Re-commissioning
- Need to know and understand more and contextual to Leeds
- Early Help
- Primary school education
- Available services

Threats Vulnerable Adolescents

- Reduction in Youth work
- Reduction in third sector funding
- Impact of welfare policy
- New narrower curriculum
- Reduced staffing numbers/change threatened relationships
- Very live political agenda
- False positive
- Financial climate

Weakness Vulnerable Adolescents

- EDT in current form
- Out of hours provision
- Patchy provision
- No city centre hubs
- Understanding of what a healthy relationship is in adolescence
- Lack of focus
- Anti-social behaviour – reasons behind it

Strengths Transitions

- Improved partnership
- Heightened awareness
- Greater drive around child's voice
- Clear tasking process, multi-agency response/ risk and vulnerability assessments
- WYP – more towards a broader safe surroundings agenda. Commitment at a very senior level.
- City wide strategic sign up.
- Willingness to change
- Ofsted recognition re: CSE developments
- Recognition of need to change practice

Opportunities Transitions

- More links between perpetrator facing and victim facing services/ partnerships
- Public awareness
- Share and learn across the region e.g. 5 WY boards
- Work a/c children and adult services include the boards
- Further evaluation/ audit for lessons for the future
- To ensure services not focussing on CSE, always hold the issue in mind to ensue effective practice
- Corporate parents role for looked after children
- Commissioning of services to work with people who present a risk

Threats Transitions

- Money/ resources
- Social media/ context
- Using CSE for 18 years and older
- Media
- Language re: vulnerability
- Moving from vulnerable to responsible
- Capacity and content etc

Weakness Transitions

- Better and more communication needed
- Language transitions often relates to young people mainly to adulthood and social care needs
- Difference In services available when under 18

Leeds Safeguarding Adults Board

Minutes – 14th October 2015

Board Membership		
Name	**Organisation**	**Attended**
Ellie Monkhouse	Interim Chair – Leeds Safeguarding Adults Board & Leeds North and Leeds South and East CCG	✓
Cath Roff (Member)	Director of Adult Social Services	
Shona McFarlane (Member)	Adult Social Care	✓
Superintendent Sam Millar (Member)	West Yorkshire Police	✓
DCI Mark Griffin (Member)	West Yorkshire Police	
Jo Harding (Member)	Leeds West CCG	
Maureen Kelly (Member)	Leeds CCG	✓
Suzanne Hinchliffe CBE (Member)	Leeds Teaching Hospitals NHS Trust	
Clare Linley (Deputy)	Leeds Teaching Hospitals NHS Trust	✓
Anthony Deery (Member)	Leeds and York Partnerships NHS Foundation Trust	✓
Marcia Perry (Member)	Leeds Community Healthcare NHS Trust	
Tanya Matilainen (Member)	Healthwatch Leeds	✓
Lisa Toner (Member)	West Yorkshire Fire and Rescue Service	✓
Diane Pellew (Member)	HMP Wealstun	
Andrew Chandler (Member)	National Probation Service	
Rachel Garry (Deputy)	National Probation Service	
Sandra Chatter (Member)	Community Rehabilitation Company	
Peter Turner (Member)	Community Rehabilitation Company	✓
Emma Stewart (Member)	Alliance of Service Experts	✓
John Statham (Member)	Leeds City Council: Environments and Housing	
Philip Bransom (Member)	Advonet	
Bridget Emery (Member)	Leeds City Council: Public Health	✓
Hilary Paxton (Ex Officio)	LSAPSU	✓
Emma Mortimer (Ex Officio)	LSAPSU	✓
Kieron Smith (Ex Officio)	LSAPSU	✓
Loraine Danby (Ex Officio)	LSAPSU	✓
Gerry Gillen (In attendance)	Leeds City Council: Legal Services	✓
Ben Eckles (Observer)	Student, Leeds CCG, Observer	✓

Item No.	Item	Action, Timescale and Person responsible
1.	**Welcome**	
	Ellie Monkhouse, Interim Chair welcomed members to the Leeds Safeguarding Adults Board meeting.	
i.	**Introductions and Apologies**	
	Members of the Board introduced themselves. Ellie Monkhouse noted apologies.	
2.	**Minutes of 18 June 2015**	
2i.	These were accepted as an accurate record. **Matters Arising/Action list from June 2015** Actions from previous meeting: Draft Information Sharing Agreement to be circulated to Board Information Governance Officers and Board Members. This action was complete and forms Item 8 of the Agenda. Item 4: Kieron Smith confirmed that members wishing to provide an amended contribution for the Board Annual Report had done so. Item 7.1: Hilary Paxton confirmed that the Adult Social Care/NHS Trust Enquiry Protocol has been updated with the requested amendment. Item 7.2: Hilary reported that the Department of Health is advising that the impending revised Statutory Guidance will remove the role of the Designated Adults Safeguarding Manager. The responsibility to have operational safeguarding leadership and a procedure for responding to concerns about a 'person in a position of trust' will however remain. Additional matters arising: Shona MacFarlane advised that Richard Jones has been appointed as the new Independent Chair. He is a former Director of Social Services, ADASS Chair and a Chief Operating Officer an NHS England area team, bringing a wealth of experience to the role. Richard will join the Board from its next meeting on the 10th December. In advance of this, an induction programme is being developed, and the Partnership Support Unit will email members seeking their availability to meet Richard.	**Action:** Partnership Support Unit to present the revised Statutory Guidance to the Board when published

Item No.	Item	Action, Timescale and Person responsible
	Shona MacFarlane confirmed that Hilary Paxton, Head of Safeguarding had commenced a secondment with ADASS working on the Transforming Care project 3 days per week until the end of March. Arrangements are in place to ensure work is progressed in Leeds during this period. Shona MacFarlane, on behalf the Board, acknowledged that Ellie Monkhouse was moving onto a new role and thanked Ellie for her valuable contributions to the Board as a member, and more recently as the Interim Chair. Board members wished Ellie well in her new role.	
3.	**LSAB Strategy and Annual Plan:** **Sub-group activity – Chairs' updates**	
	Emma Mortimer explained that the Annual Plan was agreed at the last Board meeting. The intention is that the Annual Plan will be updated at each meeting, and that each sub-group may be asked to provide a written summary of their work so as to keep the Board informed of progress, issues and challenges. **Safeguarding Adults Review sub-group:** Emma Mortimer explained that the current priority for the sub-group is a scoping exercise in relation to a SAR referral, the findings of which will be assessed by the group to consider if a SAR should be undertaken. In addition the SAR policy is being reviewed to ensure it meets the requirements of the Care Act 2014. **Quality Assurance and Performance sub-group:** The revised sub-group's first meeting has taken place. Work has commenced on developing the Quality Assurance Framework and a multi-agency audit tool. The Member Annual Self-assessment has been circulated, the findings of which will be collated and presented to the Board. The sub-group also has an action around safeguarding standards, but there is corporative approach within Leeds City Council to explore the potential for standards across Domestic Violence, Children Services and Safeguarding Adults, the sub-group will look at how it can link into this work. **Citizens Engagement sub-group** Tanya Matilainen advised that the sub-group had met once, and has been refreshing its membership. The intention is to have a smaller core group and a wider set of links, such as	

Item No.	Item	Action, Timescale and Person responsible
	with police, probation and fire service and other Board members organisations that can be involved in projects as required. The sub-group will approach Board members for support in the first instance, unless otherwise represented on the sub-group. The sub-group has a broad plan for how to take forward its actions in the Annual Plan. **Learning and Improvement sub-group** Maureen Kelly explained the Board had a formal update report on the sub-group's work and progress in August, and there were no additional updates at this time.	
4.	**Board member updates**	
	Hilary Paxton spoke to the National Probation Service: National Partnership Framework, Safeguarding Adults Boards that was tabled for the Board's awareness. Ellie Monkhouse queried if there were any implications for the Board. Kieron Smith said he felt it was a statement of commitment to the Board and its work. Peter Turner said that it helped to clarify that National Probation Service and Crime Reduction Companies are separate in their membership of Safeguarding Boards.	
5.	**Discussion items:** **i. Savile – Lessions for adult safeguarding** **ii. 'Justice for LB' – Reflecting on the lessons from Connor Sparrowhawke's death**	
	Emma Mortimer spoke to a power point presentation regarding: i. The nature and thematic learning from the Savile Inquiries ii. The context of LB's tragic death, before showing a short film about LB on the My Life My Choice website: http://mylifemychoice.org.uk/campaigns/justice-for-lb/ The presentation slides are attached to the minutes. Emma explained that learning was relevant to all organisations that provided services to people with care and support needs. Considering both of these items, Board members were asked in groups to consider the implications for the Board and for wider organisations in Leeds.	

Item No.	Item	Action, Timescale and Person responsible
	Table 1: Feedback: • Need for individuals to be at the centre of decision making, with the support of advocacy when needed • Need to consider how the Board assures itself that organisations are listening to individuals and their family/advocate • Need to consider auditing a sample of concerns that have been raised, but have not taken through safeguarding to assure us that appropriate actions have been undertaken. • Need to explore joint work with LSCB regarding Transitions and Safeguarding, not just for those with care and support needs. **Table 2: Feedback** • Need to consider our self-assessment process – does it include learning from Savile, as well as complaints, whistleblowing and safer recruitment. • Need to know about support services and their responsiveness in Leeds, particularly for people in transitions. • Need to ensure we are listening to families, and being person centred focused • Need to embed this culture in organisations • Need to promote the 6 C's, Care, Compassion, Competence, Communication, Courage and Commitment. **Table 3: Feedback** • Need to consider how we evaluate services by outcomes achieved and not just processes followed. • Need to consider how commissioning arrangements evaluate the demonstration of values • Need to promote skills and resources to fully engage with adults and their families. • Need for cultural change, not necessarily new laws, and this requires vision and leadership within organisations. **Table 4: Feedback** **<u>Savile</u>** • Need to understand different role of celebrities • Need to ensure people have a voice • Need a shared understanding of safeguarding terms	

Item No.	Item	Action, Timescale and Person responsible
	and assessment work • Volunteers are better screened and supervised; the risk is lower but not eliminated. • Horizon scanning, need for the Board to regularly consider if there are actions needed or key lessons to be learned from such incidents. **LB** • Need to promote learning and good practice across Board members • Need a greater focus on assurance around transitions • Need to consider the Board's role in assurance in contrast to that of commissioner and regulators. Does the Board want to have more active role than self-assessment, such as 'challenge visits'? Ellie Monkhouse advised NHS organisations have all undertaken evaluation of the learning from Savile in the context of their organisations. However, it is important that we also consider how other organisations across the city can benefit from this learning. Claire Linley welcomed this approach and felt that it is important that the Board routinely reflected on these national incidents and identified as a Board its learning and its required actions. There was a discussion about the level of assurance that the Board should be seeking from member organisations, and a query as to whether the member self-assessment would achieve this learning. Hilary Paxton said that the Board's assurances were at a strategic level. The self-assessment was developed by independent chairs in the region, and if it does not focus on the right issues, we can provide feedback for its development. Shona MacFarlane felt that although the Board's responses were at a strategic level, it is important that it be informed by individual stories. There is much in these reports about how we could listen better to adults and their families. Emma Stewart said whilst the focus of the Board is less on individual cases, when many people are effected in the same way, it illustrates strategic failings in services, and this should be the concern of the Board. Bridget Emery reflected that members of the public would be staggered that such events occur, and there was a role in developing general awareness of how people should expect	

Item No.	Item	Action, Timescale and Person responsible
	to be treated by services, and how they can challenge services if they are not treated appropriately. Ellie Monkhouse asked for these reflections to be collated, and for the Board to consider at a subsequent meeting, how it could work to achieve improvements for people in Leeds.	**Actions:** Partnership Support Unit to collate key issues the Board to consider at the December meeting.
6.	**Outcomes of Formal Enquiries: Case Conclusions**	
	Shona MacFarlane presented a paper proposing changes to the decision making options available to practitioners when, following a Formal Enquiry, they are deciding whether abuse has occurred. The proposal is to remove the 'inconclusive' option, and therefore allegations would be substantiated or not substantiated. It was proposed that this would provide clearer outcomes for all concerned. Hilary Paxton explained the context that this decision no longer needs to be reported as part of the national data collection. However, next year, it will be necessary to report whether the risk has been reduced and whether actions are taken. Maureen Kelly suggested we need to focus more on these new requirements in relation to risk, rather than about whether abuse is substantiated or not substantiated. Maureen queried how much difference these outcomes made to the safety of the individual. Shona MacFarlane advised that sometimes the risk is the person alleged to have caused harm, and that the enquiry provides an evidence base for actions. Clear outcomes support this. Sam Millar felt it was important to look at any issues behind such a change. Is there a concern that good decisions are not been made? or is there a concern that risk is not being well managed? These issues might need to be understood better in the first instance. Sam felt that it is sometimes reasonable for an outcome to be 'inconclusive', given the complexities of the issues involved. Hilary confirmed that regardless of this decision, there was always a need to assess risk and consider the need for a safeguarding plan.	**Action:** Quality Assurance and Performance sub-group to undertake an audit in relation to case conclusion decision making. Findings will be used to inform the decision to bring this item to the Board for further discussion.

Item No.	Item	Action, Timescale and Person responsible
	Ellie Monkhouse felt this was an issue for the Board to reflect on and revisit at a later date. Shona MacFarlane agreed that an audit regarding decision making would support a later discussion on this issue.	
7.	**Local Government Ombudsman: Safeguarding Adults Board Casework Guidance Statement**	
	Hilary Paxton presented the Local Government Ombudsman Case work statement. This clarifies the role of the Local Government Ombudsman to investigate complaints in relation to the Safeguarding Adults Board and Formal Enquiries undertaken on behalf of Adult Social Care. Hilary confirmed that references in the Local Government Association in the covering report, were errors, and should read Local Government Ombudsman in all cases.	
8.	**Leeds Safeguarding Adults Board: Information Sharing Agreement**	
	Hilary Paxton presented the updated Information Sharing Agreement. This has been shared with partners, and now finalised will form part of the new Board Constitution.	**Action**: Hilary Paxton to include the Information Sharing Agreement within the new Board Constitution.
9	**Key messages to/from other strategic partnerships in Leeds**	
	None noted on this occasion.	
10.	**Any other Business**	
	Ellie Monkhouse confirmed this was her last Safeguarding Adults Board in Leeds and thanked everyone for their support. With Richard Jones now appointed, Ellie was pleased to be leaving the Chair role in safe hands, and wished the Board and its members well for the future.	
11.	**Dates of future meetings:**	
	10th December 2015 All meetings scheduled at 2.00 pm – 4.30 pm at the Rose Bowl, Leeds Beckett University, Portland Crescent, Leeds, LS1 3HB	

Leeds Safeguarding Adults Board

Actions list from 14th October 2015

Item No.	Action	Person / organisation responsible	Deadline
Item 2i	**Action:** Revised Statutory Guidance to be presented to the Board for consideration when published	Partnership Support Unit	
Item 5:	**Actions:** Key learning discussed in relation to Savile Inquiry and LB, to be collated for the Board to consider further at the December meeting.	Partnership Support Unit	December Board Meeting
Item 6:	**Action:** Quality Assurance and Performance sub-group and undertake an audit in relation to case conclusion decision making. Findings will be used to inform the decision to bring this item to the Board for further discussion.	Shona MacFarlane	
Item 8	**Action**: Information Sharing Agreement to be included within the Board Constitution.	Hilary Paxton	

Leeds Safeguarding Adults Board

Continuing Actions From Previous Boards Meetings

Board Date	Agenda Item	Action	Lead Person/ Agency	Agreed Date	Comments
February 2015	Item 1 ii	Domestic Homicide Reviews A thematic analysis of Domestic Homicide Reviews in Leeds to be provided to the LSAB	Supt Sam Millar		Timescale to be agreed
June 2015	Item 7	Leeds Safeguarding Adults Board Strategic Plan Consultation event to be held considering the priorities for the 2016/17 Strategic Plan	Partnership Support Unit & Leeds Healthwatch		To be considered as part of Strategic Planning for 2016/17 Action relates to the new Care Act duty to consult with the Local Healthwatch and involve the community in devising the Board's Strategic Plan.

Item 2) Appendix.
Presentation slides from October Board 2015

Leeds Safeguarding Adults Board

Learning from National Concerns

LSAB Strategic Learning

- Opportunity to consider how two national concerns impact on the Board's strategic plans
- Overview of Savile Inquiries and Investigations' Findings
- Film: Connor Sparrowhawk
- Reflection

Savile Inquiries

- Savile was, '*hiding in plain sight and using his celebrity status and fundraising activity to gain uncontrolled access to vulnerable people across six decades… He only picked the most vulnerable, the ones least likely to speak out against him.*'

Superintendent David Gray, Operation Yewtree

Savile Inquiries and Investigations

- BBC
- Operation Yewtree
- Operation Outreach
- Her Majesty's Inspectorate of Constabulary
- Three NHS Investigations:
  - Leeds
  - Broadmoor
  - Stoke Mandeville

  } Independent Oversight
- Thirty-eight further hospital investigations
- A children's home, an ambulance service and a hospice

Overview

- James Wilson Savile: Born in Leeds in 1926, died aged 84 in 2001

- October 2012: ITV '*Exposure*'

- Operation Yewtree – Savile was a, '*prolific sexual predator, paedophile and rapist, with 214 criminal offences recorded across the UK*'.

Themes and learning for organisations

- Need for clarity about organisational values and attitudes
- Good governance systems in place
- A culture of openness and transparency - internally and externally
- Need for safe recruitment approaches
- Accessible, valued and robust complaints procedures, with a demonstrably clear culture of wanting to hear people's views
- A policy of non-acceptance of any form of abuse and communication of this at all levels of the organisation
- A culture of valuing safeguarding adults and children and placing this at the heart of their work

Connor Sparrowhawk aka LB Laughing Boy

'*LB is Connor Sparrowhawk. LB was a fit and healthy young man, who loved buses, London, Eddie Stobart and speaking his mind. He lived in Oxford and was in the sixth form of a local special school. LB was diagnosed with autism, learning disabilities and epilepsy*'. Dr Sara Ryan, his mum

Connor died on 4th July, at the age of 18, having drowned in a bath. He was an informal patient in the Short Term Assessment and Treatment Team inpatient unit run by Southern Health NHS Foundation Trust.

The Tale of Laughing Boy (LB)

- A 15 minute film, to find out more about LB, what happened to him and the family's subsequent campaign for justice, can be seen here:

https://vimeo.com/130521001

Connor Sparrowhawk: Reviews and Inquiries

Verita – Independent Investigation, published February 2014

- Preventable death
- Poor risk assessment
- Poor care planning
- Lack of consultation with CS or his family about his care planning and needs
- Antipathy towards parents for 'speaking up'
- Lack of reference to the Mental Capacity Act 2005
- Lack of transparency
- Failure to respond to complaints and concerns from CS's family

Connor Sparrowhawk: Reviews and Inquiries

Care Quality Commission Inspection:

- Requires improvement
- Unsafe
- Training required for all staff
- Lack of leadership

Healthwatch Oxford:

- Families shut out of care decisions when their child reached 18
- Not being helped until person hit crisis point
- Adults with LD and Autism moved miles away
- Over-use of physical and chemical restraint

Strategic Learning for LSAB

Please consider and note:

- The implications for this Board
- Implications for organisations in Leeds working with adults with care and support needs

HEALTH AND WELLBEING BOARD

WEDNESDAY, 30TH SEPTEMBER, 2015

PRESENT: Councillor L Mulherin in the Chair

Councillors N Buckley, D Coupar, S Golton, and L Yeadon

Representatives of Clinical Commissioning Groups

Dr Jason Broch	Leeds North CCG
Nigel Gray	Leeds North CCG
Matt Ward	Leeds South and East CCG
Phil Corrigan	Leeds West CCG

Directors of Leeds City Council
Victoria Eaton – Consultant in Public Health
Cath Roff – Director of Adult Social Care
Sue Rumbold – Chief Officer, Children's Services

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative
Heather O'Donnell

Representative of Local Health Watch Organisation
Linn Phipps – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers
Chris Butler - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

21 Chairs Opening Remarks

Public Health Funding – Noting the current funding challenges, including the £200m reduction in Public Health funding; the savings required by the NHS Trust Development Agency and the recent changes to Business Rate administration requiring the Local Authority to return £6m to NHS England; the Board considered the best arena in which to discuss the impact of funding changes on front-line services. The Board noted the concerns expressed generally by commissioners, practitioners, providers and service users.

Councillor Mulherin reported that LCC had responded to the Government consultation on the proposals objecting to the cuts in principle and commenting that if the in-year cuts were to be implemented nationally, that they should reflect the fact that Local Authorities such as Leeds were already underfunded for Public Health and that some other Local Authorities were currently over funded. The Chair suggested that the Board hold an additional meeting once the outcome of the consultation and the Governments'

response was released, in order to support the Board's aim to achieve a collective approach to health and wellbeing across the city

22 Appeals against refusal of inspection of documents

There were no appeals against the refusal of inspection of documents

23 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information

24 Late Items

No late items of business were added to the agenda

25 Declarations of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interest were made, however the following additional declaration was made:
Nigel Gray (Leeds North CCG) – Agenda item 14 -Children & Young People's Oral Health Promotion Plan – wished it to be recorded that he had recently been elected Chair of Governors at Scholes (Elmet) Primary School (Federated with Wetherby St James' C of E Primary School) (Minute 35 refers)

26 Apologies for Absence

Apologies for absence were received from Andrew Harris (Leeds South & East CCG) and Gordon Sinclair (Leeds West CCG). Dr Ian Cameron (Director of Public Health) and Nigel Richardson (Director of Children's Services) also tendered apologies and they were represented at the meeting by Victoria Eaton (Consultant in Public Health) and Sue Rumbold (Chief Officer, Children's Services) respectively. Additionally, the Board welcomed Heather O'Donnell as a representative of the Third Sector.

27 Open Forum

The Chair allowed a period of up to 10 minutes to allow members of the public to make representations on matters within the terms of reference of the Health and Wellbeing Board (HWB).
Health Funding – A query was raised over any actions proposed to address the impact of the cuts being made to both NHS and Public Health funding. The member of the public welcomed the assurance already given about the local response to the Government consultation on local health funding.
Julian Hartley (Leeds Teaching Hospitals NHS Trust) responded. He provided assurance that, despite presenting a significant challenge, negotiations seeking to minimise the impact on front line services were ongoing with the TDA (NHS Trust Development Authority) and Monitor (Sector Regulator for Health Services in England)

28 Minutes

RESOLVED – That, subject to an amendment to minute 5 to refer to 'CPAG – the NHS England Clinical Priorities Advisory Group', the minutes of the meeting held 10th June 2015 be agreed as a correct record

29 Development of Primary Care Services (General Practice)

The Board received a report from the three Leeds Clinical Commissioning Group Chairs providing information on the developments taking place in general practice across Leeds as part of the citywide response to the national drive to develop 7 day working and to improve access to general practice services. The report outlined the challenges faced by general practices in reconfiguring both teams and infrastructure to achieve this.

Dr Chris Mills, Clinical Lead (Leeds West CCG), gave a presentation on the key themes of the report and highlighted the drivers for change as being the changes to the population demographics, technology and the workforce

The Board discussed the following themes:

- The take up of the offer of 7 day appointments and the costs of non-attendance. It was agreed the Board should support measures encouraging take-up.
- The integration of local pharmacy provision to support 7 day general practice and the need to develop relationships between the two services
- Noted that the three Leeds CCGs had different operational models which affected patients' access to 7 day working. Additionally, 7 day working was not mandatory.

Dr Mills outlined the key considerations for the future as being:

- Preserving community elements to provide a service to meet the needs and priorities of the local community
- How that service is delivered and by whom
- Whether General Practice could commission the Third Sector to deliver more services, and how that commissioning process is undertaken
- To keep the workforce in mind during the transition period

RESOLVED

a) To note the progress that is being made with regard to developing 7-day services across Leeds and the commitment to continue to work across the City to share the learning from individual schemes
b) To lend support to the wider system changes required to support developing new models of care in Leeds
c) That having considered and discussed what further action could support improvements in access to general practice services across Leeds, the Board identified measures to encourage the take-up of 7 day access to General Practice as being key.

30 Winter Planning and System Resilience in Leeds

The Board received a report from the Chairs of the three Leeds Clinical Commissioning Groups which provided an overview of planning, investment, management and developments across the Health and Social Care system to achieve year round system resilience and the delivery of high quality effective services to its population.

Nigel Gray (Leeds North CCG) and Debra Taylor-Tate attended the meeting to present the report. The following matters were highlighted in discussions:

- The emphasis on encouraging all-year round resilience and the role of the System Resilience Group
- In order to react to influences and plan for eventualities, the Resource, Escalation Action Plan (REAP) had been developed
- The key priorities – the workforce, system flow and future of primary care
- The delayed transfer of care and the expectation of a multi-disciplinary approach to the assessment of both the patients' and the carers' situation.
- The need to ensure that the patient/carer perspective is reflected in building system resilience and that consultation includes patients and service users
- The need to consider the Children and Young People's Plan in order to prepare for service requests and support for children and young people with complex needs. It was agreed that representatives of LCC Children's Services and the CCG would liaise to consider this
- The need to consider a city wide 'bed plan' as well as the community strategy and to recognise that resilience should address overall care, not just measurable quantities such as beds.
- The need to discuss how to manage resilience planning across Yorkshire for mental health services/overnight provision, taking into account the impact of £2.8m budget reduction and different service models

(Linn Phipps and Thea Stein withdrew from the meeting for a short time)

HWB acknowledged the work done in preparing the report and recalled the impact of winter service requests on provision in 2014/15. Looking forward, it was reported that a review of elective surgery was being undertaken in order to better manage requests this year, putting the escalation process at the heart of integrating service responses

RESOLVED -

a) To note the content of the paper and the establishment of the System Resilience Group and its commitment to continue to work across the City to maintain a resilient Health and Social Care economy
b) To note the system challenges affecting both national and local delivery and the content of discussions of how joint working in Leeds can support these
c) To continue to support the integration of Health and Social Care and the critical part it plays in delivering a resilient city and maintaining a positive experience for patients and service users
d) To support the further development of a system wide Resource Escalation Action Plan (REAP), to initiate a system-wide response to the immediate pressures and achieve further Health and Social Care integration to support resilience

31 Maternity Strategy for Leeds (2015-2020)

The Chief Operating Officer (Leeds South & East CCG) submitted a report providing a brief overview of the Maternity Strategy for Leeds 2015-20 document. The report provided assurance in terms of the robust methodology

of its co-production, and its contribution to key outcomes and priorities of the Leeds Joint Health and Wellbeing Strategy (2013-2015).

Matt Ward (Leeds South & East CCG) presented the paper seeking ratification of the Strategy which had been produced in consultation with service users. The outcome sought to ensure consistency of care throughout pregnancy and early childcare.

The Board broadly welcomed the Strategy and noted the key areas for consideration identified in paragraph 3.1 of the submitted report. Members noted the link between the Strategy and LCC's 'Breakthrough Projects', specifically those seeking to address domestic violence and abuse; and reducing health inequalities. Members briefly discussed the comment that the midwifery service may not be able to provide a bespoke service to meet the needs of all individuals and; in noting the challenges ahead; Chris Butler (Leeds & York Partnership NHS Trust) offered to participate in future discussions which should also consider the impact of public health funding cuts.

(Tanya Matilainen withdrew from the meeting for a short while at this point)

RESOLVED -

a) To note and endorse the Maternity Strategy (2015 - 2020) as critical to the delivery of the Joint Health and Well-being Strategy priority 2 'to ensure everyone will have the best start in life'
b) That Health and Wellbeing Board members will hold each other and local partners to account to deliver the ambitions of this Maternity Programme

32 Future in Mind, Children and Young People's Mental Health and Wellbeing

The Chief Operating Officer (Leeds South & East CCG) submitted a report on the work undertaken in respect of the national review and publication "Future in Mind" (2015) Children and Young People's Mental Health and Wellbeing. Guidance has now been published, which sets out the requirement to submit a 5-year Local Transformation Plan (LTP) by 16 October 2015, in order to receive the allocated funds.

Matt Ward (Leeds South & East CCG) presented the report, highlighting the preparations underway in Leeds and seeking approval for the Chair of the Board to be authorised to sign off the LTP due to the tight timescales for its' submission.

The Board welcomed the Strategy, noting comments on the need to take account of the health strategies and demographics of neighbouring authorities' and the need to recognise how quickly this service would be taken up

(Matt Ward and Chris Butler withdrew from the meeting for short time at this point)

RESOLVED -

a) To note and recognise how the recent Leeds whole system review will support the content within the Leeds Local Transformation Plan (LTP)
b) That the Chair of the Health and Wellbeing Board be authorised to sign off the LTP due to the tight timescales of the submission
c) To note the intention to submit a full report of the LTP to a subsequent meeting

33 Annual Report of the Health Protection Board

The Director of Public Health submitted the first Annual Report of the Health Protection Board. The Health Protection Board had identified emerging health protection priorities for Leeds since it was established in June 2014 and had developed an annual work plan to support the arrangements in place to protect the health of communities and meet local health needs.

Dawn Bailey presented the Annual Report highlighting the overview provided of the key priorities identified by the Health Protection Board and the work undertaken to address them. Appendix 1 of the report contained the key priorities and indicators, using the Red Amber Green rating to identify progress against the associated development plan.

The following matters were discussed by the Board:

- Cervical Screening. The indicator showed a reduction in the number of screening tests and Members considered how to encourage increased take-up of this service
- Gonorrhoea in Leeds. Whilst noting that the treatment of specific conditions was not within the remit of the HWB, Members were aware of a recent media story and considered the role of Sexual Health Service
- The new migrant health screening service and the barriers new migrants felt in accessing services
- In respect of consultation and engagement, the need to consider the additional information needed to include those people who have opted out of the system

In moving the recommendations, the Chair urged all partners to continue to work together to address the issues raised in the report

RESOLVED

a) To endorse the Health Protection Board's Annual report.
b) To note the key priorities identified in the Health Protection Board Annual report.
c) To continue to contribute and/or support the Health Protection Board.
d) To note the priorities of the Health Protection Board in their planning for the refresh of the Joint Health and Wellbeing Strategy.

(Heather O'Donnell left the meeting at this point)

34 Leeds Let's Get Active

The Director of Public Health presented an update report on the Leeds Let's Get Active (LLGA) initiative, including the progress made in relation to Year 1 and 2 evaluation results and consideration of future developments.

Mark Allman (LCC Head of Service for Sport) and Steve Zwolinsky (Leeds Beckett University) presented the report which highlighted the effects of physical inactivity on the general health of the population. 64,000 Leeds residents had signed up to the scheme, 15,000 of those from the most deprived areas. Importantly, 80% of those had remained active. Discussions concentrated on the following issues:

The links to employers. The Board noted that this initial scheme had been aimed at the most inactive residents, making use of facilities during day times when usage was low - which generally precluded employed residents. On a practical level, Matt Ward suggested that the scheme outcomes could be reported back to the organisations represented on the HWB – as Leeds employers.

Measurable outcomes – Members were keen to see demonstrable outcomes such as a reduction in the number of GP visits. It was reported that evaluation of the initial LLGA scheme would allow identification of behavioural trends in different areas of the city rather than specific outcomes.

Scheme access – The Board considered availability of the scheme for residents who did not live near a facility, and whether the scheme could be expanded to include the wider family group. In response, it was noted that future phases of the initiative could develop additional activities in co-production. Evaluation of results would inform future schemes and monitoring of the wider impact would be valuable, for instance, did participants also stop smoking.

The Board noted the LLGA as a good news story for the city as the initiative had a greater positive impact than expected, however its success also brought concern over its sustainability. The Board went onto consider what role it could take to encourage residents to engage with the scheme, noting that several issues influenced the take up of the offer (such as an individual's confidence, complex needs, lifestyle choices, debt management, education). It was agreed that that the issue of the Scheme's sustainability would be included on the agenda for the future additional HWB meeting.

RESOLVED -

a) To note the update of Leeds Let's Get Active and evaluation findings based on research from year 1 and 2 of project delivery.
b) To note the information outlining the updated evaluation framework for year 3 of Leeds Let's Get Active.
c) To note the comments made on the contribution of Leeds Let's Get Active to promoting physical activity in the city and the health benefits of that.
d) To note that the issue of the sustainability of Leeds Let's Get Active initiative post April 2016 would be discussed at the future additional HWB meeting

(Matt Ward and Thea Stein left the meeting at this point)

35 Children and Young People's Oral Health Promotion Plan

The Director of Public Health submitted a report presenting the Leeds Children and Young People (CYP) Oral Health Promotion Plan (2015-19) – the Best Start Plan - for discussion on the proposed priorities and indicators. The report also sought endorsement of the Plan and support for the further development of a detailed implementation plan.

The report outlined the Plan as a preventative programme from 0-19 years which aimed to ensure that every child in the city had good oral health, providing parents, carers, children and young people with access to effective oral health support and targeted interventions to support those at risk of oral health inequalities.

Steph Jorysz and Janice Burberry attended the meeting to present the report and discussed the following matters with the Board:

- Key messages about oral health were not being picked up, possibly because the mechanisms for accessing oral health, outside of visits to the dentist, were traditionally family based. It was also acknowledged that Leeds had a bad reputation for dentist availability.
- The correlation between children's oral health and their parent's oral health. This was addressed by health visitors now being tasked with providing oral health information
- Proposals for a future scheme to invest in free toothbrushes for schools in areas identified as 'in need'

RESOLVED

a) To consider the content of the Plan and note the process of discussion and engagement that has taken place.
b) To endorse the strategic Plan and to support the development of a detailed implementation plan.
c) To agree that the Board will monitor progress as part of its Best Start priority.
d) The HWB considered how it could lend support to the work, and agreed to assist in the co-ordination of the work and partnerships, and to endorse the emerging Best Start commitments.

36 For Information: Better Care Fund Update

The Health and Wellbeing Board received a joint report from the Chief Officer Resources and Strategy (LCC Adult Social Care) and the Chief Operating Officer (Leeds South & East CCG) on the implementation of the Better Care Fund in Leeds. The report identified the responsibilities of the Health and Wellbeing Board under the BCF Partnership Agreement and provided Leeds' response to the national Quarter 1 BCF reporting process which had been submitted on behalf of the Leeds Health and Wellbeing Board.

RESOLVED - To note the contents of the report.

37 For Information: Progress on recommendations from the Director of Public Health Report 2013

The Board received an update on the progress made on the recommendations from the Director of Public Health's Annual Report, 'Protecting Health in Leeds 2013'.

RESOLVED

a) To note the good progress made on recommendations from the Director of Public Health Annual report, 'Protecting Health in Leeds' 2013.
b) To note that the Health Protection Board is now established and has oversight on the priority areas outlined in this report.

38 For Information: Delivering the Strategy

The Board received a copy of the September 2015 'Delivering the Strategy' document; a bi-monthly report which gives the Board the opportunity to monitor the progress of the Joint Health and Wellbeing Strategy 2013-15

RESOLVED – To note receipt of the September 2015 'Delivering the Strategy' Joint Health and Wellbeing monitoring report

39 Any Other Business

Commercial Food Outlets, Leeds Teaching Hospital NHS Trust – Councillor Mulherin reported that the Trust had started a review of the food offer in Leeds' Hospitals, specifically from the commercial food outlets

Pension Fund Investment – Councillor Mulherin received the Boards' support for her to write as Chair of Leeds HWB to the Local Government Pensions SB Advisory Group urging they review the practice of investing in tobacco producing companies for the purpose of the local government pension scheme. The Board noted the suggestion that NHS representatives should also contact their respective pension scheme managers seeking a similar review

40 Chairs' Closing Remarks

The Chair closed the meeting by reporting that Rob Kenyon, Chief Officer, Health Partnerships, would be leaving his post to move to Kent in the New Year 2016. Councillor Mulherin expressed the Board's thanks to Rob for the significant contribution he had made to the work of the HWB

41 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next formal meeting as Wednesday 20th January 2016 at 10.00 am. (There will be a pre-meeting for Board members from 9.30 am)