Bundle Public Board Meeting 28 March 2024

Agenda
Final Agenda Public_Board_Meeting_28 March_2024

118 09:00 - Welcome, Introductions and Apologies

119 Declarations of Interest

120 Questions from Members of the Public
Minutes adoption for approval

121 Minutes of Previous Meeting and Matters Arising

121.a Minutes of the Meetings Held on 2 February 2024
Item 121a Draft Public Board minutes 2 February_2024

121.b Actions' Log
Item 121b Public Board Actions log March 2024

122 09:10 - Patient's Story: Speech and Swallowing Service: video story

123 09:30 - Chief Executive's report
Item 123 CEO report - March 2024

124 09:40 - System Flow Update
Item 124 System Flow Update LCH

125 09:45 - Committee Chairs' Assurance Reports:

125.a Quality Committee: Quality Committee: 26 February 2024 and 25 March 2024 (Verbal update)
Item 125a Quality Committee Chairs assurance report Feb 2024

125.b Business Committee: Business Committee: 28 February 2024 and 27 March 2023 (verbal update)
Item 125b Business Committee Assurance report Feb 2024 Final

125.c Audit Committee: Audit Committee: 8 March 2024
Item 125c Audit Committee assurance report March 2024

125.d Charitable Funds Committee: 12 March 2024
Item 125d Charitable funds Committee Chair Assurance Report March 2024

125.e Nominations and Remuneration Committee: 15 March 2024
Item 125e Nom and Rem Committee March 2024 - Chair Assurance report V1.0

126 10:10 - Performance Brief: February 2024
Item 126 Performance Brief - February 2024_Board

127 10:20 - Significant Risks and Board Assurance Framework (BAF) Report
Item 127 Significant risks and Board Assurance Framework (BAF) Board Mar 2024 Final

128 10:40 - Guardian of Safe Working Hours - quarterly report
Item 128 Cover paper GoSWH Quarterly report March 24 v2

129 10:50 - Patient Safety Strategy Implementation Update
Item 129 Patient Safety Strategy Update March 24 pproved

130 11:00 - Staff Survey 2023
Item 130 Staff Survey Results 2023 Public Board March 2024 FINAL

131 11:10 - Engagement Principles

Item 131 FINAL Engagement Principles to Board March 2024

132 11:20 - Waiting List Deep Dive Findings Report
Item 132 Board Report Waiting List 'Deep Dive' Findings Report 03V2

133 11:30 - Annual Plan 2024

133.a Operational Plan (priorities) 2024/25
Item 133a 2024-25 Trust Priorities March Board Final

133.b Financial Plan 2024/25
Item 133bi Financial Plan 2024~25 cover paper
Item 133bii Final 2024-25 Financial Plan (Board 28.3.24)

133.c Draft High Level Performance Indicators for Performance Brief 2024/25
Item 133ci HLIs Board Cover Sheet_Mar24
Item 133cii Proposed HLIs for 2024_25_V0.4

134 11:40 - Corporate Governance

134.a Going Concern Statement – to approve
Item 134a Going Concern Consideration

134.b Code of Governance Paper
Item 134b Code of Governance Compliance March 2024

134.c Declarations of interest and compliance with fit and proper person requirements made by directors for 2023/24
Item 134c Directors declarations of interest

134.d Risk Appetite Statement
Item 134d Risk Appetite Statement Review Mar 2024

135 11:50 - Register of Sealings December 2023 to March 2024
Item 135 Use of Seal December 2023 to March 2024

136 11:55 - Anne Cherry Retirement

137 Any Other Business. Questions on Blue Box items and Close

138 Learning and Development Strategy Update
Item 138i L&D Strategy cover paper 23 03 24
Item 138ii L&D Strategy outline

139 Infection Prevention Control Board Assurance Framework
Item 139i IPC BAF March 2024 V2 Cover paper
Item 139ii IPC BAF March 2024 V2

140 Children, Young People and Families Strategy 2022-25 Update report
Item 140 March 24 CBU Strategy Update

141 Estate Strategy
Item 141 2023-2024 Estatemangement report Q3

142 Scrutiny Board - Supporting Healthy Weight and Active Lifestyles
Item 142 Supporting Healthy Weight and Active Lifestyles

143 Bi Annual Patient Safety and Serious Incident combined Report- September 2023-February 2024
Item 143 Safety and SI Combined Report March 24 FINAL

144 Board Workplan
Item 144 Public Board workplan 2022-23 v6 15 03 2024

Leeds Community Healthcare NHS Trust

Agenda Trust Board Meeting Held In Public

Tenants Hall Enterprise Centre Health for All Acre Close Leeds West Yorkshire LS10 4HX

Date Thurday 28 March 2024

Time 9:00 – 12:00

Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2023-24 118	9.00	**Welcome, Introductions and Apologies** *(Trust Chair)*	
2023-24 119		**Declarations of Interest** *(Trust Chair)*	**N**
2023-24 120		**Questions from Members of the Public**	**N**
2023-24 121		**Minutes of Previous Meeting and Matters Arising** *(Trust Chair)* *For approval*	
121.a		Minutes of the meetings held on 2 February 2024	**Y**
121.b		Actions' Log	**Y**
2023-24 122	9.10	**Patient Story- Speech and Swallowing Service: video story**	**N**
QUALITY AND DELIVERY			
2023-24 123	9.30	**Chief Executive's Report** *(Sam Prince)*	**Y**
2023-24 124	9.40	**System Flow Update** *(Andrea North)*	**Y**
2023-24 125	9:45	**Committee Chairs' Assurance Reports:**	
125a		Quality Committee: 26 February 2024 and 25 March 2024 (Verbal update) *(Helen Thomson)*	**Y**
125b		Business Committee: 28 February 2024 and 27 March 2023 (verbal update) *(Rachel Booth)*	**Y**
125c		Audit Committee: 8 March 2024 *(Khalil Rehman)*	**Y**
125d		Charitable Funds Committee: 12 March 2024 *(Alison Lowe)*	**Y**
125e		Nominations and Remuneration Committee: 15 March 2024 *(Brodie Clark)*	**Y**
2023-24 126	10.10	**Performance Brief: February 2024** *(Andrea Osborne)*	**Y**
2023-24 127	10.20	**Significant Risks and Board Assurance Framework (BAF) Report** *(Sam Prince)*	**Y**
BREAK			
2023-24 128	10.40	**Guardian of Safe Working Hours - quarterly report** *(Dr Nagashree Nallapeta Dr Ruth Burnett presenting)*	**Y**
2023-24 129	10.50	**Patient Safety Strategy Implementation Update** *(Steph Lawrence)*	**Y**

2023-24 130	11.00	**Staff Survey 2023** *(Jenny Allen/Laura Smith)*	**Y**
2023-24 131	11.10	**Engagement Principles** *(Steph Lawrence)*	**Y**
2023-24 132	11.20	**Waiting List Deep Dive Findings Report** *(Andrea North)*	**Y**
		APPROVAL/SIGN OFF	
2023-24 133	11.30	**Annual Plan 2024** a. Operational plan (priorities) 2024/25 (AO) b. Financial Plan 2024/25 (AO) c. Draft High Level Indicators for Performance Brief 2024/25 (AO)	**Y** **Y** **Y**
2023-24 134	11.40	**Corporate Governance** a. Going concern statement – to approve (AO) b. Code of governance compliance paper (HR) c. Declarations of interest and compliance with fit and proper person requirements made by directors for 2023/24 (HR) d. Risk appetite statement annual review (HR)	**Y** **Y** **Y** **Y**
2023-24 135	11.50	**Register of Sealings December 2023 to March 2024** (Ratify) *(Sam Prince)*	**Y**
2023-24 136	11.55	**Anne Cherry Retirement** *(Trust Chair)*	**N**
		CLOSING BUSINESS	
2023-24 137	12:00	**Any other business. Questions on Blue Box Items and Close** (Trust Chair) The Board resolves to hold the remainder of the meeting in private due to the confidential or commercially sensitive nature of the business to be transacted.	**N**

All items listed (Blue Box) in blue text, are to be received for information/assurance, having previously been scrutinised by committees, and no discussion time has been allocated within the agenda. The Trust Chair will invite questions on any of these items under any other business.

Additional items (Blue Box)		
2023-24 138	**Learning and Development Strategy *Update*** *-reviewed by Quality Committee March 2024*	**Y**
2023-24 139	**Infection Prevention Control Board Assurance Framework** *– reviewed by Quality Committee March 2024*	**Y**
2023-24 140	**Children, Young People and Families Strategy 2022-25 Update report** *– reviewed by Quality Committee March 2024*	**Y**
2023-24 141	**Estate Strategy –** *reviewed by Business Committee March 2024*	**Y**
2023-24 142	**Scrutiny Board - Supporting Healthy Weight and Active Lifestyles**	**Y**
2023-24 143	**Bi Annual Patient Safety and Serious Incident combined Report- September 2023-February 2024** *reviewed by Quality Committee March 2024*	**Y**
2023-24 144	**Board Workplan**	**Y**

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Leeds Community Healthcare NHS Trust

Trust Board Meeting held in public: 28 March 2024

Agenda item number: 2023-24 (121a)

Title: Draft Trust Board meeting minutes 2 February 2024

Category of paper: for approval
History: N/A

Responsible director: Chief Executive
Report author: N/A

Attendance

Present:	Brodie Clark CBE	Trust Chair
	Sam Prince	Interim Chief Executive
	Professor Ian Lewis (IL)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Richard Gladman (RG)	Non-Executive Director
	Bryan Machin	Interim Executive Director of Finance and Resources
	Steph Lawrence MBE	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Dr Ruth Burnett	Executive Medical Director
	Andrea North	Interim Executive Director of Operations
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Alison Lowe OBE (AL)	Non-Executive Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	Helen Robinson	Company Secretary
	Amanda Jackson	0-19 PHINS Clinical Team Manager (South Team) and Baby Bubble Leeds Lead, Leeds Community Healthcare NHS Trust - Shadowing the Executive Director of Nursing and Allied Health Professionals (AHPs)
	Satti Saghu	Head of Service, Neurology and Adult Speech and Language Therapy (For Item 98)
	Lynette Munday	Specialist Occupational Therapist (For Item 98)
	John Walsh	Freedom to Speak Up Guardian (For Item 104)
Minutes:	Liz Thornton	Board Administrator
Observers:	Jasvinder Sanghera CBE	Insight Programme Participant
	Andrea Osborne	Interim Executive Director of Finance and Resources (Designate)
Members of the public:	None present	

Item 2023-24 (94)

Discussion points:

Welcome introduction, apologies, and preliminary business

The Chair opened the Trust Board meeting and welcomed all those attending to support items on the agenda.

He welcomed two observers to the meeting; Jasvinder Sanghera, CBE (Insight Programme Participant) and Andrea Osborne (Interim Executive Director of Finance and Resources – Designate).

Apologies

Apologies for absence were received from Alison Lowe OBE (Non-Executive Director), Helen Thomson DL (Non-Executive Director) and Jenny Allen (Director of Workforce, Organisational Development and System Development).

Trust Chair's introductory remarks

The Trust Chair provided some introductory comments.

The Chair commended the Trust's staff including directors for their continued level of high performance in delivering outstanding healthcare to the communities in Leeds in the current pressurised environment. All done in the face of family pressures; disrupted service arrangements through a holiday period; continuing cost of living concerns and, the exigences of the job.

The focus now was on:

- Shaping a forward strategy to deliver excellent services within a cost pressured context.
- Developing the work with partners, whether NHS or those who are part of the many other organisations and services.
- Looking to shape the Trust in a way that makes sense in the step up to a government agenda of 'left shift.'
- Making no mistakes, no errors of judgement and no failures in delivery – carrying that out with an absolute focus on respect for the equitable needs of the population. Learning from the mistakes of others.

Item 2023-24 (95)

Discussion points:

Declarations of interest

Prior to the Trust Board meeting, the Trust Chair had considered the directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Board members. No **additional** declarations were made above those on record or in respect of any business covered by the agenda.

Item 2023-24 (96)

Discussion points:

Questions from members of the public.

No questions were raised.

Item 2023-24 (97)

Discussion points:

a) Minutes of the last meeting: 8 December 2023

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

b) Actions' log 8 December 2023

2023-24 (75): Patient Story: Letter to ICB and Local Authority re cross-border issues for patients. Completed. **Action closed.**

2023-24 (41): Health Equity Strategy – production of an ebook: **Ongoing: Executive Medical Director to provide an update on 28 March 2024.**

2023-24 (41): Health Equity Strategy - Future reports to be more outcome focussed on the redress of inequalities across the service. **Ongoing: next report due to Trust Board 28 March 2024.**

Item 2023-24 (98)

Patient story: Community Neurology Rehabilitation Service

Gillian was referred to Community Neurological Rehabilitation Service (CNRS) following a stroke in 2014 at age 49.

Gillian was a General Practitioner; however, she had not worked following her stroke due to her inability to meet work role requirements because of the cognitive multi-tasking. She explained that

she used to enjoy running and walking, however, she had not participated in such activities since having the stroke. Gillian experienced cognitive multi-tasking issues, some word finding difficulties at times and reported that her processing was much slower. She felt that she was finding herself being irritable and was struggling to multi-task and was uncertain how the CNRS could help her. Gillian did have some positive strategies in place including using a whiteboard for timetables for the family. However, she was very rigid with plans and found being flexible challenging. She was becoming increasingly frustrated with the limited long-term support available for stroke patients.

As she was struggling to cope, Gillian's GP referred her back to the CNRS in 2022 and an Occupational Therapy initial assessment was carried out.

Gillian's goal for intervention was to explore health, well-being and have a more active lifestyle as this had diminished since having the stroke. She described to the Board her experience of the Kawa Model a therapeutic method developed in Japan. The model emphasised the harmony between the person and environmental factors and believed that the harmony would enhance well-being. Occupational Therapists can use the Kawa model to understand the context of the patients, help to prioritise the problems, and provide relative intervention. She explained that using the model had helped to improve her processing of information, coping strategies and have a more balanced routine and structure.

The Board agreed that the Kawa model had been an effective tool in supporting Gillian's recovery but it might not be an appropriate intervention for all patients or at certain stages in the recovery journey.

The Board agreed that the timing of interventions was crucial. It was noted that the waiting list for CNRS was less than a year currently and the possibility the possibility of a 'buddy system' while waiting for a referral was suggested. A discussion took place about improving stroke rehabilitation services in the city including a review of next steps for the Trust's Neurological Rehabilitation Service as part of the Trust's Quality and Value Programme, exploring more opportunities for working in partnership with other services in the Trust and making better links with 3rd sector organisations such as the Stroke Association.

Action: The Chair requested that following this discussion a progress report on CNRS should be brought to the Board in six months' time.

Responsible officer: Executive Director of Nursing and AHPs

The Trust Chair thanked Gillian and members of staff for attending to support the presentation of such an interesting and helpful story to the Board.

Item 2023-24 (99)

Discussion points:

Chief Executive's report

The Interim Chief Executive presented her report which focussed on:

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

The Interim Chief Executive highlighted the launch of the Trust's Talent Development Programme specifically targeted at staff from Black and Minority Ethnic (BME) Groups. The first phase would offer 31 places for BME staff to apply for the dedicated training programme.

The Interim Chief Executive updated the Board on her recent engagement with staff including attendance at the Race Equality Network (REN) Annual General Meeting and a Leaders Network

Live Event where a positive and constructive discussion had taken place about the Trust's Quality and Value Programme 2024-2027.

No Bystanders materials had also been launched at the Leaders Network Live Event.

The Board noted that James Forrest was stepping down as Chair of the REN and members placed on record their thanks for his contribution to the development of the REN Network.

Non-Executive Director (IL) referred to the launch of Health Innovation Leeds and said he would welcome more discussion about what the Trust would be contributing to the partnership.

Outcome: the Board

- received and noted the Chief Executive's report.

Item 2023-24 Item (100)

Discussion points:

Mid-winter Update on System Flow

The Interim Executive Director of Operations introduced the report which provided an update on the Trust's involvement in initiatives to support system flow for the Leeds health and social care system.

Although pressure started to increase in December 2023 the system had coped well in meeting demand over the holiday period. The last two weeks had been the most pressurised of the winter so far with all organisations in the system experiencing challenges in meeting demand which had impacted on system flow, leading to the instigation of 'citywide silver.'

The actions being taken across the system had mitigated the pressures but significant challenges remained. The focus was on reducing attendance in Emergency Departments, admission avoidance, timely discharge, and improved process time for care act assessments through investment in agency social workers. Enabling people to return home, and improving patient experience and outcomes, continued to drive the approach in Leeds. The latest data for January 2024 showed that 81% of patients were discharged home with support which was a significant improvement.

The Board discussed how more assurance could be provided on system flow, and it was noted that it had been agreed that the System Visibility Dashboard would be shared with the next meetings of the Quality and Business Committees in order to agree what information the Committees wished to see reported.

The Board noted that overall, the City remained in a better position than in 2022/23 despite the current challenges.

Non-Executive Director (RG) asked about sickness levels in the Adult Business Unit (ABU) and whether it correlated with the increased demand for community care.

The Director of Workforce Organisational Development and System Development (LS) reported that sickness in the ABU was mainly long-term sickness which was being proactively managed, and short-term sickness levels were being closely monitored.

Outcome: the Board

- Noted the paper and the work being undertaken across the system to maintain system flow at times of extreme pressure.

Item 2023-24 (101)

Discussion points:

Assurance reports from sub-committees

a) – Audit Committee: 15 December 2023

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

- **Internal audit:** the Committee remained concerned about the number of overdue recommendations, mainly due to staffing issues at senior levels. The Internal Auditors had

stated that they were confident they would be in a position to issue a meaningful Head of Internal Audit Opinion for 2023/24, although the KPIs were likely to fall below 100% towards the end of the financial year.

The Interim Executive Director of Finance and Resources informed the Board that he had reminded directors of the importance of pursuing and ensuring overdue recommendations and responses were followed up.

- **Contracts Register:** the Committee discussed how and when best value for money reviews on existing contracts took place and suggested that consideration should be given to the efficiency testing of contracts in relation to the Trust's Quality and Value Programme, particularly where there was a quality or clinical element.
- **External Audit:** the Committee was informed that external audit work would be planned and performed to provide reasonable assurance that the financial statements were free from material misstatement and give a true and fair view. The aim was to complete the work earlier in 2024 than in 2023.

The Board noted that BAF risk 7 (Failure to maintain business continuity (including response to cyber security) was being managed had been assigned a **Reasonable** level of assurance.

b) - Charitable Funds Committee 15 December 2023
In the absence of the Committee Chair, the report was presented by the Execuitve Director of Nursing and AHPs, the key issues discussed were highlighted:

- **Charitable development updates:** the Committee received an update from the Charities Fundraiser about the work recently undertaken.
- **Finance Report:** the Committee received an update report and confirmation that last year's Annual Report had been submitted.

c) – Nominations and Remuneration Committee 15 December 2023
The report was presented by the Trust Chair, the key issues discussed were highlighted:

- **Very Senior Manager (VSM) Pay:** the Committee noted that the 5% pay rise to VSM post holders had now been made following receipt of the national instruction to pay in September 2023.
- **Critical Incentive Scheme Evaluation:** the Committee received and discussed a paper relating to the Critical Incentives scheme. Further actions including additional information on the relative costs of generating additional staff capacity as well as the benefits of an external review were agreed.
- **Executive Appointments:** the Committee received and noted an update on executive appointments.
- **The Implementation date of the Real Living Wage:** yet to be agreed.

d) - Quality Committee – 22 January 2024
In the absence of the Committee Chair, the reports were presented by the Deputy Chair of the Committee, Non-Executive Director (IL), the key issues discussed were highlighted - noting that several issues in the report were covered on the Board agenda:

- **QAIG assurance report:** a proposal for changes to the assurance received from QAIG via the flash reports was being developed.
- **Cancelled and rescheduled visits:** the Committee had received a report on a follow up audit completed in December 2023 which showed an improved picture in both the North and South Neighbourhood Teams. Work was continuing to focus on Teams in the West of the city.
- **Ofsted Report Update for December 2023 Adel Beck Secure Children's Home:** the Committee received an update of the findings and recommendations from the report published by Ofsted in response to the unannounced visit in June 2023. The overall rating of Good was welcomed.
- **Service spotlight: Update on Diabetes improvements and health equity:** the Committee received detail on health equity data related to the projects under the Diabetes pathway improvements, as a follow up to a previous spotlight session in September 2023. A further update would be brought back to Committee in 6-8 months following further work by the

Project Leads, coordinated by the Executive Director of Nursing and AHPs and Executive Medical Director.

The Board noted that the risks assigned to the Committee had been assigned a **reasonable** level of assurance**) – Business Committee – 24 January 2024**
The reports were presented by the Chair of the Committee, Associate Non-Executive Director (RB), and the key issues discussed were highlighted - noting that several issues in the report were covered on the Board agenda:

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

The Board noted that all the risks allocated to the Committee had been assigned a **reasonable** level of assurance.

f) – Committee membership proposed amendment

- The Chair informed the Board that Associate Non-Executive Director (RB) was now the Chair of the Business Committee and would be joining the Audit Committee.

Outcome: the Board

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

Item 2023-24 (102)

Discussion points:
Performance Brief: December 2023
The Interim Executive Director of Finance and Resources introduced the report which sought to provide assurance to the Trust Board on quality, performance, compliance, and financial matters. The Pack had been reviewed by the Quality and Business Committees in January 2024.

No comments were raised regarding the safe or caring domains.

On the issues highlighted under the responsiveness domain, the Board discussed waiting lists and the need to baseline service offers in the Quality and Value programme due to the mismatch between demand and capacity. A waiting lists deep dive had been undertaken in all three Business Units and there was significant variation on how waiting lists were managed. Neurodiversity waiting lists needed data cleansing and this would be completed by end of March 2024.

Non-Executive Director (KR) asked about the outcome of the podiatry strategic review.

He was informed that the Quality and Value methodology would be used to review service delivery.

There had been no change to the national and West Yorkshire financial context since the report made to the Board in December 2023 but the Board noted that there continued to be significant work ongoing across England to improve the positions of ICBs and provider organisations. The Board was updated on the forecast to deliver a £250k surplus for the Trust in 2023/24.

There were no further questions related to the performance pack.

Outcome: the Board:

- noted the levels of performance in December 2023.

Item 2023-24 (103)

Discussion points:
Significant risks and Board Assurance Framework (BAF) summary report
The Interim Chief Executive introduced the report which provided information about the effectiveness of the risk management processes and the controls that were in place to manage the Trust's most significant risks.

The Board reviewed the Board Assurrance Framework (BAF) summary which provided the current assurance level for each strategic risk.

The Board received assurance that everything was being done to mitigate the risks.

The Board noted changes to the risk register as follows:

- There were three risks scoring 15+ (extreme), two had been recently escalated and one was new:
  - Reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand
  - Mind Mate Single Point of Access (SPA) increasing backlog of referrals (system-wide risk)
  - Patient safety concerns relating to capacity in Yeadon Neighbourhood Team

The Board discussed Risk 1171: Patient safety concerns in the Yeadon Neighbourhood Team.

The Board reviewed the controls currently in place including the action planned to move staff into the team.

Non- Executive Director (IL) noted that the new or escalated risks (scoring 15+) all shared a target date of 31 March 2024 and questioned whether this was achievable.

The Executive Director of Nursing and AHPs informed the Board that progress was kept under constant review, and agreed that the concerns would not be resolved by the target date. Full details on what would have to be achieved to get to target were in the risk report.

Outcome: the Board

- for new and escalated risks, the Board received assurance that planned mitigating actions were in train.

Item 2023-24 (104)

Discussion points:

a) Freedom to Speak Up Guardian Update Report

The report covered the period of 4 August 2023 to 2 February 2024 providing a record of the work of speaking up at Leeds Community Healthcare NHS Trust (LCH) and wider work across the health and care system.

Over the period the Freedom To Speak Up Guardian (FTSUG) service had:

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

Non-Executive Director (KR) noted the number of informal concerns raised and suggested that future reports should outline the themes emerging from these cases.

The Board discussed the resourcing of the FTSUG role which was currently a part time post for two days per week and noted that the time commitment might need to be reviewed at some point in the future.

Non-Executive Director (IL) asked what the implications were for FTSU from the Care Quality Commission whistleblower.

The Executive Director of Nursing and AHPs said that the team in question were fully aware of the FTSU process but the individual concerned had decided not to take the FTSU route.

Outcome: the Board

- noted the report and continuing work to enable the embedding of this work across the Trust.

b) Self-reflection and Planning Toolkit

The FTSUG introduced the paper and explained that the tool was designed to help the organisation identify its strengths, and any gaps that needed work. Completing the tool would demonstrate to the Trust Leadership Team and Board the progress made in developing Freedom to Speak Up arrangements in the Trust.

The self-reflection tool was in three stages. Under stage 2 there were three options for a high-level action.

The Board discussed the options and agreed all three high level actions should be progressed.

Outcome

The Board agreed to:

- Undertake how the Trust work best with detriment/ reported negative impact for staff who speak up.
- FTSU training to be mandated for all new starters.
- A review of how the FTSU links with patient care / patient safety issues in the Trust.

Item 2023-24 (105)

Discussion points:

Safe Staffing Report

The Executive Director of Nursing and AHPs presented the paper which described the background to the expectations of boards in relation to safe staffing, outlining where the Trust is meeting the requirements and highlighting if there is further work to be undertaken. The report was written in the context of the current system and local pressures. The paper had been reviewed by the Quality and Business Committees in January 2024.

The report set out progress in relation to maintaining safe staffing over the last six months. It covered the range of services provided in the Trust.

The Board noted that safe staffing had been maintained across both inpatient units over the last six months.

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

Outcome: the Board

- received and noted the report and the planned work around effective care delivery.

Item 2023-24 (106)

Discussion points:

Patient Experience Six Monthly Report

The Executive Director of Nursing and AHPs presented the report which provided the Board with the six-monthly update of Patient Experience within the Trust. The report incorporated the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).

It provided:

- a review of complaints and concerns
- feedback via surveys, engagement activity, and wider feedback for the six-month period from 1 July 2023 to 31 December 2023; providing an overview of themes, learning and action.
- compares the data and qualitative information with previous years
- information from the Friends and Family Test (FFT).

Outcome: the Board

- received the report and noted the updated information.

Item 2023-24 (107)

Discussion points:

Trust Priorities 2023-24 – Q3 Exception Report

The Interim Executive Director of Finance and Resources presented the report which provided an update by exception of progress against the Trust's 2023/24 priorities at the end of Quarter 3 2023/24.

Non-Executive Director (RG) commented on the narrative style of the report compared to the more granular reporting received in previous reports to the Baord.Board He felt this new style made it more difficult to measure progress.

Outcome: the Board

- Noted the updates and exceptions to progress against the Trust priorities for the year.

Item 2023-24 (108)

Discussion points:

3rd Sector Strategy Update

The Interim Executive Director of Operations presented the report which provided an update on progress on implementation of the strategy over the last six months and noted the significant amount of work undertaken.

Outcome: the Board

- Received the report and noted the progress in implementing the 3rd Sector Strategy.

Item 2023-24 (109)

Discussion points:

Mortality report Quarter 3 2023-24

The Execuitve Medical Director presented the report which provided the Board with assurance regarding the Mortality figures and processes within the Trust in Quarter 3 2023-24.

Associate Non-Executive Director (RB) highlighted the increase in SUDIC deaths in children,

The Executive Medical Director stated that this was in line with the national picture post-pandemic and was currently under review.

Outcome: the Board

- Received and noted the report.

Item 2023-24 (110)

Discussion points:

Standing orders and standing financial instructions

The Interim Chief Executive presented the paper which summarised a number of amendments and updates.

Once approved, a fully updated version of the whole document would be made available electronically to Board members and more widely through the Trust's intranet and website.

The Audit Committee had reviewed this paper at its meeting on 15 December 2023 and agreed to recommend that the Board should approve the proposed amendments.

Outcome: the Board

- Approved version 3.5 standing orders, reservation and delegation of powers and standing financial instructions in line with the summary of changes outlined in this paper.

Item 2023-24 (111)

Discussion points:

Patient Safety Incident Response Framework Plan (PSIRP)

The Executive Director of Nursing and AHPs presented the final draft of the Trusts's PSIRP for 2 Jan 2024 – 31 March 2025. This was a national requirement as part of the implementation of the Patient Safety Incident Response Framework (PSIRF) which was replacing the historical Serious Incident

Framework from 2015 and had been reviewed and recommended for approval by the Quality Committee on 22 January 2024.

Outcome: the Board

- Approved the Patient Safety Incident Response Plan (PSIRP).

Item 2023-24 (112)

Frontline Digitisation update

The Interim Execuitve Director of Finance and Resources introduced the paper and explained that in order to maximise the benefits of digital transformation for patients and clinicians, and to harness the power of data, the NHS was investing £1.9bn to ensure there were the right digital foundations in place. This was a three-year programme of funding running from 2022/23 to 2024/25. Formal notification of the funding had been received on 2 February 2024.

Non-Executive Director (RG) informed the Board that the Business Committee had reviewed the funding streams some time ago and suggested that it should do so again at its meeting in February 2024 now that the new Associate Director of Digital Transformation was in post.

The proposal had been recommended for approval by the Business Committee on 24 January 2024.

Outcome: the Board

- Noted the plans and approved the allocation of funding against these plans for the 2023-24.

Item 2023-24 (113)

Discussion points:

Any other business and Blue Box Items

The Trust Chair referred Board members to the additional Blue Box items (115-117) on the agenda and the papers which had been circulated to support those items. He explained that the Blue Box was for items already discussed at a committee in full and where any concerns are escalated via the Chairs' assurance reports.

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

Non-Executive Director (IL) referred to Item 116 – the Trust's Research and Development Strategy Update report and it was noted that a new strategy was due to be launched in 2025.

It was agreed that a specific update on the research work would be brought back to the Board following further consideration by the Quality Committee.

Action: Further update to the Board following consideration by the Quality Committee.

Responsible Officer: Executive Medical Director

Item 2023-24 (114)

Close

The Trust Chair closed the meeting at 12.10pm

Date and time of next meeting
Thursday 28 March 2024 9.00am-12.00 noon

Additional items (Blue Box)	
2023-24 115	Information Governance/Data Protection Officer update report
2023-24 116	Research and Development Strategy update
2022-23 117	Board Workplan – to note

AGENDA ITEM 2023-24 (121b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 28 March 2024

Agenda Item Number	Action Agreed	Lead	Timescale	Status
2 February 2024				
2023-24 (98)	**Patient Story: Community Neurology Service (CNRS):** • a progress report on developments in the CNRS should be brought to the Board in six months' time.	Executive Director of Nursing and AHPs	Board meeting 4 October 2024	Board meeting 4 October 2024
2023-24 (113)	**Blue box item 116 : Research and Development Strategy:** • a specific update on the research work would be brought back to the Board following further consideration by the Quality Committee.	Executive Medical Director	To be agreed	Ongoing
4 August 2023				
2023-24 (41)	**Health Equity Strategy update:** • Update on the timescale for production of the e-book.	Executive Medical Director	Work with patients identified the e-book was not an accessible format. Outcomes of the communication event are included with patient rights on the person-centred LCH webpage	**Action closed**
2023-24 (41)	• Future reports to be more outcome focussed on the redress of inequalities across the service.	Executive Medical Director and Health Equity Lead	Outcome-focus will be progressed through the development of a measurement framework, with supporting KPIs.	To be included in report to Board in August 2024 **Action Closed**

Actions on log completed since last Board meeting on 2 February 2024	
Actions not due for completion before 28 March 2024: progressing to timescale	
Actions not due for completion before 28 March 2024: agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding at 28 March 2024: not having met agreed timescales and/or requirements	

Trust Board Meeting Held In Public: 28 March 2024

Agenda Item Number: 2023-24 (123)

Title: Chief Executive's report

Category of paper: for information

History: Not applicable

Responsible director: Interim Chief Executive

Report author: Interim Chief Executive

Executive summary (Purpose and main points)

This report updates the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest.

This month's report focusses on:

- Carer Confident Employer
- National Preceptorship for Nursing Interim Quality Mark
- Tier 3 Weight Management Service
- Collaborating in Partnership

Recommendations

Note the contents of this report and the work undertaken to drive forward our strategic goals.

1. Introduction

This report updates the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest. The report, which aims to highlight areas where the Chief Executive and senior team are involved in work to support the achievement of the Trust's strategic goals and priorities: delivering outstanding care in all our communities, staff engagement and support, using our resources efficiently and effectively, and ensuring we are working with key stakeholders both locally and nationally.

2. Carer Confident Employer

I am delighted to announce that LCH has been recognised as a Level 1 Carer Confident Employer. The Carer Confident benchmarking scheme assists employers to build a supportive and inclusive workplace for staff who are, or will become, carers and to make the most of the talents that carers can bring to the workplace. The certificate of achievement is presented to employers with a UK presence who have demonstrated that they have built an inclusive workplace where carers are recognised, respected and supported. I'd like to thank everyone involved in the application process. We will now look at ways to increase the profile around working carers, building on work undertaken previously such as awareness sessions for staff and managers, and hearing from our staff who are carers.

3. National Preceptorship for Nursing Interim Quality Mark

In a similar vein, the Trust has also been awarded the National Workforce Skills Development Unit's National Preceptorship Interim Quality Mark. The purpose of preceptorship is to provide support, guidance, and development for all newly registered practitioners to build confidence and competence as they transition from student to autonomous professional. The Quality Mark is valid for two years and will be used on documentation and literature to promote our preceptorship programme. We are so very proud to have been awarded the Quality Mark, as it truly reflects our fantastic preceptorship offer here at LCH.

4. Tier 3 Weight Management Service

The Interim Chief Executive recently attended the Adults, Health and Active Lifestyles Scrutiny Committee where a lively debate took place on the approach and plans with regard to Healthy Weight in Leeds. The Committee received several papers (available in the blue box) including one on the Tier 3 Weight Management Service provided by LCH. In summary, due to an unmanageable increase in referrals, the service was paused to new referrals from the 15 July 2023 following agreement with Leeds system partners and the Scrutiny Committee. Since the pausing of referrals there has been a 19.7% reduction in the caseload (from 1323 to 1063); however 577 patients on the caseload are still awaiting intervention. All referrals have been triaged and patients communicated with concerning waiting times, but it has been agreed that it is not yet

possible to re-open to referrals. Discussions continue with the ICB on how to manage the situation.

5. Collaborating in partnership

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

Meeting	Attendee	Date
West Yorkshire Health and Care Partnership Board meeting	Brodie Clark	5 March
West Yorkshire Chairs, NEDs, Associate NEDs and NEMs Peer Networking Session	Brodie Clark Helen Thomson	5 March
West Yorkshire Mental Health Collaborative Committees in Common	Brodie Clark Sam Prince	31 January 2024
WY Community Health Services Provider Collaborative – Exec Leads Time Out	Sam Prince Sam Prince & Brodie Clark	5 February 12 March
Leeds Partnership Executive Group	Sam Prince Andrea North Andrea North	9 February 23 February 8 March
NHS Strategic Finance Executive Group	Sam Prince & Andrea North Sam Prince, Andrea Osborne & Andrea North Steph Lawrence, Andrea Osborne & Andrea North Sam Prince, Andrea Osborne & Andrea North Sam Prince, Andrea Osborne & Andrea North	29 January 12 February 19 February 26 February 11 March
Leeds Committee of WY ICB public meeting	Sam Prince	13 March

Leeds Health and Wellbeing Board – Board to Board	Brodie Clark Sam Prince	30 January 2024
Leeds Health and Wellbeing Board workshop	Andrea North	29 February
Leeds Adults, Health and Active Lifestyles Scrutiny Board	Sam Prince	12 March
Leeds City Wide Clinical and Care Profession Forum	Ruth Burnett	6 March
Alliance Board	Sam Prince Laura Smith Andrea North Andrea Osborne	12 February
WY Finance forum	Andrea Osborne	23 February
Leeds NHS DoF Meeting	Andrea Osborne	6 February 13 February 20 February 27 February 5 March 12 March
Mental Health and Community DoFs	Andrea Osborne	16 February
Yorkshire and Humber HRD Network	Laura Smith	4 March
Leeds HRDs meeting	Jenny Allen	7 March
Community Chief People Officers meeting	Laura Smith	11 March
Yorkshire and Humber Chairs	Brodie Clark	7 February
NHS ICB and Trust Chairs' event	Brodie Clark	28 February
West Yorkshire Community Clinical Group	Steph Lawrence	29 January
Virtual Ward National Clinical Advisory Group	Steph Lawrence	21 February
Quality and People's Experience Sub committee	Steph Lawrence	6 March
West Yorkshire Stroke Planning Event	Andrea North	7 March

Yorkshire & Humber Mental Health and Community EPRR group	Andrea North	14 March
NHS England Regional Roadshow	Andrea Osborne	6 March

Sam Prince
Interim Chief Executive
March 2024

Trust Board Meeting Held In Public : 28 March 2024

Agenda item number: 2023-24 (124)

Title: System Flow Update

Category of paper: Information
History: Board

Responsible director: Director of Operations
Report author: Head of System Flow for the Leeds Health & Care Partnership

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Executive summary (Purpose and main points)

The purpose of the paper is an update so we are asking Business Committee and Board to note the content not take action.

Summary

- Patients are flowing between primary, intermediate and acute care services in Leeds.
- Waiting times for bed based intermediate care services have increased over the winter period.
- There is more demand in the system and the absolute numbers on waiting lists have grown proportionately.
- Additional capacity has been put in place to support the increase demand over winter, much of this comes to an end on 1st April.
- Our process times for admission avoidance and discharge remain too long, the HomeFirst Transfers of Care Programme is working to reduce this as it rolls out new ways of working.
- All organisations in the system are experiencing pressures equivalent to OPEL 3 or above.

Recommendations

No recommendations – information shared to provide context for any relevant decision making.

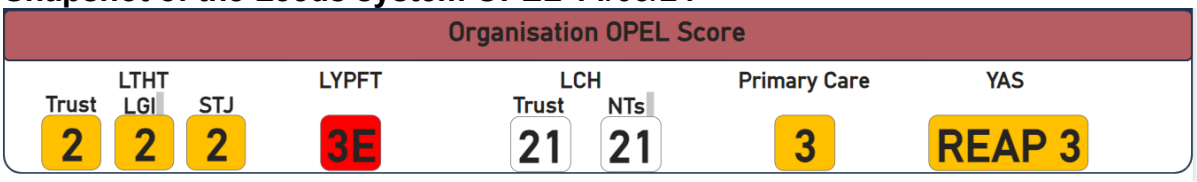
System flow update

1 Introduction

The system flow governance structure through SROG and Active System Leadership (ASL) meetings maintain oversight of the risks and mitigations to maintain flow through the system as we come toward the Easter weekend.

- All organisations in the system are experiencing pressures equivalent to OPEL 3 or above.
- Challenges with patient flow are impacting on patient safety within their organisations, with unallocated visits in LCH, ESA & corridors in use in LTHT and high out of area position for LYPFT.
- Actions being taken by the system have gone some way to mitigate the pressures and there is flow between services, but we remain significantly challenged.

Snapshot of the Leeds system OPEL 14/03/24



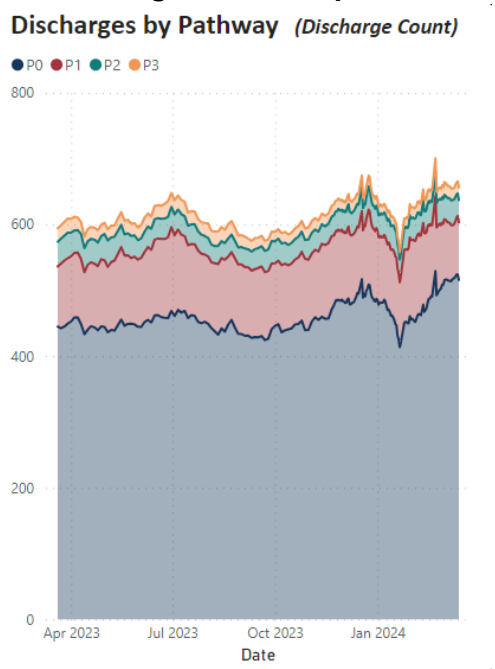
2 Background

- We remain in a better position than 2023/24 with capacity within intermediate care (home-based) services and the ability to surge into discharge to assess care home beds if essential.
-

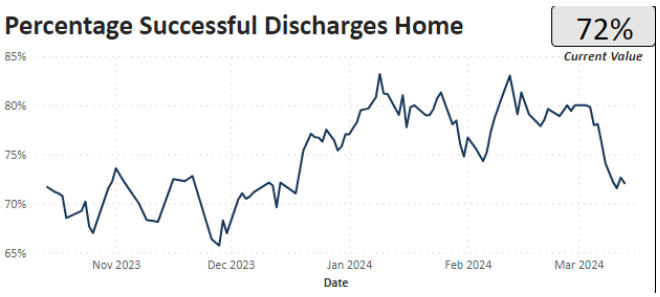
3 Current position/main body of the report

The number of people going home following a stay in hospital or in an intermediate care bed is increasing in line with the systems HomeFirst vision and programme.

% Discharges from hospital



% Discharges from CCBs



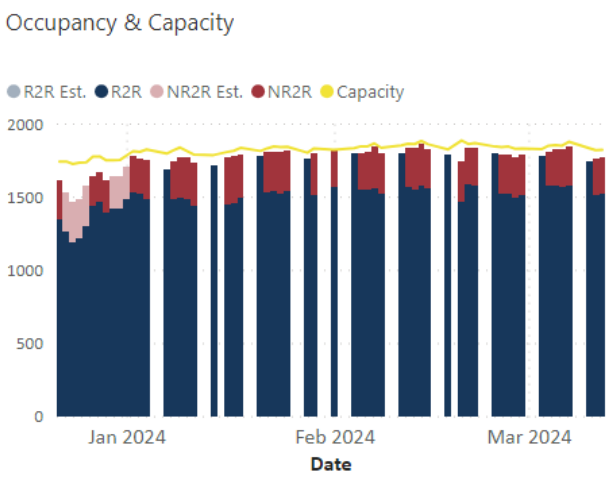
Primary care pressure summary

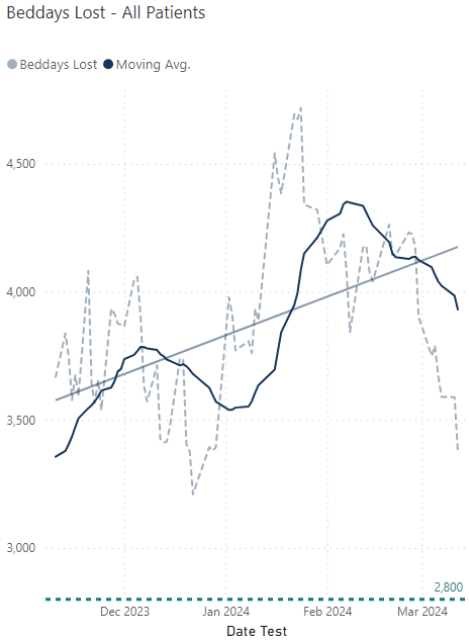
- There are pressures across primary care with some practices declaring OPEL 4 in particularly pressurised pockets.
- The system has put in additional primary care capacity for respiratory conditions in adults and paediatrics over the winter period. The adult service (AARC) will cease on the 28th March and the paediatric service (CAPS) on the 30th April.

LTHT pressure summary

- LTHT continues to prioritise ambulance handover times and to perform well against their peers.
- LTHT bed occupancy is currently at 97% (although has exceeded this) resulting in challenges admitting people in a timely way and the use of Exceptional Surge Areas (ESAs), including placement on corridors.
- The number of people waiting over 12 hours from TCI- admissions have remained high since Sept, the currently 17 per day (28day moving average)
- SDEC expansion within in LTHT opened in December and has offered increase admission avoidance capacity to the system.
- LTHT continues to have 5 additional wards open for people who no longer meet the criteria to reside in hospital and is aiming to close these and reduce reliance on agency staffing

LTHT Occupancy & No Reason to Reside Trends





System Flow Summary
Data as of 13/03/24, 17:04
Filtered by **Days** (is 28 Days), **Date** (10/11/2023 - 14/03/2024), **sourcetype** (is Hospital)

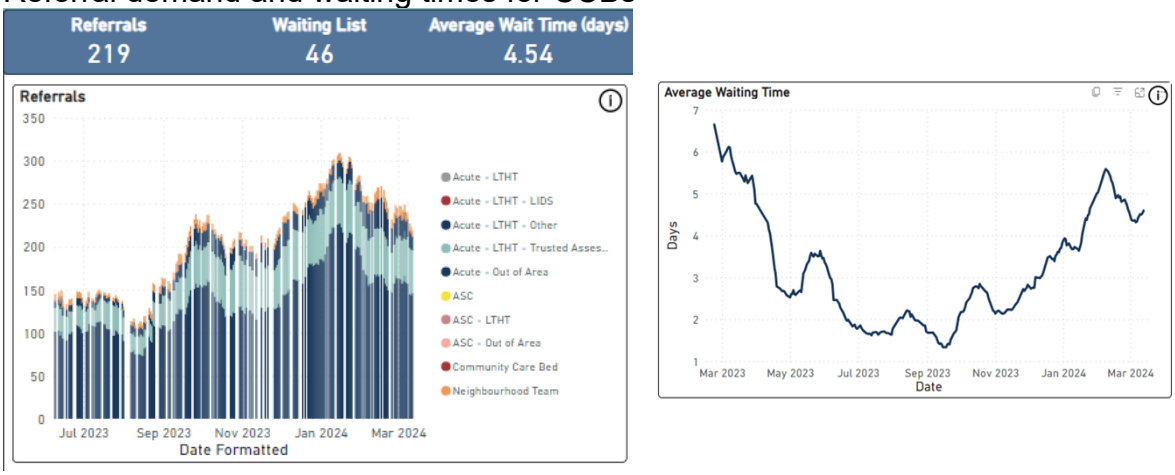
LCH Intermediate Care

- The Home Wards have reached our target is to create 115 Virtual wards beds in total by March including a new remote health monitoring service to support early discharge from hospital.
- There is an opportunity to further utilise the Home Wards' capacity and the HomeFirst programme is working to increase demand through improving awareness and referral route/pathways.
- The Neighbourhood Teams have ongoing challenges because of demand and staffing, the service continue to prioritise hospital discharge wherever possible.
- The Neighbourhood Team capacity has been supplemented by partnering with private home care companies, funded through the ICB – this funding comes to an end in April 2024.

Community Care Beds (CCB)

- Demand for the CCBs has increased since the start of Sept and has outstripped the available capacity during January leading to an increased waiting times.
- Waiting times for a CCB continue to be lower than for the same period last year when there were significantly more D2A beds in use to support pathway 2 flow.

Referral demand and waiting times for CCBs



Rehab & Recovery Beds
Data as of 14/03/24, 15:04
Filtered by **Value** (is Percentage), **Alternative Timeframe** (is 28 Days), **Date** (10/06/2023 - 15/03/2024)

- After previous successes reducing the length of stay in the CCB, we have started to see an increase at the South Recovery Hub (Alliance) and Wharfedale beds (LCH). The HomeFirst Programme and leadership teams are working with staff in the beds and partner organisations to bring the length of stay back to the KPI of 34 days.

Snapshot of CCB bed base KPIs 14/03/24

CareHome	Weekly Starts (Avg.)	Beds Occupied	Number with NR2R (Most Recent)	Max Potential Capacity	Weekly Discharges (Avg.)	Discharge LoS (Avg.)	% Discharged Home (Avg.)
Recovery Hub - North West	5	34	14	35	5	42.53	69%
Green Lane	5	33	20	34	5	40.20	49%
Recovery Hub - East	5	33	19	37	5	33.52	56%
Wharfedale Recovery Hub	5	31	7	30	5	51.95	54%
Adel Manor	5	28	9	30	6	37.45	65%
Recovery Hub - South	5	27	10	29	5	48.33	64%
Harrogate Lodge	6	26	6	28	5	33.21	65%
Seacroft Grange	1	5		-	1	25.00	33%

- Additional winter CCB capacity will close over March and 30 Community Care Beds at Adel Manor will close when the contract comes to an end in May 2024. The length of stay in the remaining beds will become more imperative to ensure people receive timely care.

Changes in CCB capacity and impact on admissions

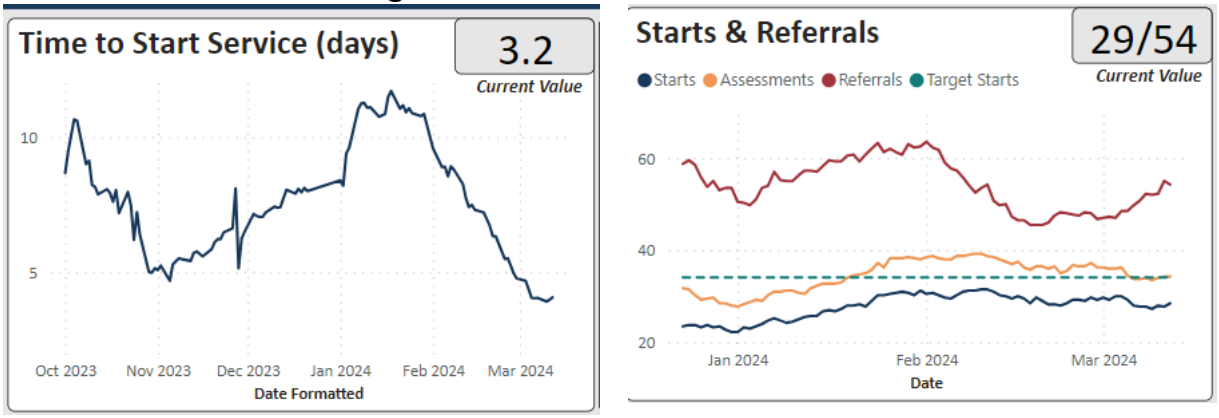
CCB capacity changes	Dates open	Date close for admissions	No. of bed	Impact on admissions (estimate)
Wharfedale	Feb 24- Mar 24	10th March	4	0.5 admissions/ week
Seacroft Grange	Feb 24 – Apr 24	31st March	5	1 admissions/ week
Adel Manor	Nov 23- May 24	14th April	30	5.05 admissions/ week
			Total	**6.55 admissions per week**

Adult Social Care

LCC - Reablement

- The HomeFirst Active Recovery Programme has successfully increased capacity within the Reablement service through new ways of working. Staffing constraints have limited the impact of this and more gains are expected as towards May and June 2024.
- The waiting time for Reablement is now at the lowest it has been at 3.2 days on average for step-up & step-down customers.

Reablement Waiting Time & Starts

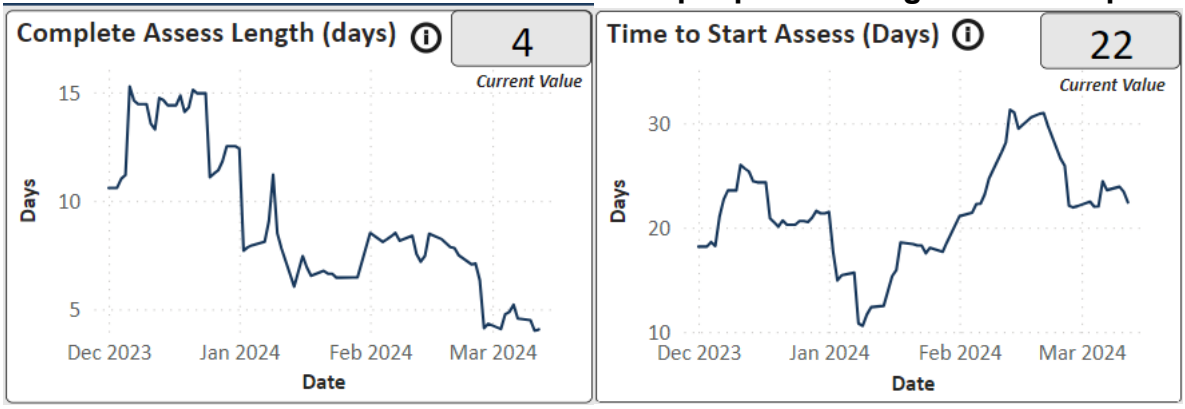


System Flow Summary
Data as of 13/03/24, 17:04
Filtered by **Days** (is 28 Days), **Date** (22/12/2023 - 14/03/2024)

Social Work Assessments

- Capacity to complete social work assessment remains a challenge.
- The length of time from referral to completion of Care Act assessment for people being discharged from hospital has increased from 22 days in Jan to 26 days on average (4 days to start & 22 days to complete). This includes people being supported at home before the care act assessment through the Short-term Assessment service.

Social Care Act Assessment Timeframes for people discharged from hospital



System Flow Summary
Data as of 13/03/24, 17:04
Filtered by **Days** (is 28 Days), **Date** (02/12/2023 - 14/03/2024)

The Case Managers in TOC are supporting social care capacity by completing trusted assessments to support Discharge to Assess pathways. In addition, the ICB is funding:

- 2 agency social workers to support discharge and upskilling of the Reablement staff.
- 4 agency social workers to support discharge from the additional winter bed capacity in the system (LTHT nR2R wards and Adel Manor CCB)

4 Next steps

The additional capacity (Short-term Assessment Service), to support people at home that has been in place over winter will continue on a month by month basis while they develop a single pathway for social care support at home and increase the capacity within their Reablement service through the HomeFirst Active Recovery work.

The Active System Leadership groups have identified a risk to the system regarding the closure of 30 community care beds in May when the Adel Manor contract comes to an end. Modelling work is currently underway to help the team identify mitigation opportunities. Work has begun to reduce the length of stay in the CCB bed bases above the 34 day HomeFirst target to support system flow with fewer beds.

A new electronic brokerage system will be implemented on the 1st April which will reduce the length of time that brokering for a care package or care home takes within LCC.

The roll out of the Transfers of Care new model of case management is expected to reduce the length of stay for people requiring a supported discharge from LTHT.

To assure ourselves that patients are not being discharged from hospital prematurely or without adequate community support we monitor the readmission rates to LTHT monthly. The average 30 day readmission rate for non-elective patients at LTHT has remained stable since Oct 22 and is currently 9.96%, reassuring us that the improvements we have made by increasing capacity and

pace have not adversely affected readmissions. There are a range of actions being taken within LTHT to maintain and reduce this further.

Progress against the winter capacity and demand plan is shown in Appendix A
The February System Flow Newsletter is shared in Appendix B

5 Recommendations

There are no recommendations for the Board/Committee paper shared for information and update

Appendix A – Leeds Winter Capacity & Demand plan

	Leeds Winter plan	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
	Demand modelling LTHT (bed deficit at 96% occupancy)	baseline	0	0	150	178	150
	Capacity gap after mitigation from currently funded discharge schemes (beds)		-19	-64	31	12	-36
	Additional impact of the admission avoidance schemes that will further reduce bed demand in		*826*	*1294*	*1733*	*1736*	*1723*
	Actual bed deficient against modelled demand (beds)		-37	-77	31	-28	-29
	Actual additional admissions		*32*	*269*	*391*	-59	-215
System Impact	Confirmed Discharge schemes (already funded) Beds Released		56.4	140.8	238.2	371.6	365.0
Acute Hospital capacity	LTHT Beckett ward	0	0	0	30	60	60
Actual		0	0	0	30	60	60
Pathway 1	LTHT Home Telemetry (children's, ERCP,	0	5	10	16	18	22
Actual		0	3	8	10	10	12
Pathway 1&2	Home First Improvement	0	9	19	28	43	47
Actual	Oct update: beds on track and reablement well ahead of target	0	34	20	15	23	24
Pathway 1	Home Ward Frailty within HomeFirst	5	5	5	15	15	15
Actual		0	0	7	9	9	15
Pathway 1	Winter Short-Term Assessment Service	0	0	30	30	30	30
Actual			0	42	55	104	68
Pathway 2	The Oaks @ Dolphin Manor (wards dependent)	0	0	0	0	0	12
Actual		0	0	0	0	0	0
System Impact	Admission/Attendance avoidance Capacity change since 22/23	814	-1,752	-985	94	601	728
Primary Care	Same Day Response service in primary care	1350	0	0	0	0	0
Actual		1350	0	0	0	0	0
Primary Care	ARI pods hub (CAPS)	672	672	840	1000	1000	1000
Actual		606	698	882	854	1272	1443
Primary Care	AARC... Adult Acute Respiratory Clinic... for 111 a	0	0	272	544	544	544
Go Live delivery from				68	391	442	425
Actual		0	0	68	390	442	423
Primary Care	LCD triage of UCR calls (prior to passing to LCH) Ambulance avoidance	120	124	150	155	155	140
Actual		85	86	75	98	81	72
Community Response	HomeFirst (enhance community response)	3	4	6	8	11	13
Actual		No additional admissions avoided this month					
Admission avoidance	LTHT SDEC enhancements	0	20	20	20	20	20
Actual		0	10		TBC	TBC	14

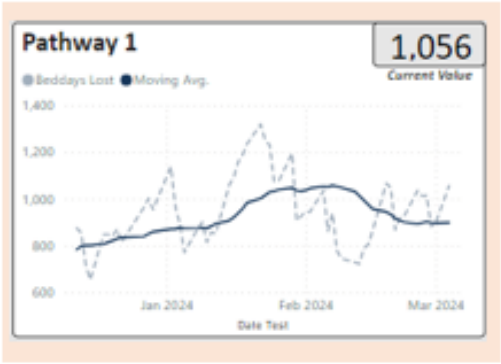
System Impact	Additional non-planned capacity actioned through System Resilience Structures in response to pressure	Jan-24	Feb-24	Mar-24
Attendance/admission avoidance	Expanding the Leeds UTC's St Georges and Wharfdale additional illness resource 8am-11pm to support the junior doctor strikes - 1st - 8th Jan *(Number of hours procured from LCD)*	120	0	
Attendance/admission avoidance	GP OOH F2F between 8am-23:59 to support the junior doctor strikes - 1st - 8th Jan *(Number of hours procured from LCD)*	128	18	
Attendance/admission avoidance	GP & Driver between 18:00 and 23:59 to support the junior doctor strikes - 1st - 8th Jan *(Number of hours procured from LCD)*	48	0	
Attendance/admission avoidance	The additional CAPS capacity, 1st Jan- 14th Jan to support with the junior doctor strikes *(Number of hours procured from GP Confed)*	93	93	
Pathway 2	4 additional beds at Wharfdale CCB unit from 5th Feb - closed 10th March		4	closed 10th March
Pathway 2	5 additional beds at Seacroft Grange - contracted until the 12th April 24		5	close 12th April

Appendix B – February 24 System Flow Newsletter

Issue 8 | February 2024 |

Leeds Health & Care Partnership

SROG & Active System Leadership Update



Pathway 1 – The additional winter Short-Term Assessment comes to an end following Easter.

The Short-Term Assessment service has proven highly successful as a bridging service throughout winter. The patient feedback has been very positive and has expedited discharges to maximise system flow.

Process review is currently being conducted for people requiring therapy input before discharge on Pathway 1. This is due to increased demand associated with the HomeFirst changes.

Pathway 2 – The demand for pathway 2 has decreased since the surge in Jan 24. The final date for admission to Adel Manor is the 15th April - plans in preparation for closure are being developed.

There are 4 additional beds at Wharfedale with an end date of *15th March*. In addition to this there are a further 5 beds open at Seacroft Grange.

Pathway 3 – New pathway 3 review meeting to begin WC 26th February led by Adult Social Care

2 Agency Social Workers to begin WC 26th February to support system flow.

Working group to be established led by LTHT and the CCC Bed Brokerage team to explore how we align all pathways especially temp to perm pathways to the Transfer of Care Choice Policy.

253

LTHT NR2R

KEY HEADLINE

CAPS clinics have been increased throughout winter to support admission avoidance and pressures on ED.

GP Confed have shared with system partners that an exit plan will begin WC 4th March in preparation for the service closing in April.

Providers are working closely to flag any potential risks to the system due to the continuous high demand on the CAPS service.

REMINDERS

Doctors Industrial Action took place between 24th February – 28th February.

The Leeds Better Care Fund Quarterly Return was submitted on the 9th February. Thank you to System Partners for your contributions to the submission.

The Better Care Fund Panel has now been reestablished.

This panel will consist of both operational and senior commissioning leads who will develop and agree the future Better Care Fund plans for the city.

Transfer of Care Choice Policy Workshop to take place on Wednesday 28th February @ East Recovery Hub to support intermediate care embedding the Transfer of Care Choice Policy into their community care bed bases.

Trust Board Meeting held in public: 28 March 2024

Agenda item number: 2023-24 (125a)

Title: Quality Committee Chair's Assurance Report 26 February 2024

Category of paper: For Assurance

History: N/A

Responsible director: Quality Committee Chair

Report author: Company Secretary

Executive summary:
This paper identifies the key issues for the Board arising from the two-item Quality Committee meeting held on the 26 February 2024, and it indicates the level of assurance based on the evidence received by the Committee. This meeting was held as a hybrid meeting in person and on MS teams.

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

Draft 2024/25 Trust Priorities
The Committee reviewed the draft priorities and provided comments prior to them being signed off by the March Board. It was agreed that the output from the Equity Board Workshop should be captured in the report for Board. Assurance was provided that sufficient engagement will have taken place prior to the Board meeting.

Quality and Value Programme
The Committee was asked to comment on the content of the paper and whether it provided the required assurance that the Quality and Value Programme had been designed to deliver on the challenging financial savings, whilst maintaining quality, safe and equitable services. Suggested changes included making giving more prominence to the EQIA process in the report, including a breakdown of protected characteristics in the metrics, including staff networks in the communications plan, and linking the metrics to the Trust values. The governance process for the programme was discussed and it was acknowledged that this would be monitored.

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 28 March 2024 **(Item 125b)**
Date of Meeting:	28th Feb 2024	**Date of next meeting:**	27th March 2024

Introduction	
Quorate meeting with a full agenda and good debate on key topics – good challenging conversations with constructive feedback provided on papers requiring comment.	
Alert	**Action**
No alerts were raised.	N/A

Advise

- Draft Trust Priorities – Committee reviewed these following TLT and QC feedback. NEDs requested further consideration of the commitments and the expectations created in relation to delivery of financial stability and sustainability, and driving down backlogs / waiting lists , but it was agreed that the priorities need to be honest and realistic about what is achievable within the financial envelope. Financial sustainability may need to be added as a strategic risk instead, to reflect the longer-term nature rather than what can be achieved in-year. The commitments to improving staff wellbeing needed further work. Committee was supportive of the approach subject to the above comments being incorporated.
- Draft Financial Plan 2024/25 – headline plan reviewed. Planning guidance expected mid-March so headlines based on planning assumptions. Working towards a breakeven plan, delivery of which requires release of £14.4m efficiency savings. The ICB financial position is a key risk and the impact on LCH not yet known. Modelling of best-worst scenarios, and Plan B shared with Committee. An additional Board meeting is scheduled for 14th March to sign off the plan. Committee was grateful for the clarity in the plan and acknowledged that discussions were ongoing ahead of the final sign off.
- Real Living Wage – Committee approved the spend associated with the retrospective payment of the £12 Real Living Wage hourly rate for affected LCH staff, backdated to 1 November 2023 in support of the decision taken at Nominations & Remuneration Committee.
- Quality & Value Programme – Committee commented on the costed plan, risks, mitigations, service redesign methodology and programme governance including questions about Board assurance and decision making. Concerns raised regarding pace, and whether there was sufficient capacity to deliver the programme or whether project management investment was required. Programme lead stressed LCH can't continue to deliver the same or more, for less money and the Committee discussed scrutiny of service design from a quality perspective within the programme governance. Service reviews would revisit the commissioned level of services.
- Digital letters business case – approved subject to further consideration of health equity risk via EQIA and whether opting out should be the default position.
- Workshop – BAME Talent Development Programme – updates to be included in Workforce report going forwards.

Committee Escalation and Assurance Report

Assurance
• Digital Update – paper being considered by TLT around strengthening IT resilience. Digital Strategy will be informed by the Q&V listening events and digital maturity assessment, with an update brought to April's meeting, and the full draft strategy in May 2024. • Waste management – significant progress has been made and the Committee was assured the Trust is well placed should the Environment Agency decide to include LCH in their audit programme of NHS Trusts management of waste compliance. • Internal Audit Annual Plan – in development. Audit Needs Assessment reviewed. Draft plan will go to TLT and Audit Committee in March 2024.
Risks Discussed and New Risks Identified
• Trust and System financial pressures

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage	12 (high)	Reasonable	N/A
Risk 3 Failure to invest in digital solutions. If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable and the impact will be delays in caring for patients and less than optimum quality of care	9 (high)	Reasonable	Committee agreed the Associate Director of Digital Transformation would be in attendance going forwards to increase assurance around this strategic risk.
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with	9 (high)	Reasonable	N/A

legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention.			
Risk 5 Failure to deliver financial and performance targets: If the Trust does not deliver key financial and performance targets, agreed with NHS England and the ICB, then it will have adverse consequences for financial governance and cause reputational damage.	12 (high)	Reasonable	N/A
Risk 6 Failure to have sufficient resource to transformation programmes: If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.	9 (high)	Reasonable	N/A
Risk 7 Failure to maintain business continuity (including response to cyber security): If the Trust is unable to maintain business continuity in the event of significant disruption then essential services will not be able to operate, leading to patient harm, reputational damage and financial loss.	12 (high)	Reasonable	N/A
Risk 8 Failure to have suitable and sufficient staff resource (including leadership): If the Trust does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, then the impact will be a reduction in quality of care and staff wellbeing and a net cost to the Trust through increased agency spend.	12 (high)	Reasonable	N/A

Author:	Helen Robinson/Rachel Booth
Role:	Company Secretary/Committee Chair
Date:	4/3/2024

Trust Board Meeting held in public: 28 March 2024

Agenda item number: 2023-24 (125c)

Title: Audit Committee Chair's Assurance Report 8 March 2024

Category of paper: for assurance
History: Not applicable

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

Meeting summary

Internal audit (Audit Yorkshire)

The Committee received the following internal audit report: National Standards of NHS Cleanliness (Follow Up) (high assurance). Two advisory reports had also been received since the last meeting, and three further reports were in draft form. The Committee discussed the difficulties delivering the plan arising from the changes to the Executive team during the year, and was assured that support had been received for the remaining audits that were outstanding for 2023/24. The plan for 2024/25 had been frontloaded so the work would be more evenly spread throughout the year, and a reserve list of audits was being held so audit staff could be fully utilised at all times.

In terms of the overdue recommendations, considerable work was being undertaken by the Interim Executive Director of Finance and Resources in order to address them. In addition, new software was shortly being introduced by Audit Yorkshire which would give key staff within the Trust direct access to recommendations, making it easier to run reports and follow anything outstanding up. The Committee heard how a high number of overdue recommendations could have a negative impact on the Head of Internal Audit Opinion, so a firm grip was being applied to this prior to year end. It was agreed that the Quality and Business Committees would spend some time looking at this in the March meetings.

The Committee reviewed the draft plan for 2024/25. The Quality and Value Programme audit had been scheduled for Q2/3 but consideration would be given to a two-part audit so independent opinion could be gained earlier and the second part would focus on delivery of the programme.

External Audit (Mazars)

The external auditor advised the Committee that the value for money audit work had now commenced and no risks or areas of significant weakness had been identified to date, although he was conscious of the financial position and sustainability challenges. There was a very minimal risk of delay to completing this work for the Trust.

The increase in fees for the additional two years of the (3+2) contract reflected the increasing complexity of auditing NHS Trusts since the fees were agreed three years ago.

Annual Report and Accounts

The Committee received assurance that the Trust was sighted on the requirements for the 2023/24 annual report and accounts process; that there were sufficient relevantly qualified and experienced staffing resources in place to deliver the workload by the final submission date of 28 June 2024; that any changes to the reporting requirements since last year had been recognised; and that a detailed plan had been prepared incorporating feedback and learning from prior years. No further changes were anticipated to the key dates, as these had already been reviewed and amended following feedback from External Audit.

Financial Controls

The Committee was given assurance that the Interim Executive Director of Finance and Resources intended to strengthen both the tender waiver process and the process for investment decisions being put before the Committee.

In terms of the Healthcare Financial Management Association (HFMA) Financial Sustainability Update, the Committee was informed that progress had been made since it was last reviewed, but concern remained about the overall room for improvement which had been identified.

Data Security Protection Toolkit Baseline Submission
The Committee noted the baseline submission and the outstanding areas that would need to be completed before the final submission in June 2024.

Assurance
The Committee reflected on the relevant sources of assurance it had received at the meeting and agreed that **Reasonable** assurance had been provided that BAF risk 7 (Failure to maintain business continuity (including response to cyber security) was being managed. It was noted that Cyber Essentials Plus accreditation had now been achieved.

Trust Board Meeting Held In Public: 28 March 2024

Agenda item number: 2023-24 (125d)

Title: Charitable Funds Committee 12 March 2024: Committee's Chair assurance report

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

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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board from the Charitable Funds Committee held on 12 March 2024.

Recommendations

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

Charitable Funds Chairs Assurance report

1 Introduction

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

2 Background

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

3 Current position/main body of the report

Charitable development updates

The committee received an update from the Charities fundraiser about the work during the last few weeks.

The Charity newsletter had been shared with members of the Committee and received positive feedback. Future editions of the newsletter would be published on the Trust intranet.

The Charitable Funds Officer outlined activity since the last meeting, which included:

- Bake sales held at White Rose Park
- Planning for the ABU Three Peaks walk
- Attendance at the SBU Celebration Event
- Attendance at the Admin Celebration Event
- Clothing collection bin to be situated at White Rose Park
- Pennies from Heaven to be launched in the Trust
- Engagement with internal staff
- Engagement with external organisations
- Pop up stall at Leeds Trinity

The Executive Director of Nursing highlighted ‘A Slice of Saturday Night’ which was a show being led by the Chief Executive and would be held in the Summer the raise funds for the Trust Charity.

The Charitable Funds Officer shared details of a grant application she was pursuing; offers of support were received from the Committee Chair and the Finance Team.

The Charitable Funds Officer would be attending the NHS Charities Together Conference in May 2024.

Finance Report

The Assistant Director of Finance – Financial Control shared the Finance Report. There were no questions on these, and all agreed it was a good update.

Committees Annual Report & Review of Terms of Reference

The Committee approved the Annual Report prior to submission to Audit Committee.

The Committee Chair suggested adding details of fundraising activities to future reports.

The Committee received the Terms of Reference prior to submission to Trust Board. The Company Secretary outlined the amendments made to the Committee membership, to include the Company Secretary and the Charitable Funds Officer.

4 Impact:

4.1 Quality

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

4.2 Resources

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

4.3 Risk and assurance

As above in relation to the potential financial risk.

5 Next steps

N/A

6 Recommendations

The Board is recommended to:
Receive this report.

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held in Public: 28 March 2024
Agenda item number: 2023-24 (125e)

Title: Nominations and Remuneration Committee – 15 March 2024: Chair Assurance Report

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Category of paper: for assurance
History: n/a

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

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting held on 15 March 2024.

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

Items discussed:

Clinical Excellence Awards Scheme:

The Committee considered and approved the eligible Consultant list as well as the proposal that the pot of money available for the 23/24 financial year for Clinical Excellence Awards should be split equitably between Consultants who were eligible.

Annual Work Plan:

The Committee approved the annual work plan.

Critical Incentive Scheme Evaluation

The Committee received and discussed a further update relating to the Critical Incentives scheme. The comparison of the cost of generating additional staff capacity was noted and the Committee were assured that an Internal Audit was currently underway to review the governance and controls associated with this scheme.

Executive Appointments

The Committee noted the following:

- That the substantive Chief Executive (Selina Douglas) would commence in post on 15 April.
- That the process to appoint a substantive Director of Finance would be held on 21st March; the Committee also considered further potential discretion in terms of starting salary for this post.
- The Committee approved the salary for the substantive Director of Nursing post which would be advertised shortly and following Steph Lawrence announcing her retirement.

Recommendations

The Board is recommended to note this information.

Trust Board Meeting held in public: 28 March 2024

Agenda item number: 2023-24 (126)

Title: Performance Brief February 2024

Category of paper: for assurance
History: Quality Committee – 25 March 2024
Business Committee – 27 March 2024

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

Executive Summary (purpose and main points)

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

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

Recommendations

Committees and the Board are recommended to:

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

Performance Brief – February 2024

Leeds Community Healthcare NHS Trust

Main Issues for Consideration

Safe

- There were 539 LCH patient incidents reported with harm.
- There were four Serious Incidents logged on StEIS (Strategic Executive Information System).
    - Two were reported in the 48-hour timeframe and two were breaches which were identified at the time of writing the report.
- There was one incident which met the criteria for Patient Safety Incident Investigation for a Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteraemia. This will be managed under the LCH Patient Safety Incident Response Plan (PSIRP) and does not require a StEIS log.
- There were 19 incidents which met the requirement for Legal Duty of Candour in January and February 2024, all were managed appropriately.
- There were four new Central Alert System (CAS) notifications in the period, all appropriate actions were taken, all have been closed.
    - One existing CAS notification remains open and under review for completion of actions, this requires a co-ordinated LCH and Leeds Community Equipment Service (LCES) response. The deadline of 01/03/2024 was not met for this alert, this is the position across the city.
    - There is one historical alert open under review as part of NHS England's Enduring Standards.

Caring

- There were 33 complaints received in January 2024 – February 2024.
- Within the Friends and Family Test the percentage of respondents reporting a good or very good experience in community care during this reporting timeframe is 92%. A decrease of 2.0% from previous reporting (November- December 2023 94%)
- There has been a slight increase of poor or very poor reports (0.19%) from the previous reporting period (January- February 2024 2.81%)

Effective

- This domain is not reported this period

Responsive

- The position is outlined in the report below, including the services presenting the greatest area of concern and areas of success or improvement
- The sustained rise in demand for Neurodisability Assessments and on-going challenges with Inter-Provider transfers to the Community Gynaecology service continue to be the primary cause for deterioration in performance against the RTT 18- and 52-week standards:
    - RTT 18-week performance fell to 43.8% by the end of December, against a target of 92%
    - Consultant-led pathways reported 711 breaches of the 52-week standard in November and December

- Learning from deep-dive workshops with Business Units has highlighted 4 key areas for improvement:
    - Waiting List Validation Processes require strengthening.
    - There is misalignment between clinical systems and clinical pathways resulting in a lack of transparency.
    - There are a small number of pathways that should be excluded from the Trust waiting list position.
    - There is a requirement for a more standardised process across Business Units to ensure robust scrutiny of waiting lists.

Well-led

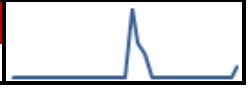
- The Overall sickness absence rate, within Corporate Services has been above 5% for the last two months, with the long-term absence over the last three months, over 3%. This is being explored to understand this in more detail.
- Long term absence due to Anxiety/stress/depression/other psychiatric illnesses continues to be the highest reason for absence
- Work continues to look at improvements in the leavers process, which is hoped will reduce the number of instances of staff reporting reason for leaving as “Not known/other” which remains highest reason for leaving
- Appraisal compliance since as far back as April 2022, has never been near the 90% target, and has mostly been around the mid-70%.

Safe – February 2024

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

NHS Leeds Community Healthcare NHS Trust

Data

Safe - people are protected from abuse and avoidable harm	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
Patient Safety Incidents reported as Harmful (per 1K contacts)	SL	1.42 to 2.09	2023/24	2.47	2.10	2.14	2.32	2.54	2.53	2.01	1.67	1.32	1.79	0.36	1.93	
			2022/23	2.21	2.06	1.87	2.01	1.88	1.87	1.54	1.73	1.78	1.54	1.95	1.86	
Serious Incidents (per 1K contacts)	SL	0 to 0.1	2023/24	0.04	0.05	0.02	0.00	0.00	0.02	0.00	0.01	0.00	*0**	*0**	*0**	
			2022/23	0.00	0.01	0.02	0.01	0.02	0.04	0.02	0.03	0.04	0.03	0.03	0.02	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	8 per year	2023/24	1	0	1	0	0	0	*0**	*0**	*0**	*0**	*0**	*2**	
			2022/23	0	1	0	1	0	0	0	0	0	0	1	3	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	2023/24	0	0	0	0	0	1	*0**	*0**	*0**	*0**	*0**	*1**	
			2022/23	0	0	0	0	0	1	0	0	1	2	0	6	
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	10 per year	2023/24	0	0	1	0	0	0	*0**	*0**	*0**	*0**	*0**	*1**	
			2022/23	0	0	0	0	2	1	0	0	1	2	0	6	
Number of Falls Causing Harm	SL	No Target	2023/24	47	36	40	56	55	39	52	45	23	46	27	466	
			2022/23	46	55	46	51	34	42	25	22	37	30	36	458	
Number of Medication Errors Causing Harm	SL	No Target	2023/24	8	7	7	7	6	8	7	4	9	7	8	78	
			2022/23	5	5	6	5	0	8	6	4	10	3	5	60	
CAS Alerts Outstanding**	*SL*	0	2023/24	0	0	0	0	0	0	0	0	0	0	1	1	
			2022/23	0	0	0	0	0	0	6	3	2	*0*	*0*	*0*	

** Reported by exception

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

Narrative

The data for this reporting period has been extracted from Datix (01/03/2024) based on patient incidents occurring under LCH care.

LCH Patient Incidents Reported as Harmful

As shown in Table 1, there were 539 (58.5%) incidents reported as harmful within January and February 2024. In comparison there were 382 (41.5%) incidents reported with no harm. This has remained consistent over the last six months reporting.

Degree of Harm	Number
No Injury	382
Minimal	416
Moderate	75
Major	17
Unexpected death	23
Expected death	8
Total	921

Table 1 – Patient Safety Incidents by degree of reported harm

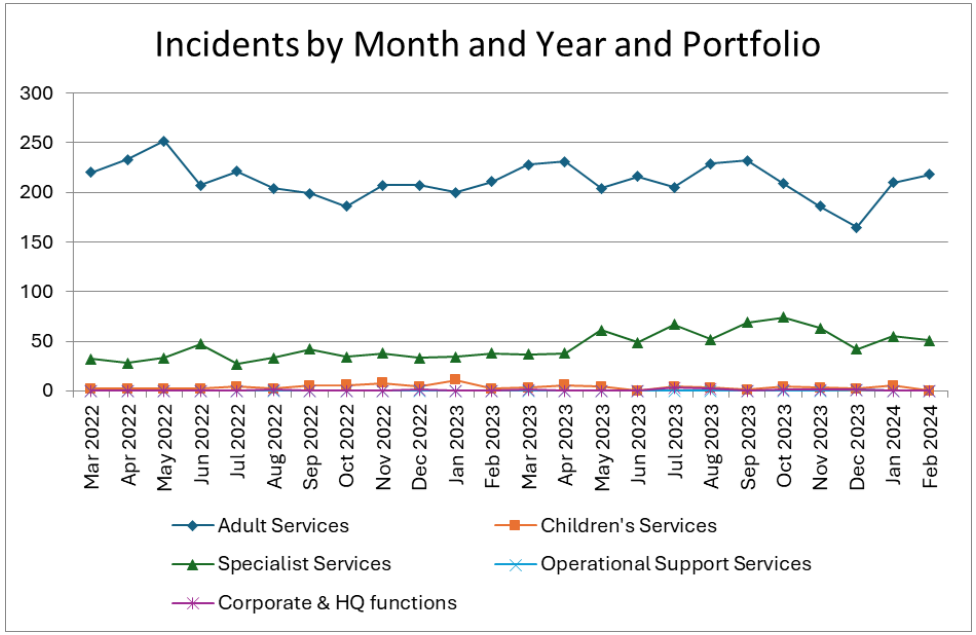


Figure 1 – Patient Safety Incidents Recorded

The number of incidents with harm reported for the Specialist Business Unit (SBU) in January and February 2024 (101 incidents) is comparable to November/ December (105 incidents) and remains within the control limits with this period slightly above the mean for both months.

For Adult Business Unit (ABU) the drop below the lower control limit in December has not continued and the overall number of incidents reported has increased in January and February 2024 (438 incidents) compared to November and December 2023 (351 incidents). The decrease in reporting for Pudsey and Yeadon Neighbourhood Team has returned to normal levels, as shown in Table 2.

	Meanwood	Pudsey	Yeadon
September /October	36	34	54
November/December	17	21	23
January/February	30	38	59

Table 2 – Incident trends within 3 selected NTs

The Children's Business Unit (CBU) reported five incidents in January and no incidents for February 2024. There was a total of 5 incidents reported in November and December 2023, the numbers are consistent with last year's data and remains within the control limits. There will be a request for services to review their no harm incidents to ensure the severity is accurately reflected.

Number of Falls causing Harm

As shown in Table 3, there were 71 falls incidents causing harm in January and February 2024, compared to 60 in November and December 2023.

	ABU	SBU	CBU	TOTAL
Sept/Oct 23	51	36	1	**88**
Nov/Dec 23	46	14	0	**60**
Jan/Feb 24	55	16	0	**71**

Table 3 – Falls with Harm trends

The number of falls incidents with harm reported has increased in this reporting period. Major harm falls have returned to reporting norms with 11 reported in January and February 2024. The highest reporting teams for falls with harm across January and February 2024 were the Yeadon Neighbourhood Team (11) and Seacroft, Pudsey, Morley Neighbourhood Teams, Community Neurology and Community Stroke Team (6 each).

	Minimal	Moderate	Major	Unexpected Death	Status of Moderate and above harm incidents
Yeadon	3	5	2	1	X2 closed as no new learning identified. X2 pending local investigation to determine is require Rapid Review X4 pending Rapid Review
Seacroft	4	1	1	0	X2 pending local investigation to determine is require Rapid Review
Pudsey	4	0	2	0	X1 pending local investigation to determine is require Rapid Review X1pending Rapid Review
Morley	3	0	3	0	X3 pending local investigation to determine is require Rapid Review
Neurology	5	0	1	0	X1 pending local investigation to determine is require Rapid Review
Stroke	3	3	0	0	X3 pending local investigation to confirm if require Rapid Review

Table 4 – Falls with Harm trends for selected services

Updates from November/December 2023

The moderate harm incident for the Community Falls Service concluded no further investigation required and was reduced to minimal harm. The major harm incident for the Cardiac Team concluded no further investigation required.

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

Number of Incidents Involving Medication Causing Harm

There were 15 medication errors causing harm reported, thirteen of these incidents were minimal harm, two were reported as moderate harm.

One moderate harm for Wetherby Neighbourhood Team relates to a missed insulin visit and the patient was admitted to hospital as a result, this will be brought to Rapid Review and learning used to inform the Triage Improvement Plan that is in the process of development.

The other moderate harm for Middleton Neighbourhood Team relates to a delay in administering analgesia due to unavailable medication, this is pending further local investigation to confirm the level of harm caused.

Of the fifteen incidents, 13 were reported in the Neighbourhood Teams and one each for School Immunisations and CAMHS.

Further information on medications incidents is included in the Quarterly medication report.

Pressure Ulcers

Validated Category 3 Pressure Ulcers

There were no validated category three pressure ulcers

Validated Category 4 Pressure Ulcers

There were no validated category four pressure ulcers.

Validated Unstageable Pressure Ulcers

There were no validated unstageable pressure ulcers.

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

MRSA bacteraemia

There was one MRSA Bacteraemia reported and a Patient Safety Incident Investigation is being completed in line with the LCH Patient Safety Incident Response Plan.

Serious Incidents

There were four incidents in the reporting period which met the criteria for Serious Incident Investigation (in line with the Serious Incident Framework 2015). Two were reported on the Strategic Executive Information System (StEIS) within the 48-hour timeframe. The other two were breaches and identified at the time of writing this report, these were missed as they were not identified as incidents predating 01/01/2024 which are needed to be managed under the Serious Incident Framework, not the Patient Safety Incident Response Framework. These have now been discussed with the ICB and StEIS logged on 01/03/2024. There was one MRSA Bacteraemia reported and a Patient Safety Incident Investigation is being completed in line with the LCH Patient Safety Incident Response Plan.

ID	Incident date	Category	Rapid Review	Date added to STEIS	Team
96573	18/01/23	MRSA Bacteraemia	N/A progress straight to PSII as per Patient Safety Incident Response Plan	N/A no StEIS required under PSIRF	IPC Team Clinical Care delivered by Kippax Neighbourhood Team
95203	9/9/23	Self Harm – Suicide	24/01/2024	01/03/2024	Leeds Mental Wellbeing Service
93924	26/9/23	Pressure Ulcer	05/01/2024	08/01/2024	Pudsey Neighbourhood Team
95550	09/12/23	Implementation of care ongoing	29/01/2024	16/02/2024- appropriate delay as not confirmed as PSII until 16/2/2024	Yeadon Neighbourhood Team
95670	12/12/23	Fracture diagnosis failed or delayed	19/01/2024	01/03/2024	Wharfedale Recovery Hub

Table 5 – Serious Incidents Investigations discussed at Rapid Review during the reporting period

Detail
ID 96573 is an MRSA Bacteraemia that is being managed under the LCH PSIRP as a Patient Safety Incident Investigation. This patient was registered with the Kippax Neighbourhood Team and the incident is pending 25-day review meeting.
ID 95203 this incident relates to a patient death and early learning has identified a potential lack of awareness around priority initiatives for Black and Minority ethnic groups as the priority initiative was not considered at the point of referral.
ID 93924 this incident is a pressure ulcer and early learning identified the need for further exploration of the allocation of the patient reassessment and the reviewing and planning stage of triage including clinical decision making.
ID 95550 this incident is related to patient deterioration and early learning identified a lack of case management, lack of escalation and action following deterioration, inadequate management of pain.
ID 95670 this incident was progressed to Patient Safety Incident Investigation outside of the Rapid Review process and will be completed jointly with partner organisation to explore the fall and the delayed diagnosis.

Table 6 – Details of Serious Incidents Investigated at Rapid Review during the reporting period

There were two Serious Incident Investigations that concluded in January/ February 2024.

- ID 91041 concluded with learning and recommendations linked to improvements required for communication, handovers, triage, catheter management, pressure ulcer management and caseload management
- ID 92419 concluded with learning and recommendations linked to mental capacity, consent, power of attorney, record keeping, reporting and escalating concerns, and professional curiosity

Duty of Candour

There were 19 incidents which met the requirement for statutory Duty of Candour.

Sixteen have been completed within the 10-day LCH standard, ten letters were sent, five did not want a letter and one a voicemail was left as LCH was unable to gain contact to obtain an address following the initial conversation.

Two Duty of Candour letters were not sent as LCH were unable to make contact following multiple attempts. The remaining one is awaiting further detail to confirm the learning response to be taken to ensure accurate details can be shared during the duty of candour conversation. Although they have not been completed within 10 days they have been dealt with appropriately and are not breaches

Central Alert System (CAS) alerts outstanding

There were four Central Alert System (CAS) notifications during this period, three of these required a response on the CAS website. Two were not relevant to LCH and one alert was relevant to LCH. All were acknowledged, assessed, and actioned within the allocated timeframe.

The National Patient Safety Alert related to the risk of death from entrapment or falls from medical beds, trolleys, bed rails, bed grab handles and lateral turning devices remains ongoing. This is being coordinated by the Medical Device Safety Officer. Monthly strategy meetings are being held with partners across Leeds and within LCH. This alert was required to be complete by 01/03/2024, this target was not met, and actions remain outstanding for LCH and other providers across the city. An update has been provided on the CAS website.

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

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

Caring – February 2024

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

NHS Leeds Community Healthcare NHS Trust

Data

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%	2023/24	94.3%	92.9%	96.0%	95.6%	94.1%	91.9%	92.7%	92.0%	94.6%	90.5%	92.1%	92.8%	
			2022/23	92.8%	91.9%	92.9%	91.0%	94.4%	94.3%	93.3%	93.0%	92.6%	91.6%	87.4%	92.2%	
Total Number of Formal Complaints Received	SL	No Target	2023/24	9	7	12	12	11	22	8	9	11	14	17	132	
			2022/23	4	12	13	8	14	17	16	6	12	15	7	136	

Narrative

Experience

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

Between January and February 2024, LCH has received 33 complaints. Two of these complaints were withdrawn by the complainant, 1 was not relevant to LCH and was passed to relevant trust and 1 was de-escalated to a concern. This is an increase in the numbers of complaints received over the previous two months, with 20 complaints reported between November and December 2023 and 30 reported between September and October.

As shown in Fig. 3, MSK and Wharfedale received the most complaints with a total of 4, MindMate SPA received 3 complaints. The other 19 teams received 1 or 2 complaints each.

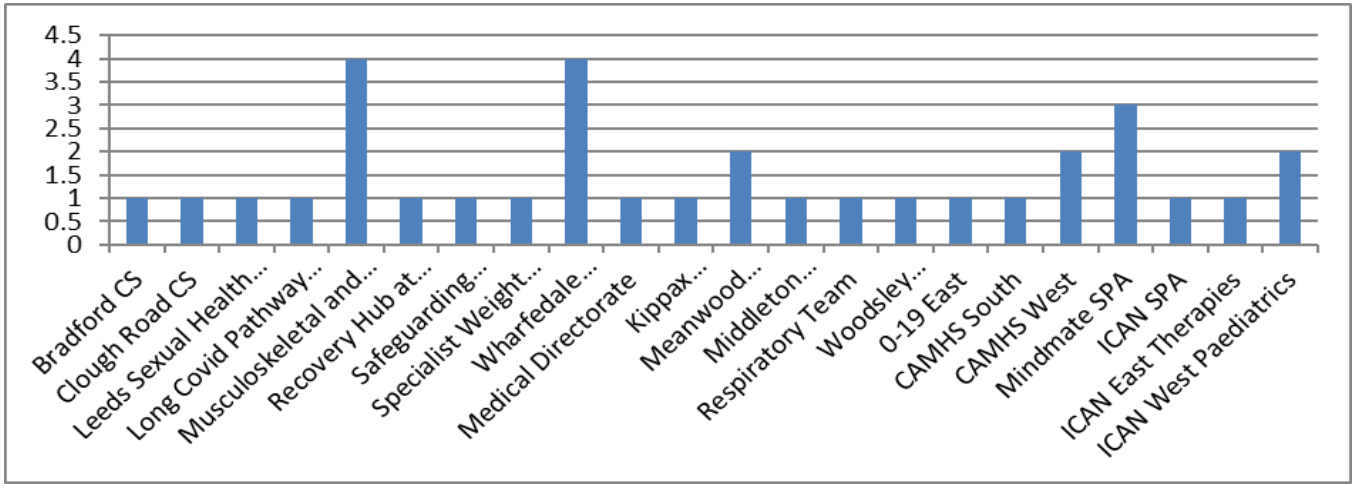


Figure 2 – Complaints received by Team

Closed complaints

There were 30 complaints closed between January and February 2024.

Patient Feedback

Good/very good responses have emphasised positive interactions with staff, and feedback has highlighted the helpful and supportive conduct of staff members during appointments. For responses that are rated poor/very poor we continue to see themes around wait times for services, and parking for MSK service sites is a new theme.

Figure 3 – Themes of responses from FFT comments

Effective – February 2024

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

Leeds Community Healthcare NHS Trust

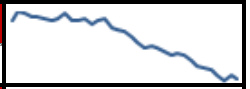
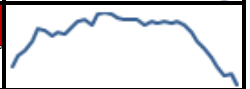
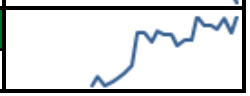
The Effectiveness Domain is not due for reporting this period, and so is not included in this report.

Responsive – February 2024

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

NHS Leeds Community Healthcare NHS Trust

Data

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
Percentage of patient contacts where an ethnicity code is present in the record	SP	100%	2023/24	97.0%	97.1%	97.1%	97.4%	97.4%	97.4%	97.4%	97.5%	97.6%	97.3%	97.2%	97.3%	
			2022/23	95.8%	95.6%	96.5%	95.8%	95.8%	95.6%	96.0%	95.8%	95.8%	95.4%	95.2%	95.7%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	2023/24	60.5%	61.4%	60.4%	56.9%	52.7%	52.0%	50.9%	46.6%	43.8%	46.6%	44.8%	44.8%	
			2022/23	80.6%	83.2%	83.4%	78.2%	77.0%	75.2%	71.8%	67.7%	64.4%	66.0%	64.2%	62.7%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	2023/24	9	23	38	71	158	199	268	343	368	416	448	448	
			2022/23	0	0	0	2	4	2	0	0	0	0	1	2	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	2023/24	42.0%	37.6%	37.4%	38.1%	31.8%	30.3%	32.4%	29.7%	28.7%	29.5%	31.4%	31.4%	
			2022/23	38.3%	49.4%	46.9%	47.5%	41.5%	44.3%	50.9%	57.8%	47.0%	45.5%	52.5%	50.3%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	2023/24	87.3%	88.0%	86.9%	84.6%	81.8%	79.1%	76.6%	73.4%	71.0%	71.3%	68.2%	68.2%	
			2022/23	86.4%	90.2%	90.6%	89.9%	89.0%	88.4%	88.6%	88.5%	86.5%	87.7%	87.2%	87.5%	
Proportion of Urgent Community Response referrals reached within two hours	SP	70%	2023/24	71.7%	67.6%	69.7%	69.5%	77.5%	74.8%	74.5%	73.5%	77.4%	72.2%	77.8%	77.8%	
			2022/23	0.5	0.6	0.5	0.6	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.7	

Narrative

A number of LCH Services continue to see levels of demand that outstrip available capacity, leading to a further increase of waiting times. The primary areas of concern are included in this report to provide assurance on the progress of mitigating actions and long-term strategic plans that seek to improve the responsiveness of our services.

Waiting List Improvement Workshops

During January and February 2024 each Business Unit held detailed workshops with support from corporate teams to review the waiting list position of every service and identify improvement actions and learning points. Learning from these workshops highlighted 4 key themes, and a summary of the actions underway are given below:

- Waiting List Validation Processes require strengthening.
- There is misalignment between clinical systems and clinical pathways resulting in a lack of transparency.
- There are a small number of pathways that should be appropriately excluded from the Trust waiting list position.
- There is a requirement for a more standardised process across Business Units to ensure robust scrutiny of waiting lists.

Waiting List Validation

Waiting List Validation is an essential weekly task that all services with a waiting list should undertake. Review has revealed that several services are not routinely validating the people showing on waiting lists. It is likely that many of the patients currently waiting more than 18-weeks are therefore not genuine long waiters, and in some services, it is possible that the majority of recent waiting list growth has resulted from the lack of robustness and completion of this process. Services have been reminded of their requirement to validate, and help is being provided from the Business Intelligence and Clinical Systems Departments in the form of increased training, guides, and team-specific support. Reports are being developed to provide greater scrutiny and oversight of the waiting list validation process. Services have been instructed to ensure lists are validated by 31 March 2024.

Mis-alignment of systems for pathway-level reporting

The reviews highlighted that there are some large discrepancies between services and their EPR on how patients are grouped into pathways. This significantly hampers the ability of reporting from a single, trusted source of truth and limits the visibility of pathway specific waiting time targets. Fully resolving such long-standing discrepancies is complex and will take significant time and resource from services, clinical systems developers, and BI developers. An approach to begin capturing the required work is being considered as part of the Quality and Value programme. This programme presents the Trust with a significant opportunity to make pathway-level reporting more achievable, which would represent a significant improvement in the scrutiny and assurance of responsiveness within the Trust.

Waiting List exclusions

A small number of pathways have been identified as not being appropriate to include within the Trust Waiting List, or within waiting list management processes, as they don’t offer waiting list models of care. These services are currently applying for waiting list exemptions via usual processes, to be signed off by the Director of Operations. This will lead to the removal of these services from internal reporting. However, the Business Intelligence Department is developing alternative approaches to maintain visibility of any emerging data quality trends and any responsiveness measures for these pathways.

Waiting List scrutiny processes (Patient Access Meetings)

Following on from the workshops, the Trust will establish a regular Patient Access Meeting, to include all pathways that manage access to care via a waiting list. It is proposed that this group sits alongside established Performance Management processes, and provides an additional level of scrutiny, analysis, and assessment of waiting lists and waiting times, and allowing a shared understanding of current pressure areas and agreed actions to develop. Proposals for this process are being jointly developed between Business Units and the Business Intelligence and Performance Department, and this meeting will be established during Q1 of 2024/25.

Current Position

Several long-standing and emerging service pressures exist alongside the above programme of improvement, and the report below contains actions and improvements being progressed in these services. Further details of other pathways under observation are included in Appendix 1.

Consultant-led RTT Pathways

Services operating RTT pathways continue to experience significant and systemic challenges to achieving waiting time standards. Demand continues to outstrip capacity across a range of ICAN Consultant-led clinics. The worst effected clinic continues to be Paediatric Neuro-Disability (PND), where the clinic has also been impacted by the long term rise in demand for autism assessments. Under NICE Guidelines, children under-5 see a Paediatrician in this clinic before a referral can be made for the assessment.

Our Community Gynaecology service has not been able to sustain recent improvements, due to changes in practice within LTHT and the very long waiting times that patients experience on the shared pathway before being accepted for Community-based care.

Trust performance against the RTT 18-week standard held steady at 44.8% by the end of February 2024. The number of people waiting over 52 weeks within these pathways has increased from 368 patients at the end of December to 448 patients at the end of February. All of these breaches occurred within either PND (432) or Community Gynae (16).

Both services are working closely with colleagues at the ICB to address changes to their pathways and make long-term, sustainable improvements., without which waiting times will continue to rise.

ICAN consultant pressures (PND, CPC and CPMC)

The ICAN Service successfully recruited 2 additional Advanced Clinical Practitioners in January 2024, reducing reliance on a medical model, and increasing clinic capacity. The service continues to address these pressures by flexibly adjusting job plans where possible to ensure that all clinics can be covered.

Community Gynaecology

LCH teams continue to proactively pull onto their waiting lists from the shared lists held by LTHT. Once patients are transferred to LCH, the responsiveness of care remains good, with the average waiting time for an appointment holding steady at 8 weeks.

The overall RTT performance will continue to deteriorate, as LTHT colleagues have confirmed that they are currently unable to see any patients from the shared pathway due to the length of their acute waiting lists. LCH, LTHT and ICB colleagues remain in conversation about how to manage risks on these pathways. A previous business case offering LCH capacity to improve the position was rejected by LTHT.

Urgent Community Response

As of the end of February 2024, the Trust had responded to 77.8% (against a target of 70%) of Urgent Community Response (UCR) patients within the required 2-hr timeframe, continuing its above-target performance for the 7th consecutive month.

Diagnostic Pathways (DM01)

Following recent recruitment to B2 and B3 roles, and the restructure of the clinical delivery model, the service recorded high levels of clinical activity during January 2024, but this sadly was not sustained in February. Trends in activity numbers are being monitored by the Business Unit Leadership team

Currently, performance against this standard continues at low levels, with 29.5% of patient waiting less than 6 weeks at the end of February 2024, against a 99% target. The total number of people waiting held steady at 948 at the end of February.

Non-Consultant Pathways

Several of our non-consultant pathways continue to offer high standards of responsiveness and are routinely meeting targets. The following services are of particular note for their consistent successes in achieving their waiting list targets:

- COVID Rehabilitation Service
- Children's Community Eye Service
- Community Fall Service
- Integrated Wound Clinics

In particular, the Integrated Clinics have seen considerable improvements simply by undertaking regular validation of their waiting lists, and this has led to them achieving 100% of patients waiting less than 18-weeks by the end of February 2024.

There remains a number of areas of concern, however, for as shown in Fig. 4 below, non-Consultant Pathways saw further deteriorations in waiting list performance during the reporting period, falling to 68.2% by the end of February 2024. This is against a target of 95%.

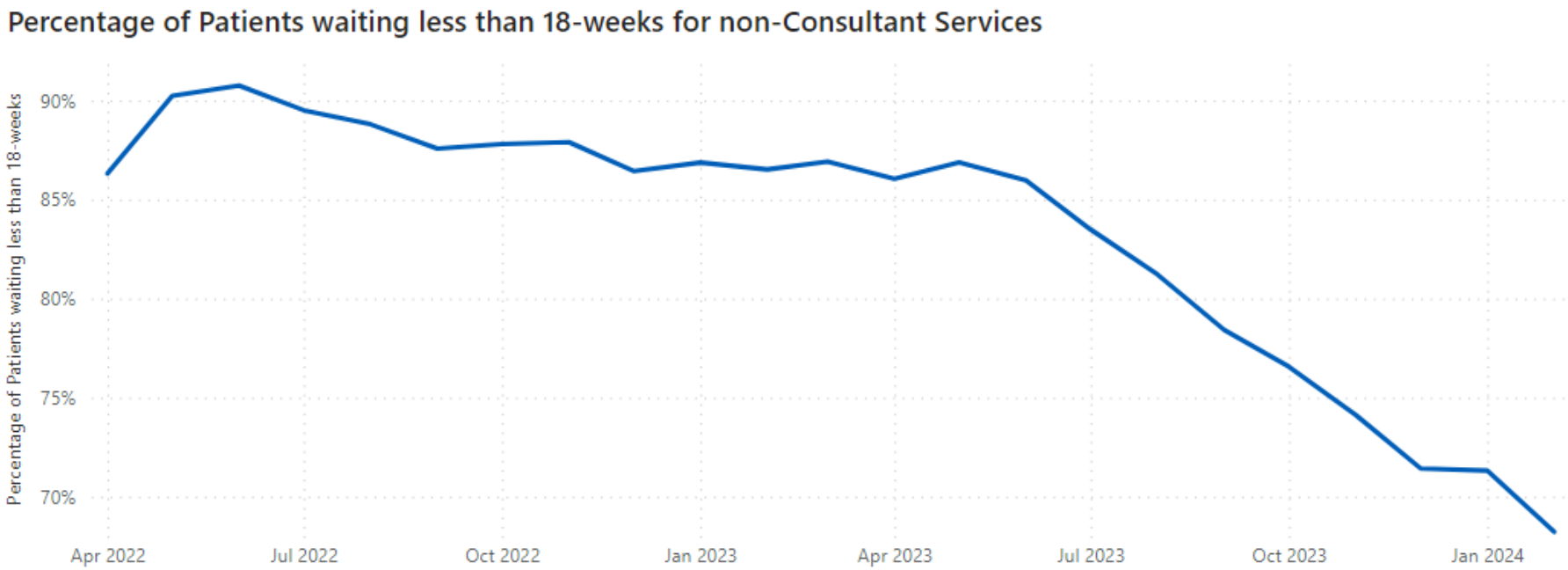


Figure 4 – Percentage of people waiting on non-Consultant Waiting Lists who had waited less than 18-weeks at the end of the month

The graph above hides the positive impacts of work underway to validate waiting lists. Much of the positive improvements have so far been seen within smaller services, but the volumes of patients waiting within larger services will take longer for the effects of validation to take effect. It is likely that the impacts of validation will lead to a slowing of the rate of deterioration, rather than leading to improvements, as there are still significant areas where demand outstrips capacity.

In each report we will highlight the top two services of concern per Business Unit for focussed attention, and further details of other pathways of concern are included in Appendix 1. The following services are being included here as areas of concern:

- Podiatry
- Leeds Community Pain Service
- Children's Occupational Therapy
- Children's Speech and Language Therapy
- Neighbourhood Team Therapies
- Continence, Urology and Colorectal Service (CUCS)

We will also select one service each report to highlight the impacts of improvement efforts. This month we have selected the Diabetes service.

Areas of Concern

Podiatry

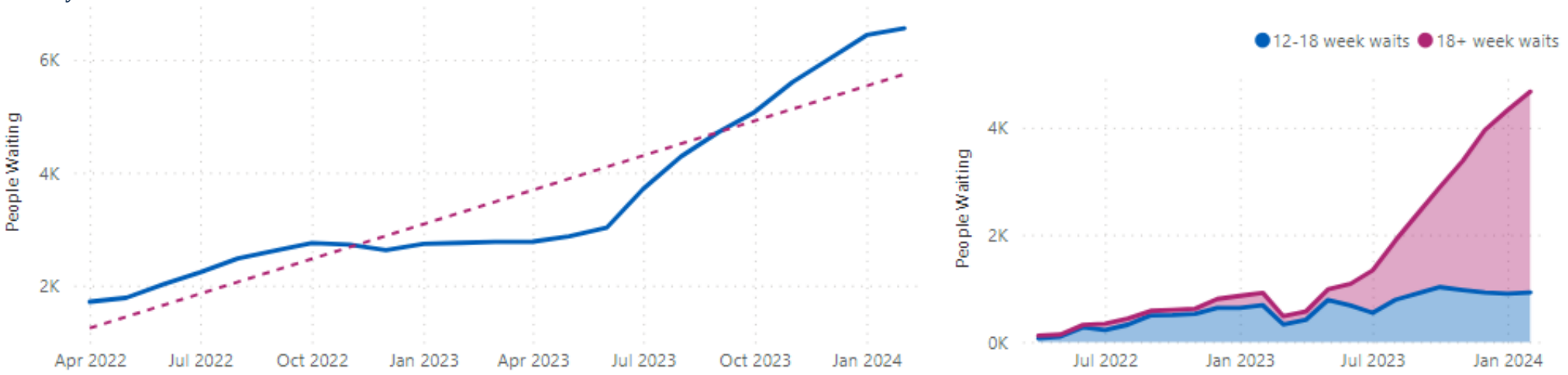


Figure 5 – Podiatry Service Waiting List

The number of patients waiting for first appointments within Podiatry continues to grow at a rapid rate (see Fig 5). The growth is focussed on patients experiencing the longest waiting times, particular those waiting more than 18-weeks. These patients are those of lowest clinical priority who, under the recently approved new model of care, would no longer meet the specifications of the service contract.

Recently the service has identified a hidden backlog of referrals for the service held within the Electronic Referral System, that had yet to be transferred to the service's clinical system. A total of 1100 patients were held in this queue. Additional administrative capacity was brought in to urgently reduce this backlog, and as of the end of February 2024, only 600 referrals remain. This transfer of records has also led to recent increases in the reported size of the waiting list. Currently the additional administrative capacity is only funded until 31 March 2024, so this presents a risk to being able to complete the transfer of records – options are being considered to address this.

Children's Occupational Therapy

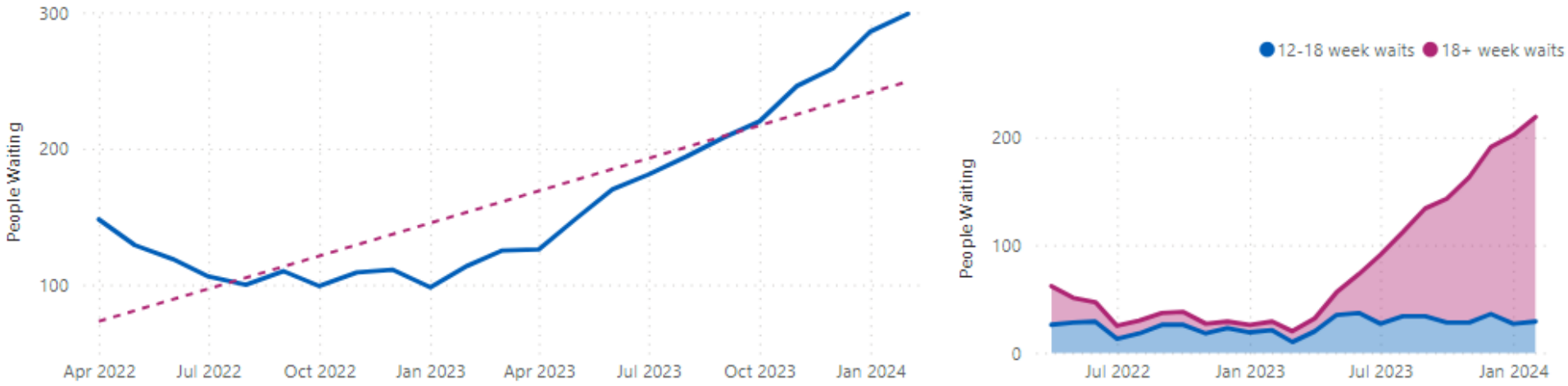


Figure 6 – Children's Occupational Therapy Waiting List

The Goal Setting and Dyspraxia Clinics remain closed, although the service expects that these clinics will re-open by the end of March 2024 as recruitment to vacant posts is completed. Patients continue to be risk assessed by senior clinicians on a regular basis.

Children's Speech and Language Therapy

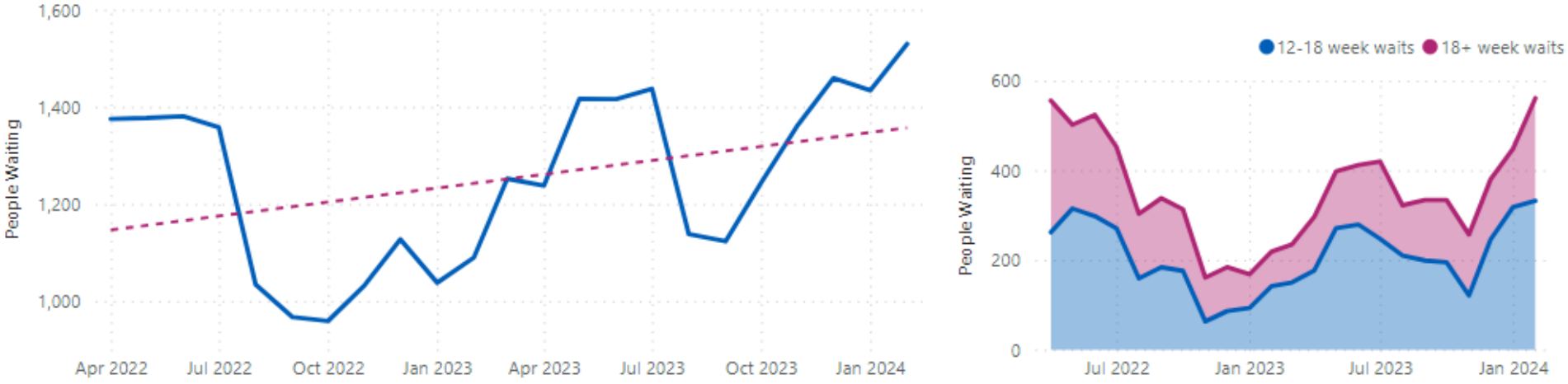


Figure 7 – Children's SLT Waiting List

The service is showing increases in the number of people waiting more than 12 weeks for care. There have been slight reductions in First Contacts in 2024 so far, and a corresponding increase in First:Follow Up Ratio. This follows the return to offering increased therapeutic intervention, as much of this work had still been paused since the COVID-19 pandemic.

The rate of growth in the waiting list this academic year compared to last is of concern, and when combined with the fact that this year's additional summer activity didn't reduce the waiting as effectively as in previous years, the service will end the academic year with a larger waiting list than in previous years.

Neighbourhood Team Therapies

NT Therapy waiting lists have begun to show signs of stabilising following long term increases. This has particularly been evident in Physiotherapy waiting lists as shown in Fig 8.

The service has been piloting several new initiatives with good initial success, including:

- Effective use of PCN/LCH joint therapist roles to see less complex cases within PCNs
- More effective deployment of triage staff to cover rapid call outs, instead of pulling other therapists away from planned visits.

All of these pilots have led to reductions in the waiting list in the teams involved, and no patient safety or staff safety incidents have been reported throughout these pilots, but the leadership team has identified some areas of learning, and so will continue to run them as pilots for another month. There is potential for further improvement as these pilots roll out city-wide.

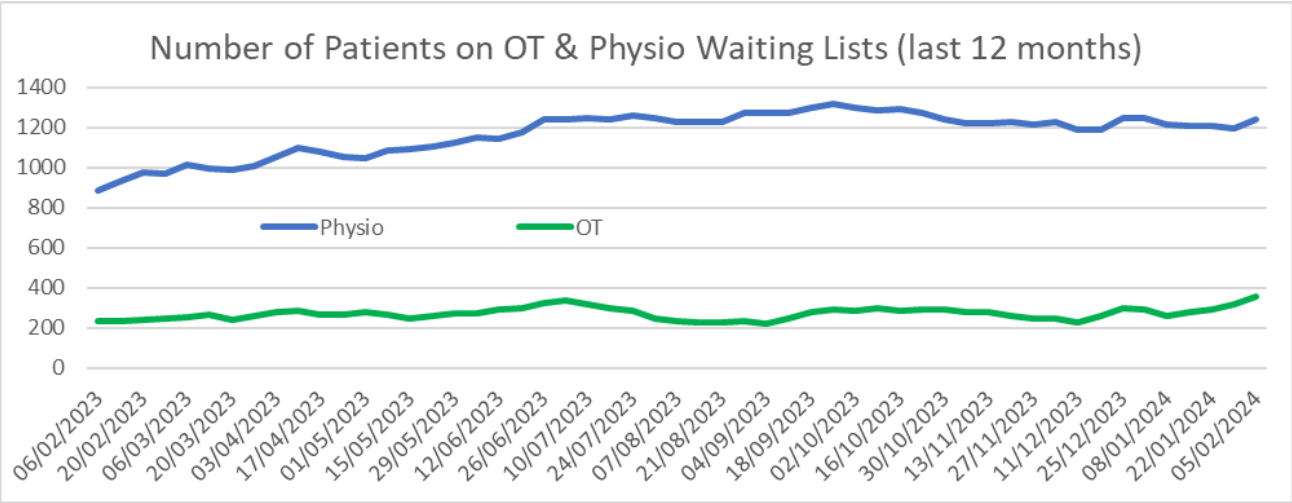


Figure 8 – NT Therapy Waiting List split by therapy type

Continence, Urology and Colorectal Service (CUCS)

Rising waiting lists and waiting times within the CUCS service continue to be a cause of concern, however some areas within the service have seen strong improvements, including:

- waiting times for Staff Nurse home visits reduced from 42 weeks to 18 weeks
- Assistant Practitioner care home visits have reduced from 38 to 23 weeks
- Assistant Practitioner home visits have reduced from 42 weeks to 30 weeks
- Catheter home visits now down to just 1 week

Concerns remain, however, as waiting times for the service overall continue to rise, particularly for patients waiting more than 18 weeks, as shown in Fig 9. These increases are focussed on Bowel and Bladder pathways. The service commenced a waiting list improvement project in January 2024 concentrating first on the bowel service offer. Patients requiring annual review have been validated and a number of patients have been identified as clinically safe to discharge. The service also plans to conduct future annual reviews via telephone where clinically safe. Waiting lists have particularly been affected by staff nurse sickness and clinic room availability. Due to the specialist nature of the service, there is limited skill mixing that would enable the staff nurses to swap and cover and the team is continuing to review their workforce requirements moving forward.

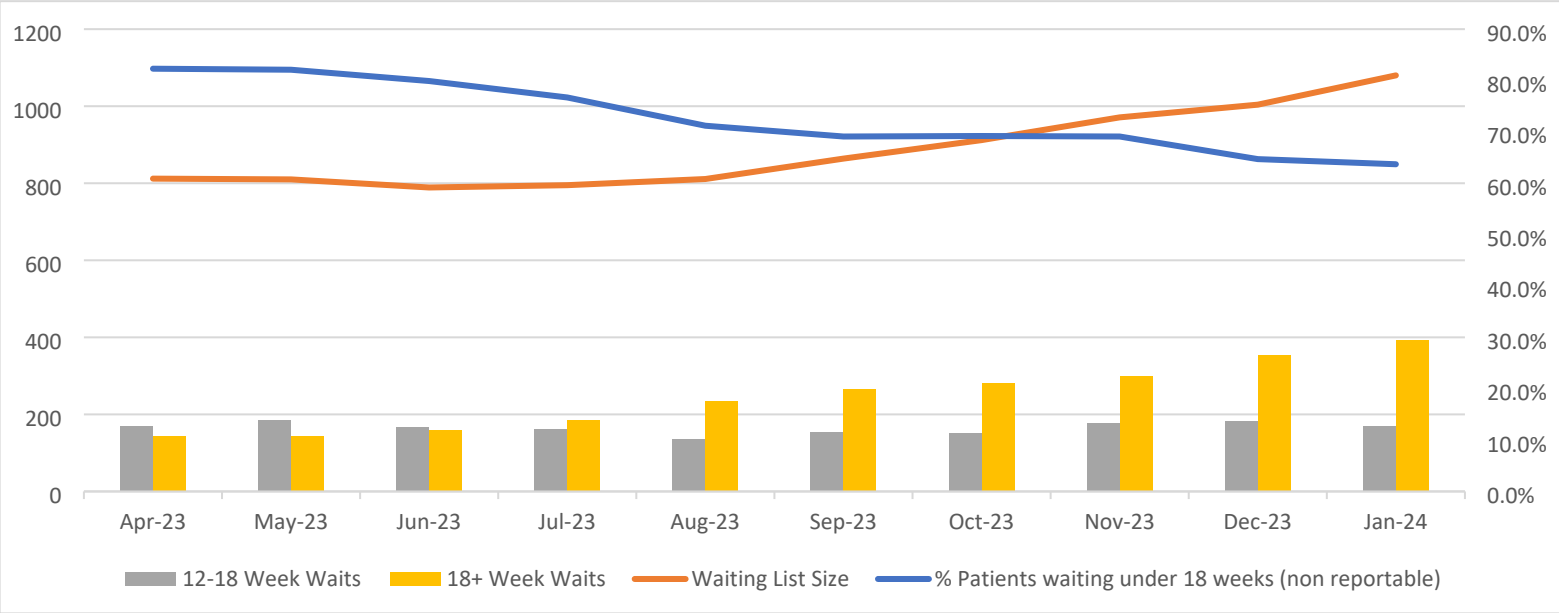


Figure 9 – CUCS Waiting List and Waiting Times

Improving Service Spotlight

Diabetes

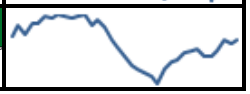
The Diabetes Service has been working hard through a Service Review Process, and along with additional investment from the Integration Project, has begun show early signs of improvement across a range of indicators. This is despite the service receiving record numbers of referrals in January and February 2024. The table below shows a number of other improvements visible within the service.

Month	Referrals	Waiting List Size	Percentage seen within 18-weeks	Number of people waiting more than 18-weeks	Waiting Time for High Priority	Waiting Time for Routine
Nov 2023	348	546	72.2%	152	20 working days	27 weeks
Dec 2023	303	555	69.7%	168	20 working days	27 weeks
Jan 2024	511	676	75.3%	167	20 working days	22 weeks
Feb 2024	577	841	81.9%	152	15 working days	18 weeks

Table 7 – Diabetes improvements in a range of indicators

Despite the level of vacancy in key clinical positions (created from gaps relating to LTHT being unable to release medical staff, and gaps caused by maternity leave), and sickness levels reaching highs of 9.3% in January 2024 (this returned to 3.5% in February), the levels of Face-to-Face patient contacts have continued to increase, reaching 366 in January and 386 in February. This is against an average of 296 per month from April to December 2023. Recent increases in referral volumes have led to increases in the total number of people waiting, and so the ongoing trends will continue to be monitored by Business Unit leadership.

NHS Talking Therapies (formerly IAPT services)

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
LMWS – Access Target; Local Measure (including PCMH)	SP	24456 by year end	2023/24	2,070	2,392	2,343	2,372	2,564	2,741	2,626	2,625	2,883	2,991	2,763	28,370	
			2022/23	2,312	2,699	2,570	2,536	2,716	2,781	2,867	3,088	2,013	2,467	2,445	30,963	
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	SP	No Target	2023/24	59.5%	65.3%	69.1%	77.9%	70.8%	76.9%	74.5%	74.1%	76.8%	75.1%	76.3%	72.6%	
			2022/23	59.7%	52.3%	43.9%	40.5%	39.0%	42.9%	40.1%	46.4%	58.4%	67.5%	69.4%	51.5%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	2023/24	**98.1%**	**98.1%**	**98.0%**	**97.9%**	**98.2%**	**98.7%**	**97.5%**	**98.7%**	**98.7%**	**98.3%**	**98.7%**	**98.3%**	
			2022/23	100.0%	99.4%	99.3%	98.9%	99.3%	98.4%	98.4%	98.5%	98.8%	98.7%	97.9%	98.7%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	2023/24	**79.3%**	**79.7%**	**82.7%**	**83.3%**	**83.7%**	**81.0%**	**81.4%**	**83.3%**	**86.8%**	**85.8%**	**87.1%**	**83.1%**	
			2022/23	92.1%	94.3%	91.2%	87.2%	84.5%	81.2%	77.8%	76.8%	75.6%	74.4%	71.9%	81.4%	

The NHS Talking Therapies service within the Leeds Mental Wellbeing Service (LMWS) continues its improvement of Waiting List performance, achieving all targets during the reporting period. Following investigation, some changes have been made to reporting procedures for Access figures, and numbers have increased further. Plans for next year have set the target at 2,400 per month, and this is achievable given the service's current activity levels.

CYPMHS Eating Disorders Service

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-22)
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	AN	0	2023/24	0	0	1	2	0	2	0	0	0	0	0	5	
			2022/23	0	0	0										
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	AN	>=95%	2023/24	13.9%	23.8%	16.3%	11.5%	37.0%	19.2%	20.8%	23.5%	43.8%	60.0%	50.0%	50.0%	
			2022/23	66.7%	92.3%	94.1%										

In February 2024, reporting commenced on Responsiveness Indicators for the Children and Young People's Mental Health Service (CYPMHS or CAMHS). In particular the eating disorders part of the service is required to report nationally on the waiting time standards described above. The teams have displayed a significant number of data quality challenges, primarily including how to correctly record clock stopping activity. The 4-week standard for routine care has been particularly affected by this issue, but efforts to improve the recording within SystmOne have led to improvements in the accuracy of these numbers.

The service does, however, still experience demand that outstrips capacity for routine care, leading to breaches each month. The service sees small numbers of patients, and so even one breach can represent a large decrease in performance.

Neighbourhood Team Indicators

Referrals into Neighbourhood Teams hit a peak in January 2024, before returning to normal levels in February. January also saw a large increase in productivity, as the teams were able to continue usual levels of patient contacts, despite having lower number of funded posts utilised.

A Perfect Week was conducted in Yeadon NT during February, to support them following concerns across a range of areas. The team and colleagues from corporate services came together well to better understand and address the challenges faced and a programme of improvements is being implemented.

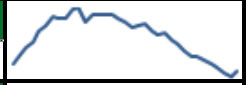
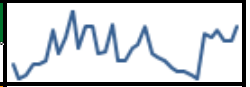
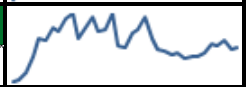
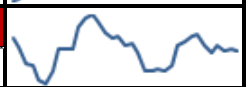
Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
Neighbourhood Team Face to Face Contacts	AN	No Target	2023/24	44,473	47,652	47,732	48,112	49,334	46,164	49,027	46,959	47,091	48,361	44,997	519,902	
			2022/23	50,745	53,399	49,949	51,131	50,654	49,440	50,389	48,284	46,875	48,368	41,803	586,579	
Neighbourhood Team Referrals (SystmOne only)	AN	No Target	2023/24	2,191	2,545	2,641	2,460	2,478	2,570	2,590	2,593	2,587	2,893	2,544	28,092	
			2022/23	2,206	2,657	2,463	2,572	2,591	2,497	2,585	2,607	2,494	2,795	2,289	30,374	
Neighbourhood Team Productivity (Contacts per Utilised WTE)	AN	No Target	2023/24	97.2	101.4	98.8	98.1	100.7	96.3	109.9	100.3	129.1	133.8	110.1	110.1	
			2022/23	100.4	107.0	102.2	105.7	103.1	102.9	106.1	102.9	104.9	102.7	91.1	96.4	
Neighbourhood Team Vacancies, Sickness & Maternity WTE	AN	No Target	2023/24	159	166	151	160	149	167	84	86	157	159	140	140	
			2022/23	110	100	106	119	114	117	122	134	156	132	133	139	
Neighbourhood Team Percentage of Funded Posts Utilised	AN	No Target	2023/24	78.2%	81.2%	83.9%	82.8%	83.8%	82.1%	92.0%	97.9%	78.1%	74.0%	85.0%	85.0%	
			2022/23	88.4%	88.6%	87.5%	85.9%	86.9%	86.4%	84.3%	83.3%	79.2%	83.6%	83.2%	83.2%	

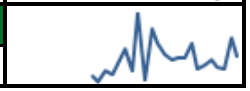
Well-Led – February 2024

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

NHS Leeds Community Healthcare NHS Trust

Data

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
Staff Turnover	LS/JA	<=14.5%	2023/24	12.3%	11.9%	11.4%	10.9%	10.9%	10.5%	10.2%	10.0%	9.5%	9.2%	9.6%	9.6%	
			2022/23	14.4%	14.5%	14.4%	14.4%	14.1%	13.9%	13.4%	13.5%	13.7%	13.1%	12.8%	12.9%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	2023/24	14.1%	14.1%	14.1%	13.4%	13.6%	13.9%	13.1%	14.6%	14.0%	13.5%	13.1%	13.1%	
			2022/23	19.2%	19.5%	18.4%	17.6%	17.1%	17.2%	16.4%	15.2%	16.5%	16.4%	15.7%	14.3%	
Short term sickness absence rate (%)	LS/JA	<=3.0%	2023/24	1.6%	1.5%	1.5%	1.4%	1.3%	2.6%	2.5%	2.7%	2.4%	2.4%	2.8%	2.8%	
			2022/23	2.8%	2.0%	2.1%	2.9%	1.8%	1.8%	2.2%	2.3%	2.8%	2.0%	1.9%	1.8%	
Long term sickness absence rate (%)	LS/JA	<=3.5%	2023/24	4.4%	4.7%	4.3%	4.5%	4.6%	3.5%	4.1%	3.8%	4.3%	3.9%	3.6%	3.6%	
			2022/23	5.1%	5.2%	5.2%	5.1%	4.7%	4.6%	4.9%	5.0%	5.1%	4.7%	4.4%	4.4%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=6.5%	2023/24	6.0%	6.1%	5.8%	5.9%	5.9%	6.1%	6.6%	6.5%	6.7%	6.3%	6.4%	6.4%	
			2022/23	7.9%	7.2%	7.3%	8.1%	6.5%	6.4%	7.1%	7.3%	7.9%	6.8%	6.3%	6.2%	
AfC Staff Appraisal Rate	LS/JA	>=90%	2023/24	72.8%	75.2%	75.7%	76.3%	76.5%	75.1%	74.3%	75.3%	74.5%	74.7%	74.5%	74.5%	
			2022/23	79.0%	78.1%	76.7%	76.0%	76.3%	75.3%	75.5%	74.4%	72.0%	72.0%	72.3%	72.1%	
Statutory and Mandatory Training Compliance	LS/JA	>=90%	2023/24	86.2%	87.0%	87.2%	88.2%	88.1%	86.1%	86.8%	86.5%	87.3%	87.0%	84.4%	84.4%	
			2022/23	88.1%	86.2%	85.6%	85.3%	85.5%	85.4%	86.3%	86.4%	86.4%	87.2%	86.2%	86.1%	

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Director	Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
'RIDDOR' incidents reported to Health and Safety Executive	AO	No Target	2023/24	0	0	0	0	0	0	0	0	0	0	0	0	
			2022/23	1	1	0	0	2	1	1	0	0	0	1	7	
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	LS/JA	No Target	2023/24	6.8%	6.6%	7.0%	7.3%	7.3%	6.9%	6.1%	6.7%	7.6%	8.0%	7.9%	7.9%	
			2022/23	7.8%	7.8%	7.8%	7.8%	7.6%	7.8%	7.8%	7.6%	7.5%	7.8%	7.9%	7.2%	
Total agency cap (£k)	AO	No Target	2023/24	417	362	376	307	485	312	314	-47	239	305	356	3426	
			2022/23	352	307	394	255	311	362	357	317	333	453	337	4133	
Percentage Spend on Temporary Staff	AO	No Target	2023/24	6.6%	6.2%	6.3%	5.9%	5.9%	6.1%	6.1%	1.1%	5.7%	5.9%	6.2%	6.2%	
			2022/23	6.3%	5.4%	6.3%	4.4%	5.4%	5.1%	5.6%	6.2%	5.7%	6.1%	6.0%	5.8%	
Starters / leavers net movement	LS/JA	>=0 in favour of starters	2023/24	13	15	16	30	4	9	13	7	5	36	18	166	
			2022/23	-2	-8	2	0	10	24	3	61	-6	45	31	179	

Narrative

Turnover

Turnover has seen a slight increase but remains healthy at 9.6%. Work to retain staff and achieve the right balance for the trust remains in focus. The latest Staff Survey results and use of workforce data is being used to target and support areas highlighting workforce issues.

'Stay conversations' are now being utilised across the trust and there have been some positive outcomes being reported but these need to be fully embedded. Guidance to support and promote the use of 'Stay conversations' will be shared and further communicated to managers via the HR/OD Business Partners.

Work is underway to update the exit interview process, so this is offered to all staff leaving the trust. Evidence shows that the likelihood of returning to the employer increases if it has been a good leaving experience. Plans are in place to change the Exit Questionnaire to a Microsoft form which will enable a more streamlined approach to collecting and analysing the data and sharing real-time results with senior managers. Return rate for completed leavers questionnaires for year 2023/24 is from approximately 40% of leavers. This data is being reviewed and will be shared at the Resourcing Steering Group in April 24.

Instances of staff reporting reason for leaving as 'Not Known/Other' remains the highest reasons for leaving, followed by work life balance and promotion. Improvement in the leaving process and training for managers should address this and help us to gain more specific feedback from staff leaving the trust but we need to respect that employees are under no obligation to share their reason for leaving.

We plan to revisit the nursing retention self-assessment tool which was completed in March 2023. This will help to further inform our work and how we can continue to support staff in their early, mid, and later careers.

We are continuing to see a positive staff net movement i.e. the number of starters –v- leavers, consistently since January 2023 but this is expected to be impacted by the financial savings required during 2024. Work is continuing with a range of resourcing initiatives to sustain supply where necessary, using a combination of traditional and hyper local recruitment methods which reaches out into our local communities, narrowing inequalities and streamlining and speeding up recruitment processes for all roles.

Apprenticeships remain a valuable way to retain, develop and upskill staff for key roles in the trust. We are recruiting to Nursing Associate and Podiatry apprenticeships which will help address the national shortage of nurses and podiatrists and fill key roles in the trust once qualified. A workshop to develop this route is planned for late April 24 as the financial situation is challenging the number of clinical apprenticeships the trust is supporting in this coming financial year which may impact on the pipeline of registered nurses and therapists available in 2027/28.

Reduce the number of staff leaving the organisation within 12 months

Staff turnover of leavers with less than 12 months service continues within tolerance at 13.1% and remains consistent and stable.

Work to improve recruitment and induction processes has been a key focus to ensure that new recruits get the best possible experience during those first few crucial months of employment as we know poor practices and experience can impact on retention during this time.

Good progress is being made on implementing an Applicant Tracking System which will support further improvement in recruitment processes and reporting.

The corporate induction continues to develop, and feedback remains positive. All new starters are also invited to attend a New Starters forum which helps us to understand what is working well and any areas for improvement and address any issues quickly.

Overall sickness absence

During 2023, the month-on-month overall sickness absence rate, has been lower than the same period during 2022. This month however at 6.4%, whilst below the organisational target of 6.5%, is just slightly higher than the same period last year.

Of concern, is that for the last two months sickness absence within Corporate services has been over 5%.

Long-term sickness absence

Whilst the Long-term sickness absence for this latest period remains just above the 3.5% target, similar to the overall sickness absence rates, this has continued to track lower than the comparable months during 2022. Anxiety/stress/depression/other psychiatric illnesses remain the highest reason for long term absence, and we continue to offer a range of support both internally and externally, around mental wellbeing.

Long term absence within Corporate services has been over 3% for the last 3 months, which is being explored in further detail. Each Business Unit continues to work with their HR contacts to focus on all long-term absence and have undertaken case reviews to ensure appropriate support is in place. The Occupational health service is working to give managers a better understanding of what support they can provide to help in these often-complex cases, and how best to engage with them at the earliest opportunity.

Short-term sickness absence

The overall short term absence rate has been below the organisational target of 3% since at least April 2022.

The highest reason for absence is for cold, cough, flu, influenza, and gastrointestinal problems, which due to the short-term nature of absence, is causing significant pressure across all business areas. There are several wellbeing initiatives that have been regularly communicated to all staff, such as reiterating the message about the importance of taking breaks and making time for 1:1s and having catch up/check-in conversations.

Appraisal

Appraisal compliance remains largely static and consistent at 74.5%. Plans are in place to reintroduce appraisal training and look at new ways to engage with colleagues and managers around the importance of appraisal. There is some analysis ongoing in terms of data sources, to ensure Business Units and central reporting are co-ordinated.

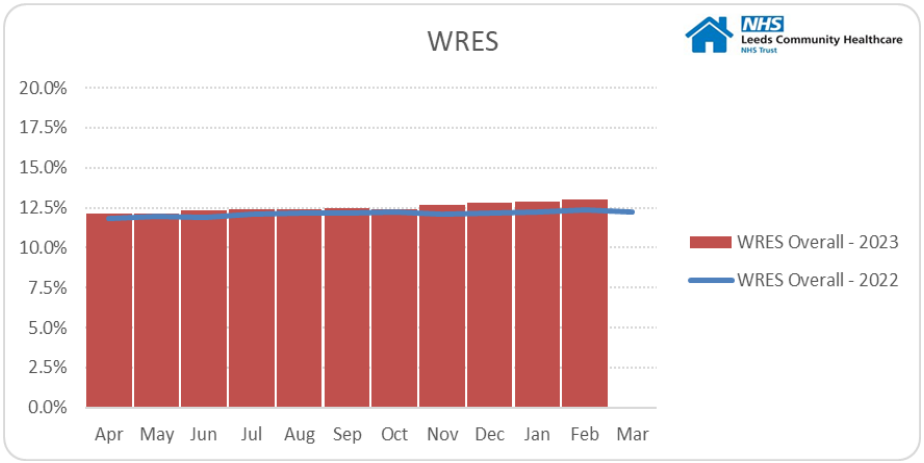
Statutory and Mandatory Training (MaST)

MaST performance continues to be consistent and stable reporting at 84.4%.

Workforce Race Equality Standard (WRES)

The overall percentage representation of BME staff continues to increase, currently the percentage representation of BME staff at Band 8 & 9 is 7.9%.

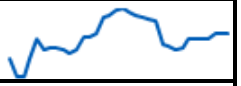
It is anticipated that actions in the WRES Action Plan 2023/24 will positively impact on BME representation, particularly the BME Talent Development Programme, BME Fair recruitment process and Cultural Conversations initiative.



Finance – February 2024

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

Data

Finance	Director	Year End Target	Financial Year	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD	Time Series (from Apr-21)
Net surplus (+)/Deficit (-) (£m) - YTD	AO	1.0	2023/24	-0.2	-0.3	-0.5	-0.4	0.0	0.0	0.0	0.0	0.3	0.3	0.3	0.3	
Capital Expenditure(£k)	AO	4149	2023/24	-1344	159	-368	-358	28	-2110	536	1060	921	754	1146	424	
CIP delivery (£k)	AO	3.03	2023/24	688	545	832	687	688	687	688	687	688	687	687	7564	

Narrative

National and West Yorkshire Context

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

Income & Expenditure (I&E) Summary

At the end of February 2024, the Trust is reporting a surplus of £250k. The year to date position is mainly driven by substantive vacancies and a favourable variance in interest received, offset by contract penalties, and inflationary pressures. A breakdown of the variances by category are provided in the tables below. Forecast for the end of year is a surplus of £250k, the position agreed with WYICB in December, with the contract penalties and non pay overspend being offset by underspends in pay and interest received.

The Trust has engaged the District Valuer to arrange a desktop valuation of the Trust owned estate. This may result in an impairment at the year end but no value has currently been included in the forecast as there is no indication of the amount.

Income & Expenditure Summary	February 2024			2023/24		
	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Forecast Outturn	Forecast Variance
	£k	£k	£k	£k	£k	£k
Income						
Income from Patient Care Activities	(188,582)	(188,473)	109	(205,767)	(205,620)	147
Other Operating Income	(12,402)	(12,720)	(318)	(13,643)	(13,945)	(302)
Total Income	**(200,984)**	**(201,193)**	**(209)**	**(219,410)**	**(219,565)**	**(155)**
Expenditure						
Pay	141,826	140,949	(877)	154,718	153,898	(820)
Non pay	58,974	61,183	2,209	64,492	66,740	2,248
Total Expenditure	**200,800**	**202,132**	**1,332**	**219,210**	**220,638**	**1,428**
Operating (Surplus) / Deficit	**(184)**	**939**	**1,123**	**(200)**	**1,073**	**1,273**
Public Dividend Capital	423	423	0	461	461	0
Profit/Loss on Asset Disp	0	(12)	(12)	0	(12)	(12)
Interest Payable	620	628	8	676	658	(18)
Interest Received	(845)	(2,229)	(1,384)	(922)	(2,430)	(1,508)
(Surplus) / Deficit	**14**	**(251)**	**(265)**	**15**	**(250)**	**(265)**
Less: Donated Asset Depreciation	(14)	(14)	0	(15)	(15)	0
Less: Capital Donations and Grants	0	15	15	0	15	15
Adjusted (Surplus) / Deficit	**0**	**(250)**	**(250)**	**0**	**(250)**	**(250)**

Income From Patient Care Activities

The year-to-date small adverse variances of £109k and full year variance of £147k mainly relates to contract penalties for Police Custody due to nursing shifts not being filled. All contracts for this financial year have been signed.

Other Operating Income

The year to date and full year favourable variances largely relates to non-recurrent income for estates.

Pay

The year-to-date favourable variance is (£877k), this is comprised of favourable variances in substantive staff of (£1,466k) due to vacancies partially offset by a £589k adverse variance from the cost of bank and agency staff covering substantive vacancies.

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

	February 2024			2023/24		
Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Budget £k	Forecast Outturn £k	Forecast Variance £k
Substantive Staff	133,703	132,237	(1,466)	145,868	144,299	(1,569)
Bank Staff	3,350	4,730	1,380	3,655	5,229	1,574
Agency Staff	4,217	3,426	(791)	4,600	3,775	(825)
Sub Total	**141,270**	**140,393**	**(877)**	**154,123**	**153,303**	**(820)**
Apprenticeship Levy	556	556	0	595	595	0
Total	**141,826**	**140,949**	**(877)**	**154,718**	**153,898**	**(820)**

There is an 81wte under establishment in February 2024 across worked substantive, bank, and agency (January 2024: 111wte under establishment).

WTE	February 2024					
	Plan	Substantive Worked	Bank Worked	Agency Worked	Total Worked	Variance
	WTE	WTE	WTE	WTE	WTE	WTE
Specialist Business Unit	756	705	11	7	723	(33)
Childrens Business Unit	663	606	10	9	625	(39)
Adult Business Unit	1,018	933	69	(6)	996	(22)
Ops Management	452	440	14	13	467	15
Corporate	312	292	12	4	308	(4)
Primary Care Network	46	41	0	0	41	(4)
Total	**3,241**	**3,017**	**117**	**27**	**3,161**	**(81)**

The run rate on substantive pay has increased in February by £966k mainly due to an estimate for the discretionary day and new starters. Bank expenditure has increased slightly in February across most services and agency has increased due to additional Medics supporting CAMHS and ICAN to address the waiting list backlog.

	2023/24											
Run Rate of Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	September £k	October £k	November £k	December £k	January £k	February £k	YTD Actuals £k
Substantive Staff	11,886	11,886	12,138	11,851	11,864	12,098	12,055	12,273	11,611	11,805	12,771	132,237
Bank staff	426	426	448	439	470	472	474	187	467	432	490	4,730
Agency staff	417	362	376	307	485	312	314	-47	239	305	356	3,426
Sub Total	**12,728**	**12,673**	**12,962**	**12,597**	**12,819**	**12,882**	**12,843**	**12,413**	**12,317**	**12,542**	**13,617**	**140,393**
Apprenticeship Levy	**45**	**45**	**79**	**47**	**48**	**48**	**48**	**48**	**50**	**49**	**49**	**556**
Total	**12,773**	**12,718**	**13,041**	**12,644**	**12,867**	**12,930**	**12,891**	**12,461**	**12,367**	**12,591**	**13,666**	**140,949**

Non-Pay including Depreciation and Interest

The overall year to date position is £837k adverse to plan. The adverse variances in other non-pay of £2,178k relate to inflationary pressures and £741k in general supplies and services mainly relates to expenditure with the local authority. These are partially offset by a non-recurrent favourable variance of £1,384k in interest received due to the higher-than-expected interest rates, clinical supplies, and services £53k for services provided by our partners due to vacancies, premises £426k and depreciation of £460k.

The annual forecast adverse variance is expected to reduce to £725k due to additional expenditure controls and non-recurrent expenditure with the local authority included in the year-to-date position not expected to continue.

	February 2024			2023/24		
Non Pay Costs	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Budget £k	Forecast Outturn £k	Forecast Variance £k
Drugs	862	950	88	941	1,035	94
Clinical Supplies & Services	26,258	26,205	(53)	28,771	28,730	(41)
General Supplies & Services	5,801	6,542	741	6,282	6,972	690
Establishment Expenses	3,192	3,334	142	3,477	3,693	216
Premises	8,602	8,176	(426)	9,495	9,016	(479)
Depreciation	9,081	8,621	(460)	9,908	9,451	(457)
Other Non Pay	5,177	7,355	2,178	5,618	7,843	2,225
Total Non Pay Costs	**58,973**	**61,183**	**2,210**	**64,492**	**66,740**	**2,248**
Public Dividend Capital	423	423	0	461	461	0
Profit/Loss on Asset Disp	0	(12)	(12)	0	(12)	(12)
Interest Payable	620	628	8	676	658	(18)
Interest Received	(845)	(2,229)	(1,384)	(922)	(2,430)	(1,508)
Total Non Pay	**59,171**	**59,993**	**822**	**64,707**	**65,417**	**710**
Less: Donated Asset Depreciation	(14)	(14)	0	(15)	(15)	0
Less: Capital Donations and Grants	0	15	15	0	15	15
Total Adjusted Non Pay	**59,157**	**59,994**	**837**	**64,692**	**65,417**	**725**

Non pay expenditure in February has reduced for clinical supplies and services mainly due to a one-off invoice for local authority expenditure included within the January position. General supplies and services have reduced mainly due to outsourcing expenditure within CAMHS included in the January position. Establishment expenses have increased mainly due the transfer of mobile phone expenditure to capital following the approval of the Trust's frontline digitisation bid in January. Premises have reduced due to year-to-date amendments made in January and other non-pay has increased mainly due to the release of non-recurrent benefits in January's position to fund the ICB contract reduction agreed.

Run Rate of Non Pay Costs by Category	2023/24 April £k	May £k	June £k	July £k	August £k	September £k	October £k	November £k	December £k	January £k	February £k	YTD Actuals £k
Drugs	93	93	74	90	86	76	86	81	81	79	111	950
Clinical Supplies & Services	1,970	1,970	2,455	1,726	2,566	2,802	2,718	3,349	944	3,014	2,691	26,205
General Supplies & Services	576	576	344	732	257	488	472	504	1,638	605	351	6,542
Establishment Expenses	334	334	357	276	291	324	237	779	260	(156)	298	3,334
Premises	727	727	683	790	881	530	664	770	873	852	680	8,176
Depreciation	743	743	779	917	816	915	819	567	781	748	793	8,621
Other Non Pay	961	925	531	944	661	559	623	461	766	(91)	1,015	7,355
Total Non Pay Costs	**5,403**	**5,367**	**5,223**	**5,475**	**5,558**	**5,694**	**5,619**	**6,511**	**5,343**	**5,051**	**5,939**	**61,183**
Public Dividend Capital	39	39	38	39	38	39	38	39	38	38	39	423
Profit/Loss on Asset Disp	0	0	0	0	0	(8)	0	0	0	(4)	0	(12)
Interest Payable	48	48	49	50	49	76	58	57	57	84	53	628
Interest Received	(175)	(175)	(178)	(187)	(199)	(201)	(221)	(225)	(223)	(223)	(222)	(2,229)
Total Non Pay	**5,314**	**5,278**	**5,132**	**5,377**	**5,446**	**5,600**	**5,494**	**6,382**	**5,215**	**4,946**	**5,809**	**59,993**
Less: Donated Asset Depreciation	(2)	(2)	(1)	(1)	(2)	(1)	(1)	(1)	(2)	(1)	(1)	(14)
Less: Capital Donations and Grants	0	0	0	0	0	0	15	0	0	0	0	15
Total Adjusted Non Pay	**5,313**	**5,277**	**5,131**	**5,376**	**5,444**	**5,599**	**5,508**	**6,381**	**5,213**	**4,945**	**5,808**	**59,994**

Delivery of Efficiency Plans

The Trust has £8,252k of planned efficiencies to deliver during 2023/24 of which £4,578k is a non-recurrent saving (£3,978k vacancy factor and £600k interest receivable). At the end of February, £7,564k of savings have been delivered which is in line with plan. The forecast assumes that the efficiency programme will be delivered in full.

	February 2024			2023/24		
Savings Scheme	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Plan £k	Forecast Outturn £k	Forecast Variance £k
Vacancy factor	3,647	3,647	0	3,978	3,978	0
Incremental Drift	1,273	1,273	0	1,389	1,389	0
Interest receivable	550	550	0	600	600	0
Contribution from developments	777	777	0	848	848	0
Procurement - management of price increases	1,317	1,317	0	1,437	1,437	0
Total Efficiency Savings Delivery	**7,564**	**7,564**	**0**	**8,252**	**8,252**	**0**
Recurrent	3,368	3,368	0	3,674	3,674	0
Non-recurrent	4,197	4,197	0	4,578	4,578	0
	7,564	**7,564**	**0**	**8,252**	**8,252**	**0**

Summary by Business Unit

	February 2024			2023/24		
Savings Scheme	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Plan £k	Forecast Outturn £k	Forecast Variance £k
Specialist Business Unit	1,084	789	(295)	1,183	1,044	(139)
Childrens Business Unit	606	1,222	616	661	1,151	490
Adult Business Unit	1,194	1,194	0	1,302	1,302	0
Ops Management	753	432	(320)	821	470	(351)
Total	**3,636**	**3,637**	**0**	**3,967**	**3,967**	**0**
Corporate	3,378	3,378	0	3,685	3,685	0
Interest Receivable	550	550	0	600	600	0
Total Efficiency Savings Delivery	**7,564**	**7,565**	**0**	**8,252**	**8,252**	**0**

Analysis of Variances by Business Unit and Corporate Directorates

Business Unit Summary	February 2024			2023/24		
	YTD Plan	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£k	£k	£k	£k	£k	£k
Specialist Business Unit	57,491	58,076	585	62,730	63,369	639
Childrens Business Unit	30,556	29,952	(604)	33,328	32,765	(563)
Adult Business Unit	51,786	51,351	(435)	56,381	56,020	(361)
Ops Management	14,328	14,754	426	15,616	16,077	461
Estates	5,367	4,471	(896)	5,938	5,037	(900)
Corporate	20,989	20,928	(61)	22,920	22,918	(2)
Primary Care Network	0	(1)	(1)	0	0	0
Reserves	(2,216)	129	2,344	(2,358)	(166)	2,192
Depreciation	9,096	8,606	(490)	9,922	9,440	(482)
Contract Income	(187,580)	(187,326)	255	(204,676)	(204,386)	290
Operating (Surplus) / Deficit	**(183)**	**939**	**1,123**	**(200)**	**1,073**	**1,273**
Public Dividend Capital	423	423	0	461	461	0
Asset Disposal	0	(12)	(12)	0	(12)	(12)
Interest Payable	620	628	8	676	658	(18)
Interest Rec	(845)	(2,229)	(1,384)	(922)	(2,430)	(1,508)
(Surplus) / Deficit	**14**	**(251)**	**(265)**	**15**	**(250)**	**(265)**
Less: Donated Asset Depreciation	(14)	(14)	(1)	(15)	(15)	0
Less: Capital Donations and Grants	0	15	15	0	15	15
Adjusted (Surplus) / Deficit	**(0)**	**(250)**	**(250)**	**(0)**	**(250)**	**(250)**

Income by Business Unit/Corporate Directorate

Income Variance	February 2024			2023/24			
	YTD Plan	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance	
	£k	£k	£k	£k	£k	£k	Comments
Income from Patient Care Activities							
Specialist Business Unit	(277)	(298)	(21)	(302)	(299)	3	**YTD Variance** - Variance due to profiling of LSH PrEP activity plan
Childrens Business Unit	(871)	(871)	0	(954)	(954)	0	
Adult Business Unit	(398)	(398)	0	(430)	(430)	0	
Ops Management	(121)	(137)	(16)	(132)	(150)	(18)	**YTD Variance** - Variance due to profiling of Loan Equipment Service **Forecast Variance** - Variance due to profiling of Loan Equipment Service
Reserves	5	5	0	5	5	0	
Contract Income	(186,919)	(186,772)	147	(203,954)	(203,792)	161	**YTD Variance** - £135k Estimated penalties in Police Custody (Q1-Q3 actuals, Q4 estimate) and £12k 0-19 Service Penalties **Forecast Variance** - £150k Estimated penalties in Police Custody (Q1-Q3 actuals, Q4 estimate) and £12k 0-19 Service Penalties
Subtotal Income from Patient Care Activities	**(188,582)**	**(188,472)**	**110**	**(205,767)**	**(205,620)**	**147**	
Other Operating Income							
Specialist Business Unit	(2,742)	(2,752)	(11)	(3,127)	(3,147)	(19)	**YTD Variance** - Additional lease car income **Forecast Variance** - Additional lease car income
Childrens Business Unit	(1,675)	(1,671)	5	(1,817)	(1,812)	5	
Adult Business Unit	(1,106)	(1,170)	(64)	(1,201)	(1,271)	(70)	**YTD Variance** - Additional lease car income **Forecast Variance** - Additional lease car income
Ops Management	(98)	(141)	(43)	(102)	(151)	(49)	**YTD Variance** - LTHT salary recharge income **Forecast Variance** - LTHT salary recharge
Estates	(1,301)	(1,610)	(309)	(1,427)	(1,706)	(279)	**YTD Variance -** Over recovery on Estates recharges due to ad-hoc room hire from third parties. **Forecast Variance** - Over recovery on Estates recharges due to ad-hoc room hire from third parties.
Corporate	(2,149)	(2,143)	6	(2,326)	(2,329)	(3)	
Primary Care Network	(2,005)	(2,006)	(0)	(2,206)	(2,206)	0	
Reserves	(665)	(659)	6	(714)	(715)	(1)	**Budget** - Primarily relates to apprenticeship funding
Below EBITDA	0	(15)	(16)	0	(15)	(15)	**YTD Variance** - Donation income **Forecast Variance** - Donation income
Contract Income	(662)	(554)	108	(723)	(594)	129	**YTD Variance** - LCC One Adoption West Yorkshire (OAWY) and Therapeutic Social Work Team (TSWT) **Forecast Variance** - LCC One Adoption West Yorkshire (OAWY) and Therapeutic Social Work Team (TSWT)
Subtotal Other Operating Income	**(12,403)**	**(12,720)**	**(318)**	**(13,644)**	**(13,945)**	**(302)**	
Total	**(200,985)**	**(201,192)**	**(208)**	**(219,411)**	**(219,566)**	**(155)**	

Income by Commissioner

Contract Variance	February 2024			2023/24			
	YTD Plan	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance	
	£k	£k	£k	£k	£k	£k	Comments
Income from Patient Care Activities							
ICB							
Block	(119,618)	(119,618)	(0)	(130,459)	(130,459)	0	
Leeds Mental Wellbeing Service (LMWS)	(15,693)	(15,693)	0	(17,119)	(17,119)	0	
Mental Health	(8,160)	(8,160)	0	(8,902)	(8,902)	0	
Community Beds	(4,242)	(4,242)	0	(4,620)	(4,620)	0	
Pain Service	(623)	(623)	0	(680)	(680)	0	
Tier 3 Weight Management	(582)	(582)	0	(635)	(635)	0	
Subtotal ICB	**(148,917)**	**(148,917)**	**(0)**	**(162,414)**	**(162,414)**	**0**	
NHS England							
Prison Service	(4,668)	(4,668)	(0)	(5,092)	(5,092)	0	
Liaison and Diversion	(1,203)	(1,203)	(0)	(1,312)	(1,312)	0	
Public Health	(500)	(500)	(0)	(531)	(531)	0	
Reconnect	(206)	(206)	(0)	(236)	(236)	0	
Covid	(68)	(68)	0	(69)	(69)	0	
MPX	(8)	(8)	0	(8)	(8)	0	
Block	(0)	(0)	(0)	(0)	(0)	0	
Subtotal NHSE	**(6,652)**	**(6,652)**	**(0)**	**(7,248)**	**(7,248)**	**0**	
NHS Other							
Community Dental Service (CDS)	0	0	(0)	0	0	0	
Subtotal NHS Other	**0**	**0**	**(0)**	**0**	**0**	**0**	
Local Authority							
0-19 Service	(9,863)	(9,851)	12	(10,760)	(10,747)	12	**YTD Variance** - £12k 0-19 Service Penalties **Forecast Variance** - £12k 0-19 Service Penalties
Police Custody	(7,784)	(7,650)	135	(8,492)	(8,343)	149	**YTD Variance** - £135k Estimated penalties in Police Custody (Q1-Q3 actuals, Q4 estimate) **Forecast Variance** - £150k Estimated penalties in Police Custody (Q1-Q3 actuals, Q4 estimate)
Sexual Health	(5,692)	(5,692)	(0)	(6,210)	(6,210)	0	
Community Beds	(1,700)	(1,700)	(0)	(1,857)	(1,857)	0	
Leeds Equipment Service (LES)	(1,428)	(1,429)	(0)	(1,558)	(1,558)	0	
Infection Control	(866)	(866)	(0)	(945)	(945)	0	
PrEP	(262)	(287)	(25)	(286)	(287)	(1)	**YTD Variance** - Variance due to profiling of LSH PrEP activity plan
Dementia Beds	(233)	(233)	0	(255)	(255)	0	
East Leeds Recovery Hub	(158)	(158)	(0)	(172)	(172)	0	
Other	(121)	(121)	(0)	(132)	(132)	(0)	
SLT Traded Provision	(35)	(35)	0	(38)	(38)	0	
Library	(8)	(8)	(0)	(9)	(9)	0	
Subtotal Local Authority	**(28,152)**	**(28,029)**	**122**	**(30,714)**	**(30,554)**	**160**	
Other	**(4,862)**	**(4,874)**	**(13)**	**(5,391)**	**(5,405)**	**(14)**	
Income from Patient Care Activities Total	**(188,582)**	**(188,472)**	**110**	**(205,767)**	**(205,620)**	**147**	

Contract Variance	February 2024			2023/24			
	YTD Plan	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance	
	£k	£k	£k	£k	£k	£k	Comments
Other Operating Income							
Education & Training	(4,341)	(4,335)	6	(4,705)	(4,707)	(2)	
Research & Development	(319)	(315)	4	(343)	(346)	(3)	
Internal Transfer	0	0	(0)	0	0	(0)	
Non Patient Care Services to Other Bodies	(518)	(486)	32	(566)	(531)	35	**YTD Variance** - Undertrade against SLT training income. **Forecast Variance** - Undertrade against SLT training income.
NHS Salary Recharges and Other	(1,550)	(1,508)	42	(1,684)	(1,642)	42	**YTD Variance** - Estates recharges offset by favourable variance on Non-NHS Salary Recharges. **Forecast Variance** - Estates recharges offset by favourable variance on Non-NHS Salary Recharges.
Non-NHS Salary Recharges and Other	(5,676)	(6,061)	(386)	(6,347)	(6,706)	(359)	**YTD Variance** - Over recovery on Estates recharges, LCC One Adoption West Yorkshire (OAWY) and Therapeutic Social Work Team (TSWT) **Forecast Variance** - Over recovery on Estates recharges, LCC One Adoption West Yorkshire (OAWY) and Therapeutic Social Work Team (TSWT)
Donation	0	(15)	(15)	0	(15)	(15)	**YTD Variance** - Donation income **Forecast Variance** - Donation income
Other Operating Income Total	**(12,403)**	**(12,720)**	**(318)**	**(13,644)**	**(13,945)**	**(302)**	
Income Total	**(200,985)**	**(201,192)**	**(208)**	**(219,411)**	**(219,566)**	**(155)**	

Pay by Business Unit/Corporate Directorate

The table below shows the year to date pay position for each Business Unit split by substantive, bank and agency.

Business Unit	Pay Group	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
Specialist Business Unit	Substantive	35,025	34,052	(973)	38,216	37,129	(1,087)
	Bank	19	672	653	21	733	712
	Agency	547	1,057	510	597	1,111	514
Specialist Business Unit Total		**35,591**	**35,781**	**190**	**38,834**	**38,973**	**139**
Childrens Business Unit	Substantive	29,964	27,870	(2,093)	32,686	30,458	(2,228)
	Bank	179	614	435	179	680	501
	Agency	360	1,110	750	393	1,275	882
Childrens Business Unit Total		**30,503**	**29,595**	**(908)**	**33,258**	**32,413**	**(845)**
Adult Business Unit	Substantive	43,275	40,277	(2,998)	47,188	43,934	(3,253)
	Bank	68	2,514	2,446	75	2,796	2,721
	Agency	133	352	220	145	430	285
Adult Business Unit Total		**43,476**	**43,144**	**(332)**	**47,407**	**47,160**	**(247)**
Ops Management	Substantive	14,294	13,565	(729)	15,578	14,803	(775)
	Bank	1	521	520	1	567	566
	Agency	62	591	529	63	623	559
Ops Management Total		**14,356**	**14,676**	**320**	**15,642**	**15,993**	**351**
Corporate	Substantive	15,077	13,799	(1,278)	16,473	15,094	(1,379)
	Bank	105	410	305	114	455	342
	Agency	57	313	257	62	337	275
Corporate Total		**15,239**	**14,522**	**(717)**	**16,648**	**15,886**	**(762)**
Reserves	Substantive	2,661	3,232	571	2,928	3,472	544
	Bank	0	0	0	0	0	0
	Agency	0	0	0	0	0	0
Reserves Total		**2,661**	**3,232**	**571**	**2,928**	**3,472**	**544**
Grand Total		**141,826**	**140,949**	**(877)**	**154,718**	**153,898**	**(820)**

	February 2024			2023/24			
Pay Variance	**YTD Plan**	**YTD Actual**	**YTD Variance**	**Annual Budget**	**Forecast Outturn**	**Forecast Variance**	
	£k	**£k**	**£k**	**£k**	**£k**	**£k**	**Comments**
Specialist Business Unit	35,591	35,781	190	38,834	38,973	139	**YTD Variance** - Overspend due to agency usage in Police Custody. **Forecast Variance** - Overspend due to agency usage in Police Custody.
Childrens Business Unit	30,503	29,595	(908)	33,258	32,413	(845)	**YTD Variance** - Vacancies across HCP, CNT and ICAN. **Forecast Variance** - Vacancies across HCP, CNT and ICAN
Adult Business Unit	43,476	43,144	(332)	47,407	47,160	(247)	**YTD Variance -** Vacancies across the Neighbourhood Teams. **Forecast Variance** - Vacancies across the Neighbourhood Teams.
Ops Management	14,356	14,676	320	15,642	15,993	351	**YTD Variance** - Unachieved vacancy factor and over established in MSK Admin. **Forecast Variance** - Historic admin unachieved vacancy factor
Corporate	15,239	14,522	(717)	16,648	15,886	(762)	**YTD Variance** - Vacancies across multiple departments. **Forecast Variance** - Vacancies across multiple departments.
Primary Care Network	1,946	1,945	(1)	2,141	2,141	0	
Reserves	714	1,286	572	786	1,330	544	**YTD Variance** - Estimate for discretionary day. **Forecast Variance** - Estimate for discretionary
Total	**141,826**	**140,949**	**(877)**	**154,718**	**153,898**	**(820)**	

Non-Pay by Business Unit/Corporate Directorate

	February 2024			2023/24			
Non-Pay Variance	YTD Plan	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance	
	£k	£k	£k	£k	£k	£k	Comments
Specialist Business Unit	24,918	25,345	427	27,326	27,841	515	**YTD Variance -** Overspend on Enteral Feeding. **Forecast Variance** - Overspend on Enteral Feeding.
Childrens Business Unit	2,600	2,899	299	2,841	3,117	276	**YTD Variance -** Overspend due to subcontracting activity to Oakdale. **Forecast Variance** - Overspend due to subcontracting activity to Oakdale.
Adult Business Unit	9,815	9,776	(39)	10,604	10,561	(44)	**YTD Variance** - Underspend on travel and Medical & Surgical equipment. **Forecast Variance** - Underspend on travel and Medical & Surgical equipment.
Ops Management	190	356	166	208	385	177	**YTD Variance** - Overspend due to Allocate IT software costs. **Forecast Variance** - Overspend due to Allocate IT software costs.
Estates	6,668	6,081	(587)	7,365	6,743	(621)	**YTD Variance** - Underspend due to utilities and repairs. **Forecast Variance** - Underspend due to utilities and repairs.
Corporate	7,899	8,549	649	8,597	9,361	764	**YTD Variance** - Overspend due to IT Hardware, Mobile Telephony, LYPFT Procurement Recharge, BME Talent Programme. **Forecast Variance** - Overspend due to IT Hardware, Mobile Telephony, LYPFT Procurement Recharge, BME Talent Programme.
Below EBITDA	9,082	8,622	(460)	9,907	9,451	(456)	**YTD Variance** - Underspend due to Depreciation. **Forecast Variance** - Underspend due to Depreciation.
Primary Care Network	59	59	0	65	65	0	
Reserves	(2,257)	(503)	1,754	(2,421)	(783)	1,638	**YTD Variance** - Negative budget due to transferring funding to Business Units for TLT approved expenditure and negative actuals due to non-recurrent benefits. **Forecast Variance** - Negative budget due to transferring funding to Business Units for TLT approved expenditure and negative actuals due to non-recurrent benefits.
Total	**58,974**	**61,183**	**2,209**	**64,492**	**66,740**	**2,248**	

Capital Expenditure

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

At the end of February 2024, the Trust has spent £13.8m compared to a plan of £14.3m. The main year to date expenditure on owned assets is £1.4m on the HQ project and £0.9m on Frontline digitisation. On the lease expenditure, the year to date and forecast variance relates to increased costs for RPI following the remeasurement of the right of use leases, lease car additions and the addition of the Trust HQ Lease in September. The year to date variance for the Frontline Digitisation is due to the phasing of the plan. Spend was planned for March and has now commenced due to the approval of the funding and the requirement that all the funds are committed by the end of the financial year. A refurbishment contribution has also been received towards the HQ fit out costs of £0.142m.

The Trust is forecasting to spend £16.3m by the end of March 2024. This is an underspend of £0.7m. The underspend consists of £0.149m agreed ICB 5% reduction to support the ICB system, and £1m leases (£2.8m underspend relating to leases not starting as planned in 23/24 for Killingbeck and St Georges, offset by £1.6m of increased IFRS 16 costs from the remeasurement of CHP leases, lease cars £0.175m). This is offset by additional frontline digitisation costs of £0.6m from the successful bid for additional funding from the national underspend.

	February 2024			2023/24		
Capital Scheme	YTD Plan £k	YTD Actual £k	YTD Variance £k	Annual Plan £k	Forecast Outturn £k	Forecast Variance £k
Estate Maintenance	370	127	243	443	443	0
Estates - HQ Project	1,433	1,433	0	1,433	1,445	(12)
Clinical Equipment	290	153	137	350	204	146
IT Hardware	166	0	166	200	200	0
IT - National Cyber Security	331	27	304	400	400	0
Hannah House Garden Charitable Fund Donation	0	(15)	15	0	(15)	15
Sub-Total	***2,590***	***1,725***	***865***	***2,826***	***2,677***	***149***
PDC Capital - Frontline Digitisation	*0*	*862*	(862)	*1,194*	*1,748*	(554)
Sub-Total Capital Expenditure	***2,590***	***2,587***	***3***	***4,020***	***4,425***	***(405)***
Lease Cars IFRS 16	275	438	(163)	300	475	(175)
Property Leases IFRS 16 - Additions	5,260	3,210	2,050	6,524	3,733	2,791
Property Leases IFRS 16 - Remeasurement	6,128	7,647	(1,519)	6,128	7,736	(1,608)
Lease Disposals	0	(43)	43	0	(48)	48
Sub-Total Finance Lease Expenditure	***11,663***	***11,252***	***411***	***12,952***	***11,896***	***1,056***
Total Capital Expenditure	**14,253**	**13,839**	**414**	**16,972**	**16,321**	**651**

Statement of Financial Position (Balance Sheet) and Cash

The Trust Statement of Financial Position is shown in the table below. As at the end of February 2024 the Trust is reporting Total Equity of £60.9m compared to a planned position of £61.2m. The cash variance is mainly due to the reduction of Trade and other payables compared to the plan.

Statement of Financial Position	February 2024 YTD Plan £m	YTD Actual £m	YTD Variance £m
Property, Plant and Equipment	34.8	34.4	(0.4)
Intangible Assets	0.1	0.1	0.0
Right of Use Assets	58.8	61.2	2.4
Trade and Other Receivables	0.0	0.0	(0.0)
Total Non Current Assets	**93.6**	**95.7**	**2.0**
Current Assets			
Trade and Other Receivables	9.7	10.6	0.9
Cash and Cash Equivalents	48.5	41.8	(6.7)
Total Current Assets	**58.2**	**52.4**	**(5.8)**
Total Assets	**151.8**	**148.1**	**(3.8)**
Current Liabilities			
Trade and Other Payables	(30.3)	(25.0)	5.3
Borrowings	(7.0)	(7.8)	(0.8)
Provisions	(0.6)	(0.6)	0.0
Total Current Liabilities	**(37.8)**	**(33.3)**	**4.5**
Net Current Assets/(Liabilities)	**20.4**	**19.1**	**(1.3)**
Total Assets less Current Liabilities	**114.0**	**114.7**	**0.7**
Non Current Borrowings	(51.6)	(53.5)	(1.8)
Non Current Provisions	(0.0)	(0.4)	(0.4)
Total Non Current Liabilities	**(51.6)**	**(53.8)**	**(2.2)**
Total Assets less Liabilities	**62.4**	**60.9**	**(1.5)**
TAXPAYERS EQUITY			
Public Dividend Capital	2.0	0.8	(1.2)
Retained Earnings Reserve	27.7	24.7	(3.1)
General Fund	18.5	19.5	1.0
Revaluation Reserve	14.2	15.9	1.7
Total Equity	**62.4**	**60.9**	**(1.5)**

Aged Receivables

As at the end of February the Trust had £5,802k of receivables outstanding, £5,282k of non-NHS and £550k of NHS invoices. This is an increase on the previous months aged debt total of £4,183k.

The over 90-day non-NHS debt has decreased from £1,518k in January to £262k in February. Outstanding receipts have been received from Leeds City Council (LCC) which have paid the majority of the overdue debts outstanding . There are still several invoices outstanding with the Leeds GP Confederation amounting to £68k. Discussions are ongoing with this organisation to resolve the non-payment.

At the end of February Leeds City Council (LCC) were the main debtor, with £2,879k outstanding for contracted services, the majority of which, £2,806k, is within the 0-30day category.

	Current month - Feb 2024				
Aged Receivables	TOTAL	0-30 Days	31-60 days	61-90 days	Over 90 days
Organisation Type		£000	£000	£000	£000
Receivables non NHS	5,252	4,487	439	64	262
Receivables NHS	550	435	36	41	38
TOTAL Receivables	**5,802**	**4,922**	**475**	**105**	**300**

Aged Payables

£2,557k of payables are outstanding at the end of February. This is an increase compared to the previous month figure of £2,557k. The outstanding invoices within the 31 to 60 days category relates to the delay in receipting of orders and procurement issues. An action plan has been developed and is progressing with LYPFT.

	Current month - Feb 2024				
Aged Payables	TOTAL	0-30 Days	31-60 days	61-90 days	Over 90 days
Organisation Type		£000	£000	£000	£000
Payables non NHS	(2,349)	(1,424)	(454)	(116)	(355)
Payables NHS	(208)	(198)	0	0	(10)
Total Payables	**(2,557)**	**(1,622)**	**(454)**	**(116)**	**(365)**

Better Payment Practice Code

The Trust's cumulative Better Payment Practice Code performance has exceeded the 95% target for paying invoices within 30 days for non-NHS invoices at the end of February 2024 and for the value of NHS invoices as shown in the table below.

The NHS invoices by number figure is lower than target at 94.4%. This is an improvement since January (92.7%). The shortfall is due to the delayed payments of some small value invoices at the beginning of the financial year with the NHS Business Services Authority because of delayed supplier set up by NHS SBS. There have also been delays with the approval of invoices and the receipting of orders within the Trust and the finance team have introduced additional monitoring measures to try and ensure the timely approval of due payments going forward.

	February 2024		
BPPC Measure	**YTD**	**Target**	**RAG**
NHS Invoices			
By Number	94.4%	95.0%	**A**
By Value	99.4%	95.0%	**G**
Non NHS Invoices			
By Number	95.4%	95.0%	**G**
By Value	97.8%	95.0%	**G**
Total			
By Number	95.4%	95.0%	**G**
By Value	98.3%	95.0%	**G**

Appendix 1

Waiting List Summary

Business Unit	Service	Waiting List Size - Feb 24	Waiting List Size - Apr 23	Change	Current Performance *(%age patients waiting under 18 weeks)*	Plan
ABU	Neighbourhood Team Therapy	1676	1254	+422	79.2%	Narrative in main body
ABU	CUCS	1024	812	+212	65.4%	Narrative in main body
CBU	Child Development Centres (CDC)	512	579	-67	11.7%	Narrative in main body - relating to ICAN Consultant Clinics
CBU	Community Paediatric Clinics	267	301	-34	69.1%	Narrative in main body - relating to ICAN Consultant Clinics
CBU	Paediatric Neuro Disability (PND) Clinics	1649	1098	+551	25.4%	Narrative in main body - relating to ICAN Consultant Clinics
CBU	Children's Audiology	948	860	+88	29.5% (6-week target)	Narrative in main body – relating to DM01 Diagnostic Services
CBU	Children's Occupational Therapy	299	126	+173	36.5%	Narrative in main body
CBU	Children's Speech & Language Therapy	1530	1238	+292	85.0%	Narrative in main body
SBU	Community Gynaecology	209	440	-231	3.6%	Narrative in main body
SBU	MSK	8700	7961	+739	87.1%	The service continues to experience a steady growth in the number of people waiting for care to start. Although the service has been successful in delivering increased patient contacts in 2023/24 so far, these increases have mostly been for follow up appointments, leading to an increase in the service's First:Follow Up Ratio
SBU	Podiatry	6557	2778	+3779	42.9%	Narrative in main body

SBU	Respiratory	513	255	+258	92.0%	The service is showing early signs of improvement to the number of people waiting over 18-weeks, primarily as the service has re-commenced waiting list validation work since January workshops
SBU	Diabetes	841	487	+354	81.9%	Narrative in main body
SBU	Tier 3 Weight Management	578	396	+182	1.4%	The service remains closed to new referrals. The number of patients waiting is showing some signs of slow reduction
SBU	Cardiac Service	179	162	+17	99.4%	No significant concerns, however, the service has reported some breaches of local targets so continue to monitor
SBU	Community Neurological Rehabilitation Service	117	102	+15	79.5%	No significant concerns, however, the service has reported some breaches of local targets so continue to monitor
SBU	Community Stroke	94	73	+21	100.0%	No significant concerns, however, the service has reported some breaches of local targets so continue to monitor
SBU	Community Pain Service	1291	783	+508	85.8%	Narrative in main body
SBU	Community Dental Service					Current waiting list reporting is unavailable since the switch to a new EPR. Plans are in place to resume reporting from April 2024

Leeds Community Healthcare NHS Trust

Trust Board Meeting: 28 March 2024
Agenda item number: 2023-24(127)

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

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Category of paper: For assurance
History: Trust Leadership Team 13 March 2024

Responsible director: Chief Executive
Report author: Risk Manager / Company Secretary

Executive summary

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

The narrative on threats and opportunities provides the Board with an understanding of the internal and external environment within which the Trust operates.

The report provides the Board with information about risks currently scoring 15 or above, after the application of controls and mitigation measures. It also provides a description of any movement of risks scoring 12 (high risks) since the last report was received in February 2024.

Risk register recent changes:

There are four risks scoring 15 (extreme) or above on the risk register as of 4 March 2024:

- Risk 877: Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand
- Risk 1048: Mind Mate SPA increasing backlog of referrals (system wide risk)
- Risk 1171: Patient safety concerns in Yeadon Neighbourhood team
- Risk 1179: Impact/Management of Neurodevelopmental Assessment Waiting List

One new risk scoring 12 or above has been added since the last report was received in February 2024:

- Risk 1179: Impact/Management of Neurodevelopmental Assessment Waiting List

No risks have been escalated to 12 or above.

No risks have been de-escalated from 12 or above.

No risks have been closed after being de-escalated from 12 or above to the target level.

Board assurance framework (BAF)

Details of the levels of assurance provided by the committees are included in this report. The Business Committee met in January and February 2024, Quality Committee met in January 2024, and reasonable assurance was provided for all of the strategic risks the committees reviewed.

Recommendations

The Board is recommended to**:**

- Note the risks scoring 12 and above, which have been scrutinised by Business and Quality Committees
- Note the assurance levels for strategic risks assigned to the Board's committees.

1. Introduction

The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 or above after the application of controls and mitigation measures.

The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks), which have been scrutinised by the Quality and Business Committees.

The report provides a description of risk movement since the last register report was received by the Board (February 2024), including any new risks, risks with increased or decreased scores and newly closed risks.

2. Background

This paper has previously been considered by the Trust Leadership Team (TLT) at its meeting March 2024.

3. Risk register movement

There are four risks scoring 15 (extreme) or above on the risk register as of 4 March 2024:

Risk	Current Score	February 2024	November 2023
Risk 877: Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand	15	15	12
Risk 1048: Mind Mate SPA increasing backlog of referrals (system wide risk)	15	15	12
Risk 1171: Patient safety concerns in Yeadon Neighbourhood team	15	15	N/A - new
Risk 1179: Impact/Management of Neurodevelopmental Assessment Waiting List	15	N/A - new	N/A - new

3.1 New or escalated risks (scoring 15+)

One new risk scoring 15 or above has been added since the last report was received in February 2024:

Risk 1179	Initial risk Score **15** (extreme)	Current risk score **15** (extreme)	Target risk score **9** (high)

Title: Impact/Management of Neurodevelopmental Assessment Waiting List

Description: As a result of insufficient staff capacity to meet and support the growing number of children on the waiting list for a neurodevelopmental assessment. There is a risk of significant delay in children being seen, diagnosed, and receiving suitable support and/or referred to other services such as the STARS team, the hospital autism and learning disability team. Resulting in (Patient harm): Deterioration in presentation, including mental health (impact on child, family and wider services and poor patient experience).

Controls in place:

- Additional capacity to undertake assessments through outsourcing, overtime and agency staff
- Dedicated clinician time to respond to duty queries from families, young people and professionals
- Maintenance of the Neurodiversity information hub
- Focus on staff wellbeing / support

Action Planned:

- Clinical risk management plan for those waiting.
- Ongoing discussions with commissioners and wider system/decisions re managing Neurodiversity demand and capacity.
- Scoping for a Relationship Manager role (temporary)
- Increasing capacity to Neurodiversity information hub to develop further.
- Recruiting 0.6 wte mental health practitioner to undertake Mental Health assessments and offer psycho education and support groups – and will work with CAMHS and psychology assistants to deliver interventions and support.

Rationale for risk score: Whilst there are a number of impacts resulting from the long waiting times for Neurodiversity assessment, the highest risk relates to patient harm and patient experience. The risk impact has been assessed as 3 (moderate) with an almost certain likelihood - this is based on the number of children waiting for assessment and the prioritisation of priority children. The waiting list continues to increase.

Date to reach target: 17/07/2024.
Risk Owner: General Manager for the Children's Business Unit
Lead Director: Executive Director of Nursing

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

No risks scoring 15 or above have been de-escalated**.**

3.3 Risks scoring 12 (high)

To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not contained to extreme risks. Senior

managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12.

Table 1. Details of risks currently scoring 12 (high risk).

ID	Description	Rating (current)
836	CAMHS waiting list for follow-up appointments	12
874	Sickness levels – Neighbourhood Teams	12
913	Increasing numbers of referrals for complex communication assessments in Integrated Children's Additional Needs Service (ICAN)	12
957	Increased demand for the Adult Speech and Language Therapy service	12
981	Application of constant supervision at WYOI	12
1070	Capacity pressures in Neighbourhood Teams impacting on ability to deliver full range of clinical supervision and annual appraisals	12
1125	National supply issues with enteral feeding supplies by Nutricia	12

3.4 **New or escalated risks (scoring 12)**

No new risks scoring 12 have been added to the risk register.

One risk has been escalated to a score of 12 (high)

Risk 1125	Previous risk score **9** (high)	Current risk score **12** (high)
Title: National supply issues with enteral feeding supplies by Nutricia **Description:** Due to the ongoing national supply issues involving enteral feeding supplies, Nutricia are not fulfilling their contractual obligations. There is a risk that patients (adults and children who are enterally fed) will not receive the required supplies, delivery schedule not met, and deliveries may be only partially complete or substituted products received. The impact of this could be that the substituted products may not provide optimal nutritional requirements, follow-up care could be delayed as staff are prioritising supply queries, and staff maybe required to work additional hours to contact and support patients and amend the existing regimes, leading to health and wellbeing concerns. **Reason for escalation:** Risk increased from 9 to 12, due to a significant increase from beginning of December 2023 in the number and severity of supply issues. These have impacted patient care,		

patient safety and patient satisfaction. Financial loss and reputational damage to LCH are also being experienced.

New mitigating actions:
Regular meetings with the contractor are planned to discuss and try to resolve issues.

Expected date to reach target: 28/03/2024.
Risk Owner: Head of Service
Lead Director: Executive Director of Nursing and AHPs

3.5 **Risks de-escalated from a score of 12.**

No risks have de-escalated from a score of 12.

4. Board Assurance Framework Summary

The purpose of the BAF is to enable the Board to assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively or highlights that certain controls are ineffective or there are gaps that need to be addressed.

Definitions:

- Strategic risks are those that might prevent the Trust from meeting its strategic objectives (goals)
- A control is an activity that eliminates, prevents, or reduces the risk.
- Sources of assurance are reliable sources of information informing the Committee or Board that the risk is being mitigated i.e., success is being realised (or not)

Directors maintain oversight of the strategic risks assigned to them and review these risks regularly. They also continually evaluate the controls in place that are managing the risk and any gaps that require further action.

Following agreement of the strategic goals for 2024/25 at the end of March, an exercise will be undertaken to ensure the BAF reflects any required changes to the strategic risks. This exercise will take place in early 2024/25 and a revised BAF will be taken to the Trust Board meeting in June 2024.

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

Levels of assurance have been provided to the Board for 8 out of the 10 strategic (BAF) risks during January and February 2024, all of which received reasonable assurance. Details of the assurance levels is provided at **Appendix A** (please also refer to the Chairs' assurance reports in the Board papers pack).

5. Recommendations

The Board is recommended to**:**

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

Appendix A. Board Assurance Framework levels of assurance

Details of strategic risks (description, ownership, scores)								Level of Assurance				
Risk		Risk ownership		Current risk score				Committee agreed level of assurance				
Strategic Goal(s)	Risk	Responsible Director(s)	Responsible Committee(s)	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Additional Information
Deliver outstanding care	**Risk 1 Failure to deliver quality of care and improvements:** If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm.	DoN	QC	4	4	**16**				✓		
Deliver outstanding care	**Risk 2 Failure to manage demand for services:** If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage.	DoO	QC/BC	4	3	**12**				✓		
Deliver outstanding care. Use our resources wisely and efficiently	**Risk 3 Failure to invest in digital solutions:** If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable and the impact will be delays in caring for patients and less than optimum quality of care.	DoF/MD	QC/BC	3	3	**9**				✓		
All four strategic goals	**Risk 4 Failure to be compliant with legislation and regulatory requirements**: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention.	SMT	QC/BC/TB	3	3	**9**				✓		
Use our resources wisely and efficiently	**Risk 5 Failure to deliver financial and performance targets:** If the Trust does not deliver key financial and performance targets, agreed with NHS England and the ICB, then it will have adverse consequences for financial governance and cause reputational damage.	DoF	BC	3	4	**12**				✓		
Use our resources wisely and efficiently	**Risk 6 Failure to have sufficient resource for transformation programmes:** If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.	DoO	BC	3	3	**9**				✓		

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

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held in Public: 28 March 2024
Agenda Item: 2023-24 (128)

Title: Quarter 3 Report 23.24 of the Guardian of Safe Working Hours

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Category of paper: For assurance

History: Nil

Responsible director: Executive Medical Director

Report author: Guardian of Safe Working Hours

Executive summary (Purpose and main points)

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

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

Main issues for consideration

- CAMHS ST historic rota compliance and payment issues discussion and plans for next step of action

- Work in progress to improve Medical staffing and HR support for Junior doctors in LCH

Recommendations

Board is recommended to:

- Support GSWH with the work in progress to improve medical staffing and HR support for Junior doctors in LCH.

- To note the progress made with CAMHS historic rota issue and conclusion.

- To note that there is a risk for the Trust of potential grievance concern that could be raised by Junior doctors affected by CAMHS historic rota issue.

Quarterly Report of the Guardian of Safe Working Hours

1.0 Purpose of this report

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

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

2.0 Background

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

3.0 Quarterly report of guardian of safe working hours

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

Department	No.	Grade	Status
Adults	0		LCH contract
CAMHS	6	ST	LCH contract
	0	ST	Honorary contract
	5	CT	Honorary contract
Community Paediatrics	4	ST Level 1	LCH contract
	4	ST Level 2/ Grid trainee	Honorary contract
Sexual Health	1	ST	LCH contract
GP	2	GPSTR	LCH contract
Community Gynae	1	ST	Honorary contract
Dental Services	0		Honorary contract

3.1 **Rota gaps and CAMHS ST rota**

The CAMHS ST non resident on call rota consists of a 1:5 rota, and gaps on this rota are covered by locums, typically doctors who have worked on the rota in the past or doctors currently working for LCH who are willing to do extra shifts. The current CAMHS ST on call rota is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota to double check the Locum shifts picked up by Junior doctors.

Rota Gaps (number of night shifts needing cover)		Dec 2023		Jan 2024		Feb 2024	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	11	n/a	12	n/a	7
	Internal Cover	n/a	6	n/a	10	n/a	7
	External cover	n/a	5	n/a	2	n/a	0
	Unfilled	n/a	0	n/a	0	n/a	0

3.2 **Exception reports**

No exception reports were filed during this quarter.

3.3 **Fines**

No fines levied by the GSWH during this quarter.

3.4 **Feedback from trainees**

Junior Doctors Forum (JDF) was held on MS teams on 11/01/2024.

Junior doctors raised issues around delay in obtaining generic work schedules from LTHT HR team. This is a significant issue affecting junior doctors in paediatrics. Plan was made for LCH medical administrators to share the generic work schedules when this is received from LTHT team to cut down on the delay.

Support for CAMHS junior doctors was discussed and JDF team noted the progress made with Medical education admin team introducing a structed CAMHS junior doctor induction. GSWH and LNC junior doctors representative will be part of this induction to have better engagement with CAMHS junior doctors.
GSWH and LNC junior doctors representative will continue to be part of paediatric induction and have offered this support to other departments as well.

4.0 Impact

This report has been informed by discussions with JNC, HR business partner BMA IRO and guidance received from NHS employers and Health Education England.

4.1 CAMHS Historic ST rota issue

Disclaimer: Section 4.1 contains information that is historic and complex. Work to resolve the issue continues. It contains overview of the issue but not the nuances. GSWH is unable to present the report verbally to the Board at this meeting. The paper will be presented by Medical Director who will be able to guide the board with the nuances. GSWH will be presenting the issue again and any further updates at next meeting on 07/06/2024.

Issue with compliance of CAMHS non-resident on-call rota was raised as a concern by a junior doctor in April 2021. The issue affects junior doctors on the CAMHS non-resident on-call rota employed by the Trust from the year 2016/2017 until 2021.

GSWH and BMA IRO requested a working group with LCH team (consisting of Deputy MD, Medical education admin lead, Director of workforce and assistant director of workforce) to review the concern raised. The team held several meetings to resolve the concern.

Issue related to CAMHS historic rota can be summarised into three main areas.

- Compliance of CAMHS rota from year 2016 to 2021

GSWH and BMA IRO remain concerned about the Juniors' rotas prior to the monitoring exercise in 2021. Alth due to no evidence that a system populated work schedule was provided to the Junior doctors who worked in CAMHS. Work schedules were populated manually. There is no evidence of formal NROC rota monitoring as per the 2016 terms and conditions. Rota was monitored in 2021 and was shown to have two areas of non-compliance. This is the same rota that was in place until 2021 from 2016/2017 when the new JD contract was introduced.

LCH's response to this issue - regular reports were provided to the Board by the then Guardian for Safe Working hours and none of those mentioned any issues around rota being non-compliant. Director of workforce/HR have checked in with relevant team (CAMHS medical lead, DME and GSWH during this period) in terms of their recollections from that time and no issues were raised / no exception reports were filed nor any complaints raised by the Juniors doctors.

Additionally, DMD was informed that during that period in effect monitoring of the rota was occurring on an informal basis by the Juniors themselves and

with the support of key Consultants. Team accepts that this was not on a formal basis and did not use the necessary software.

In summary, the working group team agreed to disagree on this issue of work schedules and rota monitoring. BMA IRO will present this conclusion to the Junior doctors that BMA represent. If they wish to escalate their grievance further to a formal stage, LCH would then respond to that with a formal investigation which would take account of all the work done so far as well as seek to interview the individuals raising the grievance. Any investigation report would then be considered by an independent panel.

- Discrepancy in pay and on call supplements for JD on CAMHS Rota

During the work carried out to investigate the CAMHS historic rota, issues with few individual doctors with regards to pay banding, supplements, and premia was noted.

This did not follow a pattern and each individual doctor has different issue. It was agreed that BMA IRO will work with HR/ Director of workforce on a case-by-case basis to resolve the issue.

- Impact of HR support on CAMHS rota and support for junior doctors

GSWH has worked closely with Director of workforce to review the current support from HR and the challenges faced by medical and dental staff in general.

There is significant progress with Director of workforce supporting JDs, BMA and GSWH through regular meetings and attending JDs to trouble shoot HR issues. This is certainly great progress that has been appreciated by all JDs.

Another protective factor has been the support and proactive engagement of medical education team and Deputy Medical Director providing support over and beyond their role to help with HR issues.

Progress has been made over the last year to optimise the HR support for Medical and Dental staff including all junior doctors. There is clarity around the new structure of support from HR business partners for Medical and dental issues. It is clear as to who to contact with regards to HR issues and how to escalate this if necessary. GSWH acknowledges the progress made and would like the Trust board to note the progress made by LCH HR team.

GSWH will continue to work with Junior doctors to work with HR team for any future concerns.

5.0 Recommendations

Board is recommended to:

- Support GSWH with the work in progress to improve medical staffing and HR support for Junior doctors in LCH.

- To note the progress made with CAMHS historic rota issue and conclusion.

- To note that there is a risk for the Trust of potential grievance concern that could be raised by Junior doctors affected by CAMHS historic rota issue.

Trust Board Meeting Held in Public : 28 March 2024

Agenda item number: 2023-24 (129)

Title: Patient Safety Strategy Implementation Update Report

Category of paper: for assurance
History: N/A

Responsible director: Executive Director for Nursing and Allied Health Professionals

Report author: Deputy Director for Nursing and Quality and Head of Clinical Governance

Executive summary

The purpose of the paper is to provide Board with a six-monthly update of progress against the implementation of the national Patient Safety Strategy into the Trust.

The Strategy was published in 2019 and tested in early adopter sites. The learning from the early adopters has been used to inform the implementation of the various elements of the Strategy.

The Trust completed a soft launch of the Patient Safety Incident Response Framework in January 2024 with full transition planned for April 2024.

There is continued significant work required to achieve successful implementation which is being driven by the Trust implementation group and will transfer to the Clinical Governance Team in conjunction with the clinical Business Units from April 2024.

Recommendations

The Board is recommended to:

Read and consider the paper, agree the level of assurance provided.

1 Introduction

The Patient Safety Strategy was launched in 2019 and aims to change the culture of patient safety reporting and investigation. The Strategy supports the key focus of investigation is learning and improvement that makes a difference to quality and safety and results sustained change and improvement. Investigation will be led with a systems and human factors approach with three key focuses of insight, involvement and improvement which are described more fully in the national strategy.

2 Background

The Strategy set out workstreams to support the following key focuses and to achieve overall concordance with the Strategy:

- The **Patient Safety Incident Response Framework (PSIRF)** which was published in August 2022, replaces the Serious Incident Framework (2015). This provides a new approach to how NHS organisations respond to patient safety incidents for the purpose of learning and improvement.

- Appointing two **Patient Safety Specialists** as leaders within organisations to implement the Strategy and keep a focus on safety.

- The **Learning From Patient Safety Events service (LFPSE)** replaces the existing National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS), creating a single national NHS system for recording patient safety events.

- The **Framework for Involving Patients** in patient safety that focuses on how the NHS can involve patients, families and carers in their own safety; as well as being partners, alongside staff, in improving patient safety.

- The **Patient Safety Syllabus** which supports the investigation approaches and focuses on systems thinking and human factors. There are five levels, two have been released via the e-learning platform, two further levels have been identified for Patient Safety Specialists to complete and the fifth is pending publication.

3 Current Position

LCH continues to co-lead the citywide Patient Safety Specialist Network with the ICB where partner organisations across Leeds meet to discuss implementation of the Strategy and how this can be done better together. Organisations are at different stages of assessment and implementation and the group is a valuable resource for each partner.

Patient Safety Incident Response Framework (PSIRF): LCH completed a soft launch of the framework on 2 January 2024, the full transfer is planned for 1 April 2024. Quarter Four has been utilised as a transition period to complete any incidents reported prior to January 2024 that are being managed under the previous process of the 2015 Serious Incident Framework.

An involvement workstream remains in effect and will be reviewed to ensure the group has defined goals to achieve and embed in practice, with a specific focus on

how we involve patients in their own safety in a genuine and meaningful way. Project support for the implementation is planned to end in March 2024, local management for the implementation will continue.

The associated Patient Safety Incident Response Plan (PSIRP) was approved by Board and the ICB. There are five associated improvement groups. Three are Trust wide:

- Falls.
- Pressure ulcers.
- Deteriorating patient.

The falls and pressure ulcer groups have commenced and report six monthly to Quality Assurance and Improvement Group. The deteriorating patient improvement plan is being developed based on a thematic review of the associated incidents during Quarter Four. There are two service level improvement plans, for meatal tears, being managed by the Colorectal and Urinary Continence Service, and for incidents resulting from Triage Hubs decisions in Neighbourhood Teams that is being managed by the service.

A Patient Safety Incident Response Policy is required. The content is nationally mandated and tailored to local systems. The policy was reviewed by the Clinical and Corporate Policy Group in February 2024 and an updated draft will be heard in March 2024 prior to submission to Trust Leadership Team for ratification.

Patient Safety Specialists: LCH has nine Patient Safety Specialists. Six of the nine have commenced level three and four training of the Patient Safety Syllabus.

Learning From Patient Safety Events service (LFPSE): LFPSE was implemented in December 2024. There is duplication from the mandated national fields, work is ongoing with specialities and Business Intelligence to reduce duplication.

Framework for Involving Patients: The Trust has recruited the nationally mandated two Patient Safety Partners. The Partners are joining various meetings and contributing a patient voice to linked projects. For example, by joining Quality Committee, contributing to Trust workshops, supporting patient engagement initiatives, supporting the recent Perfect Week improvement project in Yeadon Neighbourhood Team. Their contributions have resulted in reviewing the wording of patient correspondence for understanding in addition to their above contributions.

Patient Safety Syllabus: Level one patient safety training is in place. Trust Leadership Team approved inclusion of the level two training in the mandatory training suite, this went live in December 2023. Communications were completed to support implementation.

Levels three and four patient safety training have been released. It contains five modules, six Patient Safety Specialists are currently working on module three, with end of module case studies being completed for modules one and two.

The requirements for training for the Patient Safety Incident Investigation has now been established. The training requirements are nationally mandated. HSSIB (Health Services Safety Investigation Body) are providing the training which equates to three and a half days as follows:

- A twelve-hour course for leading investigations is elearning based and can be completed over a period.
- A six-hour engagement/involvement training course is face to face.
- An online three-hour training course for leading After Action Reviews.

The Patient Safety Team are waiting for confirmation from Business Units of the nominated leads. On receipt they will share the training requirements and links to register with HSSIB. Completion of the training will be monitored at Service level with confirmation of completion of the training shared with the Patient Safety Team.

In the interim the Patient Safety Specialists will support investigation leads to ensure our Patient Safety Incident Investigations have the appropriate Patient Safety Strategy focus of systems and human factors.

As the Patient Safety Specialists have not completed their training fully and the investigation leads have not started their training, there is a Trust risk that the investigations required as part of the PSIRF launch in January 2024 may lack the full systems and human factors focus and methodologies expected. This is assessed to be low risk to Trust reputation and a risk that applies to other Trusts as the training schedule and PSIRF launch has been planned nationally.

The overarching risk (1156) has been reviewed with a risk score of four for unlikely minor harm to both patient safety and reputation. The risk will be reviewed for closure on 30 April 2024 once the full launch is completed.

4 Conclusion

There remains significant work to complete on the continued planning and implementation required to establish the Patient Safety Incident Response Framework and Response Plan in practice.

LCH have launched the PSIRF and internal PSIRP and training has commenced for the Patient Safety Specialists. Planning has started for training the investigation leads.

5 Recommendations

The Board is recommended to:

Read and consider the paper, agree the level of assurance provided.

Trust Board meeting held in public: 28 March 2024

Agenda item number: 2023-24 (130)

Title: 2023 Staff Survey Results – Trust Board Update

Category of paper: For information

History:

- Initial Headlines Report shared at TLT (24 January 2024)
- Initial Headlines Report shared at Private Board (02 February 2024)
- This paper shared at TLT (20 March 2024)

Responsible director: Director of Workforce

Report authors:

- Senior Organisational Development & Learning Lead
- Head of Organisational Development & Improvement

Recommendations

- Note the release of 2023 Staff Survey results and findings to date; and endorse the proposed approach to the dissemination and use of the above.

Introduction

This brief paper sets out the key staff survey results and narrative for Leeds Community Healthcare for 2023, full details are contained in appendices 1-4.

The paper includes comparisons against 2022 data as well as how we benchmark against the Community Trust comparator group and national average scores. It also outlines the approach for the dissemination of the information and how the organisation proposes to use the intelligence to strengthen our ongoing approach to staff engagement and provide further focussed areas for continuing improvement.

Trust Leadership Team (TLT) received this report on the 20th of March 2024. Previously, prior to the national results embargo being lifted, we shared an 'Initial Headlines' paper with TLT on the 24th of January 2024 and with the Private Trust Board on the 2nd of February 2024.

Our results are benchmarked against 16 Community Trusts in England and compared against the national average scores. Traditionally, the Community Trust comparator group is one of the highest scoring groups across the whole NHS.

Our 2023 key findings, compared to 2022 include:

- Our highest response rate to date of 61.7% (up 3.4% on 2022).
- Increased Engagement and Morale scores for the overall Trust and across all Business Units.
- Significant improvements and ‘increased scores’ against 6 of the 7 People Promise themes.
- Overall, 85% of the questions recorded an improved score.
- We also note that our scores are in the average range (and on some occasions) higher than the Community Trust comparator group. This is a real improvement on last year where we typically scored just below the average score.
- We are above the national average scores for all 7 People Promise themes and Engagement and Morale scores.

Specific areas to celebrate

We have some of the best scores for the following themes compared to the comparator group. These include:

- Care of patients / service users being the organisation's top priority.
- Acting on concerns raised by patients / service users.
- As a Trust we respect individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).
- We have a strong anti-bullying and anti-harassment culture.
- Our staff feel safe to speak up about anything that concerns them in the organisation and are confident the organisation would address any concerns.

Areas of focus

These themes relate to areas to improve following initial analysis.

- Despite making further improvements compared to 2022, we still sit below the sector average of all the burnout questions. Our staff are more likely to come to work unwell and suffer from work-related stress compared to the sector average.
- We have seen an increase in staff experiencing instances of physical violence at work from patient/service users/members of the public. Also, the reporting of these instances has dropped compared to 2022.
- We are trending downwards for staff, feeling they have adequate materials, supplies, and equipment to do their work.
- We have identified increased reports of staff feeling discriminated against from patients/service users because of their ethnicity. Initial analysis indicates that this is limited to one or two services in the Adult Business Unit, and we have reached out to them to provide support in addressing this issue.

Equality Diversity and Inclusion (Detailed analysis Appendix 4)

The Workforce Disability Equality Standard data

Staff with a Long-Term condition or illness experiencing bullying, harassment from patients/service users has decreased by 5% over the last 12 months to 25% (staff without a Long-Term Condition or illness is 16%), and staff experiencing the same from managers has increased from 9% in 2022 to 10% this year.

Staff with a Long-Term condition or illness who experience bullying or harassment from their colleagues has decreased by 1% from last year to 13% this year. Staff who experience and report bullying, and harassment has increased 2% to 60% this year which is our highest figure since 2017.

Feeling pressure to come to work from managers has decreased from 24% last year to 19% this year. Feeling that the organisation values respondents' work has increased from 45% in 2022 to 50% this year. 78% of staff with a Long-Term condition or illness agreed that the Trust was providing them with reasonable adjustments.

The Workforce Race Equality Standard data

In 2023 there was a 2% increase in Black and Minority Ethnic (BME) staff experiencing bullying harassment or abuse from colleagues, 15% say they have experienced this as opposed to 13% in 2021, this latest figure is still well below the 25% percentage reported in 2020.

There has been a two-percentage increase in staff from a BME background experiencing bullying and harassment or abuse from patients/service users/members of the public since last year from 16% in 2022 to 18% in 2023, action on this links well to the continued 'No Bystanders' work embedding in the organisation and hopefully improving reporting.

The number of BME colleagues who report believing the organisation provides equal opportunities for career progression and promotion remains at 50%. This question was answered positively by 67% of white colleagues, so there remains clear disparity in experience here, which we continue to address through our range of Equality, Diversity & Inclusion work.

Responding to messages in the survey

At an organisational level we will continue to focus on the following themes as we know they make a difference to the working experience of our people.

- Staff retention.
- Health and wellbeing.
- Correlation of health and wellbeing with culture in teams.
- Leadership support and behaviours.
- Equality, diversity, and inclusion.

We previously agreed on this approach with TLT, and we will continue to work with them to communicate and monitor the action being taken to address these themes, as well as any other organisational themes that may arise.

We will work with relevant teams to address the following specific issues identified in this year's results.

- Ensuring staff are reporting instances of physical violence at work.
- Supporting staff who are suffering with work-related stress or are coming to work when unwell
- Supporting staff within the Adult Business Unit who have told us they feel discriminated against from patients/service users because of their ethnicity.

Further actions on focus areas

We will carry out the following actions to support the organisation in understanding the messages in the survey.

- A deep dive analysis into key themes and areas of interest such as health and wellbeing, equality diversity and inclusion and violence at work.
- A thematic analysis on the free text comments to examine the free text data and identify common themes.
- Further analysis of WRES and WDES metrics, in order to share with the Equality, Diversity and Inclusion Forum and with our staff network leads for analysis and recommendation.

Our approach to cascading results

We want to continue the journey of improvement, which has seen the response rate increase for the last 4 years, so that we continue to develop an inclusive culture and make LCH a great place to work for all.

Our intent is to achieve this through implementing a business unit led cascade approach to engagement. This will enable enables a deeper dive with the analysis to understand the results and lead to consistent local action planning.

To support this work, analysis of service and team level survey results has already been completed and compiled into reports and heatmaps for all business units, services, and teams. We will recommend the business units hold conversation spaces to enable the opportunity to share and learn, and also to discuss the offer of support to those teams in need of intervention and in respect of staff engagement. This includes triangulation of other cultural data.

We have agreed with TLT to ring-fence Organisational Development and Improvement (ODI) support to services and teams within each business unit that have the greatest need. ODI business partners will work with business unit leaders to identify these services and teams. They will also support with identifying and celebrating the 'most improved' services/teams along with the 'top performing' services/teams, with the aim of harnessing shared learning.

The success of this approach is with leadership teams being responsible for cascading the results and making time for conversations with their teams to co-design, embed, and own local action plans. These need to be regularly reviewed as part of team meetings, and 'next steps' feedback to teams. Our people need to be a part of the change to feel and see the improvements. It is important that the staff survey becomes an integrated part of our cultural barometer rather than an annual standalone initiative.

In terms of cascading results, these have already been shared with TLT, General Managers and Leadership Teams. We also plan to share focused and themed results with the Equality, Diversity & Inclusion Forum, Race Equality Network, Health and Wellbeing Group and Senior Operational Strategy Group. This report will be shared with staff-side colleagues through both the JNC and JNCF.

Conclusion

This report sets out the key staff survey results for Leeds Community Trust, with comparisons against 2022 data, our Community Trust comparator group and national benchmarking data, along with a supporting narrative.

The report provides analysis by People Promise themes and outlines our approach to disseminating understanding and acting on our data at all levels in the organisation, from team to Board.

The analysis provides us with a positive, promising outlook. Key findings include:

- Our highest response rate to date of 61.7% (up 3.4%).
- Increased Engagement and Morale scores for the overall Trust and across all Business Units.

- Significant improvements and 'increased scores' against 6 of the 7 People Promise themes.
- Overall, 85% of the questions recorded an improved score.
- We are above the national average scores for all 7 People Promise themes and Engagement and Morale scores.

We also note that our scores are in the average range (and on some occasions) higher than the Community Trust comparator group. This is a real improvement on last year where we typically scored just below the average score.

Following the lifting of the embargo on Wednesday 07 March 2024, we will be sharing the survey results trust wide via an article from our Interim CEO, Sam Prince. We have also developed an infographic to support this message (see Appendix 5). We will continue to provide updates through Leaders Network and the Staff Survey Hub on My LCH.

Recommendations

- Note the release of 2023 Staff Survey results and findings to date; and endorse the proposed approach to the dissemination and use of the above.

Appendices

- **Appendix 1** – 2023 Staff Survey Results (Complete Paper).
- **Appendix 2** – LCH vs. National average (People Promise, Engagement and Morale)
- **Appendix 3** – Significant Increases/Decreases, 2022-23 Comparison.
- **Appendix 4** – Workforce Disability and Race Equality Standards Analysis
- **Appendix 5** – 2023 Results Infographic.

Appendix 1 – 2023 Staff Survey Results (Detailed results)

This appendix provides the LCH staff survey results for 2023 in detail. Participation in the annual NHS Staff Survey is a mandatory requirement for all NHS organisations. NHS

England sets the framework and questions for the survey, and we commission IQVIA to manage the survey for us.

Background

We have now received our survey reports and data from both IQVIA and the National Survey Coordination Centre. This includes:

- Organisation level reports and NHS People Promise themes from IQVIA.
- National benchmarking report from Survey Coordination Centre which compares us to other comparable community trusts (group data only, not by individual named Trust).
- Access to all Trust results nationally following lifting of embargo 7th March 2024
- Access to an online portal where we can extract data to produce reports with a breakdown by business unit, service, and teams.

We are waiting for our Workforce Equality and Disability Standard reporting from IQVIA. This is additional (non-standard reporting), this report is due by the 29th of March 2024.

In 2021, the questions were aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be by 2024. The survey tracks progress towards the seven elements of the People Promise. Over future years, this will continue to provide trend data, which will year help us understand both the areas we are improving in and sustaining, and our areas for focus.

The NHS People Promise sets out, in the words of staff, the things that would most improve their working experience and are made up of 7 elements:

1. We are compassionate and inclusive.
2. We are recognised and rewarded.
3. We each have a voice that counts.
4. We are safe and healthy.
5. We are always learning.
6. We work flexibly.
7. We are a team.

In support of this, we measure the results against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). Reporting also includes sub-scores, which feed into the People Promise elements and themes. All the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.

Engagement and morale indicators

We are proud to say we achieved another record response rate of 61.7%. We have consistently achieved improved response rates over the last 4 years. Comparing

response rates over the last four years we are +3.4% (2022) +9.7% (2021) and +16.7% (2020). We have achieved this through a combination of a dedicated resource to engage around the staff survey, collaborating between teams and services, implementing an effective communication and engagement plan, and receiving senior level sponsorship from the CEO, directors, and general managers. We will reflect on the response rates in our discussions with the business units and identify the key actions we can take to boost the response rate for the 2024 survey.

The levels of staff engagement and morale are included in the table below. Please note the Morale breakdown by business unit was only made available from 2021.

Staff Engagement

Business Unit	Engagement 2020	Engagement 2021	Engagement 2022	**Engagement 2023**
Trust Wide	7.2	6.9	7.1	**7.2**
ABU	7.0	6.8	6.8	**7.2**
CBU	6.9	6.8	6.9	**7.1**
SBU	7.4	7.0	7.1	**7.3**
Operations	7.5	7.7	7.2	**7.2**
Corporate	7.5	7.6	7.3	**7.3**

Staff Morale

Business Unit	Morale 2020	Morale 2021	Morale 2022	**Morale 2023**
Trust Wide	6.0	5.8	5.9	**6.1**
ABU		5.4	5.5	**5.9**
CBU		5.6	5.7	**6.0**
SBU		5.8	6.0	**6.2**
Operations		7.1	6.3	**6.4**
Corporate		6.5	6.2	**6.3**

We have consistently improved both our Engagement and Morale scores over the last 3 years. The engagement score is significant, as there are correlations between staff engagement, patient experience, and patient outcomes. For this reason, it is used to compare each NHS Trust with others and is used by the CQC in their Well Led assessments. Our scores for engagement and morale are in line with the Community Trust group average and are improving year by year.

People Promise themes: Comparison 2022 vs. 2023

We are pleased to say we have made significant improvements across 6 or the 7 People Promise themes compared to 2022. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*

People Promise Theme	2022 score	2022 respondents	**2023 score**	2023 respondents	**Statistically significant change?**
We are compassionate and Inclusive	7.63	1844	**7.74**	2033	Significantly Higher
We are recognised and rewarded	6.33	1841	**6.50**	2036	Significantly Higher
We have a voice that counts	7.08	1832	**7.18**	2018	Not significant
We are safe and healthy	6.13	1843	**6.32**	2028	Significantly Higher
We are always learning	5.78	1774	**6.03**	1965	Significantly Higher
We work flexibly	6.69	1837	**6.94**	2028	Significantly Higher
We are a team	6.96	1841	**7.10**	2035	Significantly Higher

*Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

We are above average in all People Promise themes and Engagement and Morale scores compared with Trusts nationally (see Appendix 2).

Analysis by People Promise theme

This section of the report provides analysis of the results by People Promise theme. A list by question of the most significant increases/decreases compared to 2022 can be seen in Appendix 3.

1.We are compassionate and inclusive

This group of questions relate to the importance of, and difference that, roles and the organisation make to patients, the recommendation of LCH as a place to work and to provide care, compassionate leadership and diversity and inclusion.

As you can see from the image our scores are ‘average’ or just above when compared to the Community Trust comparator group however they are significantly higher than the national average of 7.30.

All sub-theme scores in this theme have improved on both 2021 and 2022.

We are proud to say we are one of the highest scoring Trusts for our comparator group for the sub-theme of **Diversity and Inclusion**.

	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.53	7.47	8.65	7.32
Best result	7.81	7.76	8.77	7.59
Average result	7.53	7.50	8.63	7.32
Worst result	7.01	7.14	8.03	6.91
Responses	2026	2035	2027	2028

Analysing individual questions LCH scored close to the best score for the following questions:

- *Care of patients / service users is my organisation's top priority* - 84.5% (up 3.4% compared to 2022) and just 0.5% below the best score for the sector. The national average for this question is 75.1%.
- *My organisation acts on concerns raised by patients / service users* – 82.3% (up 2.6%) and just 1.1% below the best score for the sector. The national average is for this question is 70.5%
- *I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc)* – 81.8% (up 2.5%) and just 1.2% below the best score of the sector. The national average for this question is 70.6%.

We also moved into the average range for the following questions, previously we just fell below the average scores:

- *My immediate manager works together with me to come to an understanding of problems* (up 4.7%)
- *I would recommend my organisation as a place to work* (up 4.2%)
- *My immediate manager takes effective action to help me with any problems I face* (up 3.7%)
- *Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age* (up 2.8%)

Although we made a significant improvement (up 3.7% compared to 2022) we still fall below the sector average of 77% for this question:

- *If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation* - 74.8%

However, we are still close to 10% above the national average for this question (64,9%)

2. We are recognised and rewarded

This theme includes questions on the recognition and value the organisation gives and pay, alongside people showing appreciation to one another and the value shown by immediate managers.

Compared to 2002 we have improved our score across all five questions. We now sit above average for the following questions compared to the Community Trust comparator group:

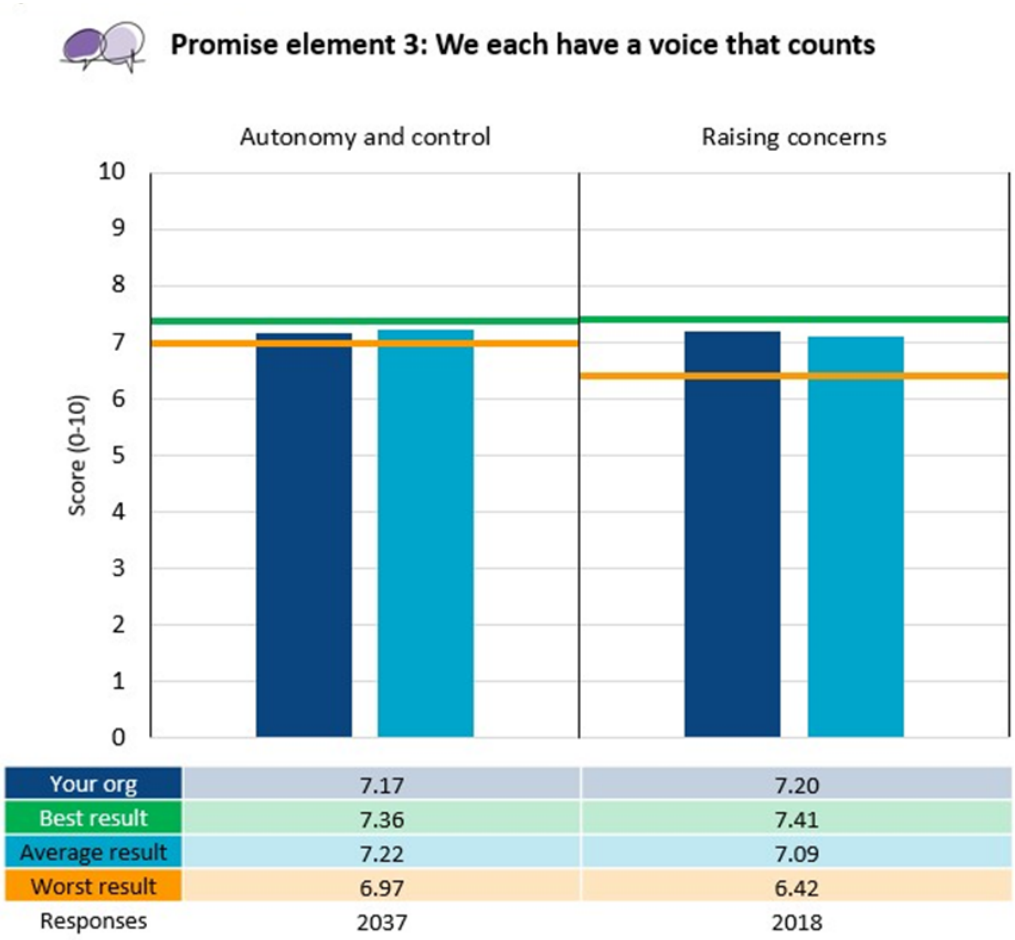
- *Satisfaction with my level of pay* - 38.4% (up 6.1% compared to 2022)
- *Satisfaction with the extent to which my organisation values my work* - 55% (up 2.9%)
- *The people I work with show appreciation to one* another - 78.8% (up 1.3%)

And we sit in the average range for the other two questions:

- *My immediate manager values my work* - 76.6% (up 2.6%)
- *Satisfcation with the recognition I get for good work* – 62%. (up 3%)

3. We each have a voice that counts

This section of the People Promise includes questions on making improvements, autonomy, and control, as well as raising, and acting on concerns.



	Autonomy and control	Raising concerns
Your org	7.17	7.20
Best result	7.36	7.41
Average result	7.22	7.09
Worst result	6.97	6.42
Responses	2037	2018

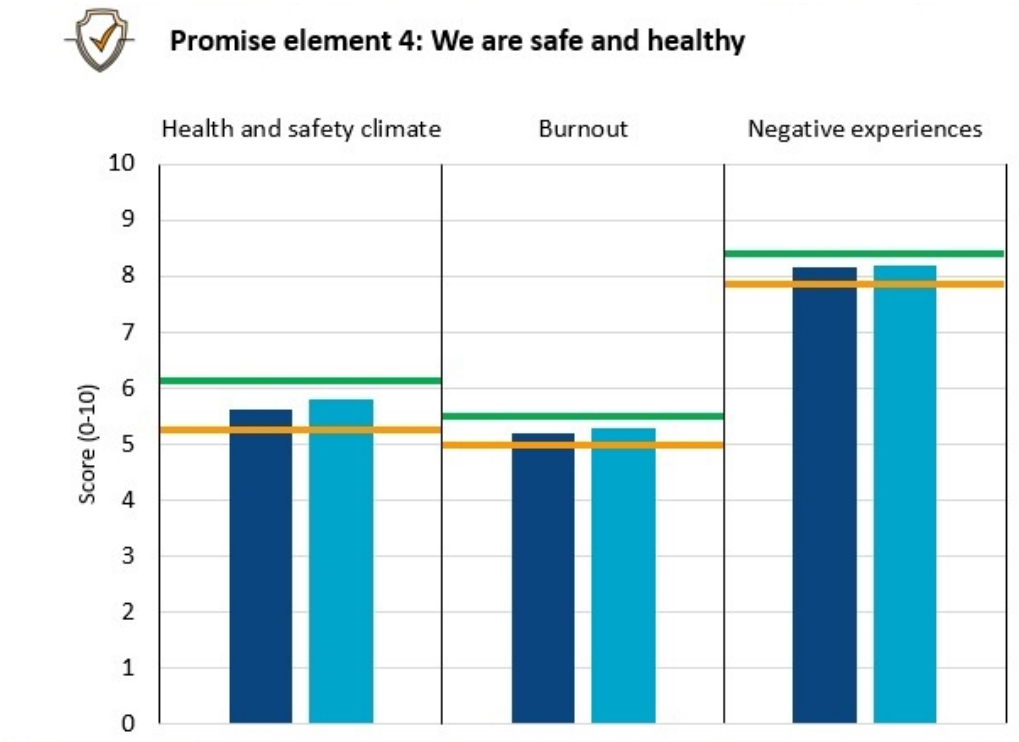
Overall, we have slightly improved our position compared to 2022 for this theme. We sit well above average for the sub-theme of 'Raising Concerns'. This is demonstrated by improvements in the following questions, where we now sit close to the best score in the Community Trust comparator group.

- *I feel safe to speak up about anything that concerns me in this organisation* - 76.6% (up 3.8% compared to 2022) and well above the national average of 62.3%
- *If I spoke up about something that concerned me, I am confident my organisation would address my concern* - 66% (up 4.1%) and well above the national average of 50%.

Our continued area of focus for this theme is the question *"I am able to make suggestions to improve the work of my team / department"*. Despite an improved score of 74.5% (up 1%) we still lag behind the sector average by 2.8%.

4. We are safe and healthy

This category covers health and safety climate, burnout, and negative experiences such as work-related stress, bullying and harassment.



	Health and safety climate	Burnout	Negative experiences
Your org	5.62	5.18	8.15
Best result	6.13	5.49	8.41
Average result	5.80	5.29	8.19
Worst result	5.24	4.98	7.86
Responses	2037	2035	2030

For the sub-theme 'Health and safety climate' we have improved our overall score compared to 2022 (5.62 compared to 5.4) but we still fall below the sector average. Looking at the seven questions which make up the sub-theme we sit below average on all questions except the following where we are average for the sector, increasing our scores for both questions.

- *I have unrealistic time pressures* (down 3.6%)
- *My organisation takes positive action on health and wellbeing* (up 1.2%)

Following an improvement of 8% colleagues across the trust are feeling more positive about staffing levels, we now sit just below the average for the sector for the question:

- *There are enough staff at this organisation for me to do my job properly.*

This hopefully reflects the work and focus on workforce plans to support recruitment and retention of staff, using initiatives such as hyper local recruitment and 'stay' conversations.

There are some areas of focus for this theme.

1. *"I have adequate materials, supplies and equipment to do my work".* This question has been trending downwards since 2019 where we sat at 69%, close to the best

score in the Community Trust comparator group. The average for the sector in 2023 is 67% and we now score well below that on 63%

2. Colleagues are not reporting instances of physical violence at work. Demonstrated by the question *"The last time you experienced physical violence at work, did you or a colleague report it"* where we dropped a sobering 8.3.%. In 2022 we had one of the best scores in the sector however our score of 68.5% falls well below the sector average of 75%. This issue is further enhanced by the fact instances of physical violence at work from patient/service users/members of the public have increased by 2% (overall score of 8% stating 'yes') and we now fall below average for the sector of 6%.

For the sub-theme 'Burnout' despite making improvements for a second year in a row we still sit below average for the sector. We know burnout is not directly linked to health and wellbeing initiatives as we sit in the average response in the sector to the question *'My organisation takes positive action on health and well-being'* with our result increasing again by up 1.1% and up 5.2% since 2021. It's also worth pointing out that the national average result is 57.8%, so we are 10.3% higher.

Our burnout responses are more likely linked to our staff coming to work despite not feeling well or at their best, undoubtedly because they don't wish to let their colleagues down and create more pressure. This is highlighted by the answer to the following questions.

- *During the last 12 months have you felt unwell as a result of work-related stress.* Where 42% of colleagues agreed they had, compared to a sector average of 37%
- *In the last three months have you ever come to work despite not feeling well enough to perform your duties*. Where 55% of colleagues agreed they had, against a sector average of 52%

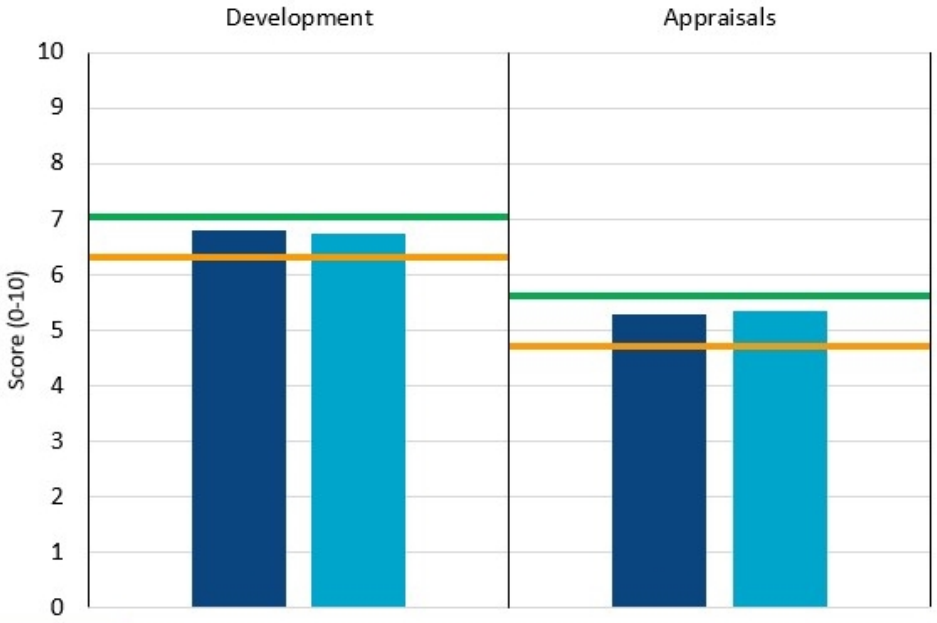
Under negative experiences sub-theme, we scored average for the sector across all questions except the question relating to instances of physical violence previously mentioned Like last year continue to have the lowest and close to the 'best' scores for the sector for the questions:

- *In the last 12 months how many times you have personally experienced harassment, bullying or abuse at work from managers.*
- *In the last 12 months how many times you have personally experienced harassment, bullying or abuse at work from other colleagues*.

5. We are always learning

This section of the People Promise covers questions on development and appraisals.

Promise element 5: We are always learning



	Development	Appraisals
Your org	6.78	5.27
Best result	7.04	5.61
Average result	6.73	5.36
Worst result	6.31	4.70
Responses	2030	1965

Overall, we sit in the average range for the 9 questions which make up the 'We are always learning' theme. We do have some of the best scores in the sector for the following questions.

- *There are opportunities for me to develop my career in this organisation* - 61.4 (up 4.5% compared to 2022) and well above the sector average of 55%
- *I have opportunities to improve my knowledge and skills* - 77.4 (up 1.4%) just below the sector best score of 79%

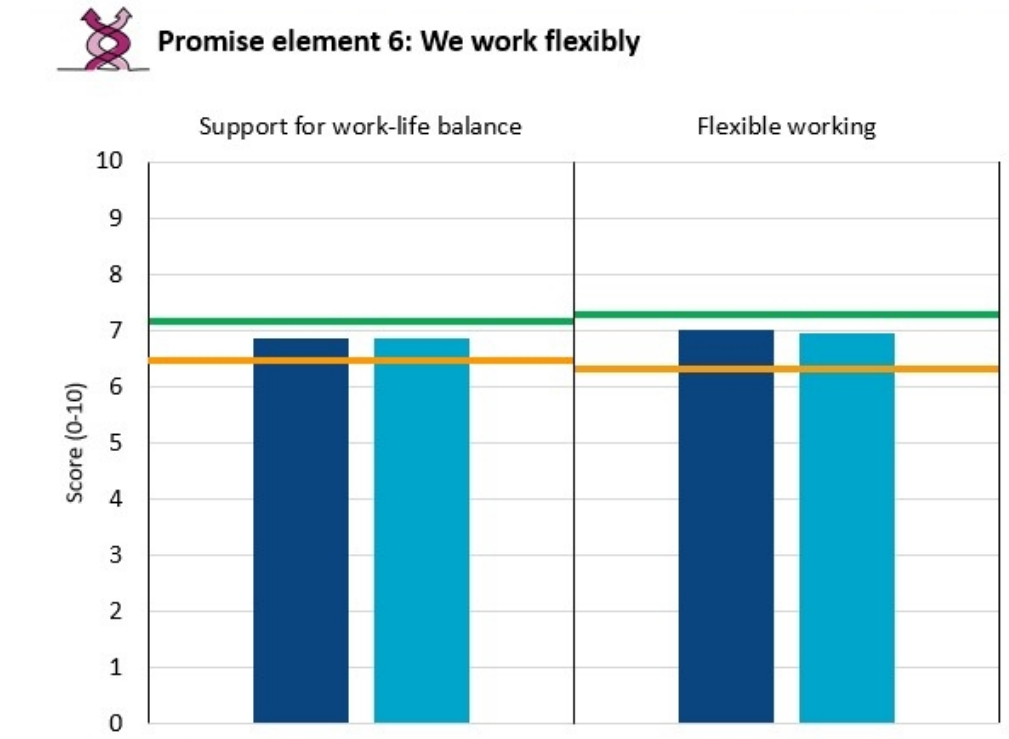
This is an area we will continue to focus on in 2024 with the development of a new leadership approach and learning and development strategy. This work is already underway and has been co-developed by teams across LCH who have responsibilities for various aspects of learning and development.

Appraisal rates have been trending downward since 2018. This year we scored 86.5% to the question '*In the last 12 months, 'have you had an appraisal, annual review, development review'*, compared to a sector average of 89% and a national average of 83%. Work is already under way in how we ensure all staff have an annual appraisal along with examining how we make it easier to record and report on annual appraisals.

Interestingly we do know from our results that staff who have had an appraisal do really value them as we sit close to the sector's best for *'It left me feeling that my work is valued by my organisation'*. Where our score of 40% is just below the best score of 42%.

6. We work flexibly

These were a set of new questions introduced in 2021 focusing on work-life balance and flexible working. As you can see from the graphic below, we scored within the average for 'support for work-life balance' and just above average for 'flexible working'.



	Support for work-life balance	Flexible working
Your org	6.86	7.02
Best result	7.17	7.29
Average result	6.86	6.95
Worst result	6.47	6.32
Responses	2034	2030

We have made some great improvements across the 4 questions which make up this theme which has moved us into the average range for the sector.

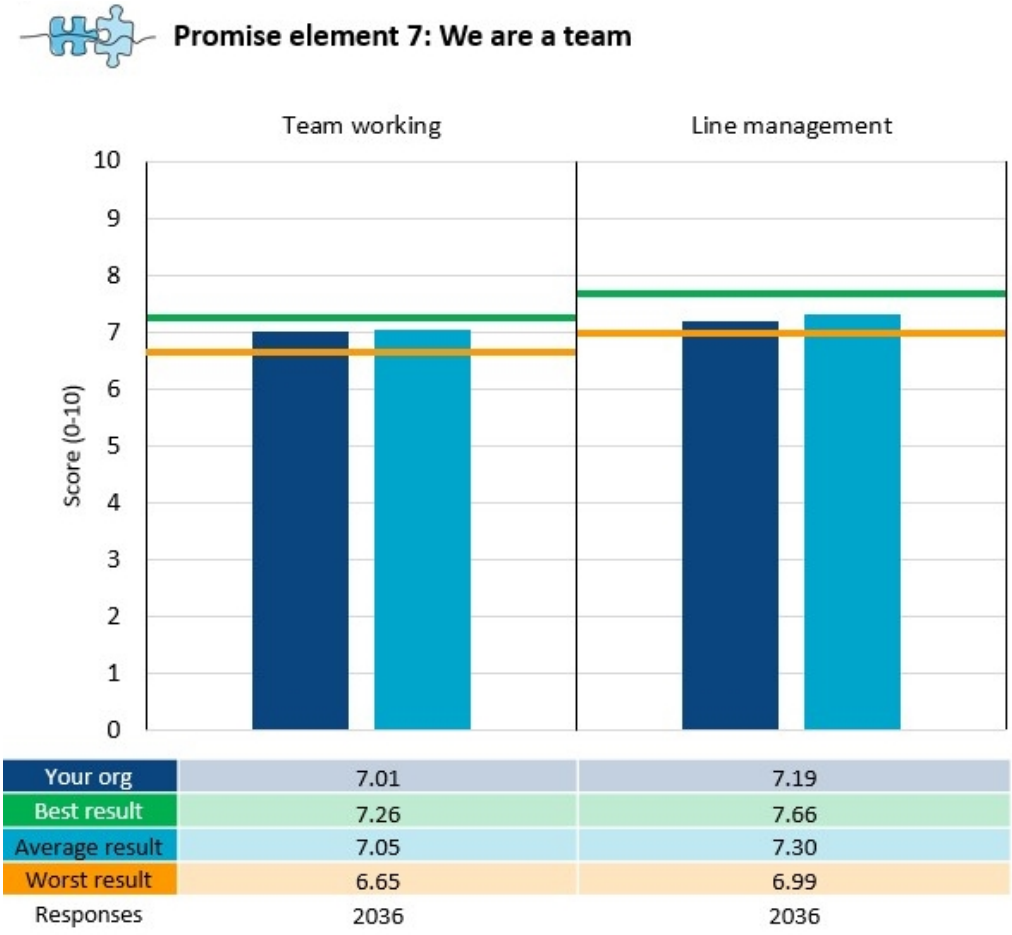
These include:

- *The opportunities for flexible working patterns* - 70.6% (up 4.3% compared to 2022)
- *My organisation is committed to helping me balance my work and home life* - 62% (up 6%)
- *I achieve a good balance between my work life and my home life* - 61.6 (up 3.4%)
- *I can approach my immediate manager to talk openly about flexible working* - 79.3 (up 4.5%)

These scores hopefully reflect the work we did in the last 12 months linking flexible working with increased retention of staff.

7. We are a team

This section covers team working and line management. Answers within it may be seen to correlate with the overall culture and behaviours within the organisation; deriving from the colleague behaviours that individual employees experience every day in their working environment.



	Team working	Line management
Your org	7.01	7.19
Best result	7.26	7.66
Average result	7.05	7.30
Worst result	6.65	6.99
Responses	2036	2036

We have made some significant improvements for the theme 'We are a team' compared to our 2022 results. Last year we scored poorly and close to the sector worst for the questions '*The team I work in often meets to discuss the team's effectiveness'* and *'Team members understand each other's roles'.*

As can be seen below both questions have improved compared to 2022 and we have moved into the average for the comparator group.

- *The team I work in has a set of shared objectives* (up 1.6%)
- *The team I work in often meets to discuss the team's effectiveness* (up 4.8%)

Similar to last year we have improved our score compared to 2022 against all the *'My immediate line manager'* questions but we still score below the sector average for three out of the four questions. One clear area of focus is the question '*My immediate manager gives me clear feedback on my work'* although we made a small improvement on 2022 (up 1.7% to 67.9%) we sit well below the sector average of 73.1%

On this last point we have recently developed a new leadership approach with several workstreams launching new offers in 2024. These include:

- A new compassionate and inclusive leadership programme
- A line manager induction for new and new to role colleagues
- Specific and tailored leadership development and coaching programmes for BME staff
- An agreement to use the apprenticeship levy to fund cohorts of leadership development apprenticeship

We will use this data to inform aspects of the programme content. As well as evaluating these programmes we will track the impact of this work across the immediate line manager questions in 2024.

Appendix 2 – LCH vs. National average (People Promise, Engagement and Morale)

Org Type	We are compassionate and inclusive	We are recognised and rewarded	We have a voice that counts	We are safe and healthy*	We are always learning	We work flexibly	We are a team	Engagement	Morale
LCH	**7.74**	**6.50**	**7.18**	**6.32**	**6.03**	**6.94**	**7.10**	**7.2**	**6.1**
NHS National Average	**7.30**	**6.00**	**6.72**	**-**	**5.64**	**6.28**	**6.80**	**6.89**	**5.95**
Community	**7.71**	**6.43**	**7.12**	**-**	**6.00**	**6.87**	**7.18**	**7.23**	**6.20**
Acute and Acute and Community	**7.23**	**5.91**	**6.67**	**-**	**5.59**	**6.17**	**6.72**	**6.86**	**5.90**
Acute Specialist	**7.55**	**6.13**	**6.93**	**-**	**5.79**	**6.40**	**6.93**	**7.29**	**6.14**
MH & LD & Community	**7.58**	**6.43**	**6.98**	**-**	**5.92**	**6.83**	**7.17**	**7.11**	**6.18**
Ambulance	**6.80**	**5.30**	**5.93**	**-**	**4.85**	**5.33**	**6.16**	**6.01**	**5.52**

***2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see the NHS Staff Survey website for more details**

Appendix 3 – Significant Increases/Decreases, 2022-23 Comparison

These table shows questions where we have seen a statistically significant change. The factor we have used to determine this is any change above or below 3% against our 2022 result. This is the factor IQVIA recommends and is commonly used by all survey providers.

Question	Staff Selecting	2022	**2023**	**Difference**
I am able to meet all the conflicting demands on my time at work.	Staff selecting Agree/Strongly agree	39.1%	43.6%	**4.5%**
There are enough staff at this organisation for me to do my job properly.	Staff selecting Agree/Strongly agree	23.2%	31.3%	**8.1%**
The recognition I get for good work.	Staff selecting Satisfied/Very satisfied	59.5%	62.5%	**3.0%**
My level of pay.	Staff selecting Satisfied/Very satisfied	32.3%	38.4%	**6.1%**
The opportunities for flexible working patterns.	Staff selecting Satisfied/Very satisfied	66.2%	70.6%	**4.4%**
I have unrealistic time pressures.	Staff selecting Never/Rarely	23.2%	26.8%	**3.6%**
I have a choice in deciding how to do my work.	Staff selecting Often/Always	62.0%	65.2%	**3.2%**
My organisation is committed to helping me balance my work and home life.	Staff selecting Agree/Strongly agree	56.0%	62.0%	**6.1%**
I achieve a good balance between my work life and my home life.	Staff selecting Agree/Strongly agree	58.2%	61.6%	**3.4%**
I can approach my immediate manager to talk openly about flexible working.	Staff selecting Agree/Strongly agree	74.8%	79.3%	**4.5%**
The team I work in often meets to discuss the team's effectiveness.	Staff selecting Agree/Strongly agree	65.1%	69.9%	**4.8%**
Team members understand each other's roles.	Staff selecting Agree/Strongly agree	70.2%	73.8%	**3.7%**
My team has enough freedom in how to do its work.	Staff selecting Agree/Strongly agree	59.9%	63.0%	**3.1%**
Teams within this organisation work well together to achieve their objectives.	Staff selecting Agree/Strongly agree	57.8%	61.2%	**3.4%**
My immediate manager works together with me to come to an understanding of problems.	Staff selecting Agree/Strongly agree	71.6%	76.3%	**4.7%**
My immediate manager cares about my concerns.	Staff selecting Agree/Strongly agree	74.7%	77.6%	**3.0%**

My immediate manager takes effective action to help me with any problems I face.	Staff selecting Agree/Strongly agree	70.0%	73.7%	**3.8%**
On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	Staff selecting 0 hours	34.1%	38.6%	**4.5%**
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	Staff selecting No	41.8%	44.8%	**3.0%**
How often, if at all, do you feel burnt out because of your work?	Staff selecting Never/Rarely	28.3%	32.1%	**3.9%**
How often, if at all, do you feel worn out at the end of your working day/shift?	Staff selecting Never/Rarely	17.0%	20.2%	**3.1%**
How often, if at all, do you feel that every working hour is tiring for you?	Staff selecting Never/Rarely	53.7%	58.7%	**5.1%**
How often, if at all, do you not have enough energy for family and friends during leisure time?	Staff selecting Never/Rarely	34.1%	37.6%	**3.6%**
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	Staff selecting Never	76.6%	81.2%	**4.6%**
On what grounds have you experienced discrimination? Other	Staff not selecting	69.7%	77.4%	**7.7%**
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	Staff selecting Agree/Strongly agree	77.8%	82.1%	**4.3%**
We are given feedback about changes made in response to reported errors, near misses and incidents.	Staff selecting Agree/Strongly agree	70.2%	73.9%	**3.8%**
It helped me agree clear objectives for my work.	Staff selecting Yes, definitely	34.1%	37.7%	**3.6%**
There are opportunities for me to develop my career in this organisation.	Staff selecting Agree/Strongly agree	56.9%	61.4%	**4.5%**
I have opportunities to improve my knowledge and skills.	Staff selecting Agree/Strongly agree	73.0%	77.4%	**4.4%**
I feel supported to develop my potential.	Staff selecting Agree/Strongly agree	60.3%	63.6%	**3.3%**
I am able to access the right learning and development opportunities when I need to.	Staff selecting Agree/Strongly agree	58.6%	64.3%	**5.7%**
Care of patients / service users is my organisation's top priority.	Staff selecting Agree/Strongly agree	81.1%	84.5%	**3.4%**
I would recommend my organisation as a place to work.	Staff selecting Agree/Strongly agree	64.8%	69.0%	**4.2%**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	Staff selecting Agree/Strongly agree	71.1%	74.6%	**3.6%**

I feel safe to speak up about anything that concerns me in this organisation.	Staff selecting Agree/Strongly agree	72.8%	76.6%	**3.8%**
If I spoke up about something that concerned me I am confident my organisation would address my concern.	Staff selecting Agree/Strongly agree	61.9%	66.0%	**4.1%**
I often think about leaving this organisation.	Staff selecting Strongly disagree/Disagree	44.6%	49.7%	**5.1%**
I will probably look for a job at a new organisation in the next 12 months.	Staff selecting Strongly disagree/Disagree	50.7%	55.0%	**4.3%**
As soon as I can find another job, I will leave this organisation.	Staff selecting Strongly disagree/Disagree	61.1%	65.2%	**4.1%**
The last time you experienced physical violence at work, did you or a colleague report it?	Staff selecting Yes	76.8%	68.5%	**-8.3%**
On what grounds have you experienced discrimination? Ethnic background	Staff not selecting	69.1%	57.9%	**-11.2%**
In the last month have you seen any errors, near misses or incidents that could have hurt staff and/or patients/service users?	Staff selecting Never	73.8%	70.5%	**-3.4%**

Appendix 4

Equality Diversity and Inclusion

The Workforce Disability Equality Standard data

Staff *experiencing harassment, bullying or abuse from the public in the last 12 months* (WDES Indicator 4ai) has decreased for both groups, 29.8% in 2022 to 25.4% for staff with a LTC or illness and 21.3% in 2022 to 16.2% in 2023 for staff without an LTC or illness. The disparity of experience has increased from 8.5% 2022 to 9.2% in 2023.

Staff experiencing *harassment, bullying or abuse from managers in the last 12 months* (WDES Indicator 4aii) has increased from 8.8% 2022 to 9.7% for staff with a LTC or illness. The percentage of staff without an LTC or illness has decreased from 4.8% in 2022 to 3.2% in 2023. The disparity of experience has increased from 4% 2022 to 6.5% in 2023.

Staff experiencing *harassment, bullying or abuse from other colleagues in the last 12 months* (WDES Indicator 4aiii) has decreased from 14.1% in 2022 to 13.6% in 2023 for staff with a LTC or illness and from 8.6% in 2022 to 8.5% in 2023 for staff with an LTC or illness. The disparity has reduced slightly from 5.5.% in 2022 to 5.1% in 2023.

There has been a decrease in staff with a LTC or illness responding *that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months* (WDES indicator 4aiv) from 58.2% in 2022 to 53.6% in 2023 whilst there has been an percentage increase by staff with an LTC or illness from 58.6% in 2022 to 60.3% in 2023. This has resulted in a growth in disparity from 0.4% in 2022 to 6.7% in 2023.

The percentage of staff with a LTC or illness compared to staff without a LTC or illness *believing that the Trust provides equal opportunities for career progression or promotion (WDES Indicator 5)* has increased for both groups and the disparity in experience has narrowed to 1.2%. From 53.5% in 2022 to 62.5% for staff with an LTC or illness and from 63.7% in 2022 to 64.9% for staff without an LTC or illness.
Percentage of Disabled staff compared to nondisabled staff saying *that they have felt pressure from their Manager to come to work, despite not feeling well enough to perform their duties (presenteeism)* (WDES Indicator 6) has been reduced from 23.9% in 2022 to 19.2% for staff with an LTC or illness and 13.1% in 2022 to 10.7% in 2023 for staff without an LTC or illness. Despite the reduction overall a disparity of experience of 8.5% remains.

The percentage of staff with an LTC or illness compared to staff without an LTC or illness saying that *they are satisfied with the extent to which the organisation values their work* (WDES indicator 7) has increased from 44.7% in 2022 to 50.1% for staff with a LTC or illness and 54.8% in 2022 to 57.2% for staff without a LTC or illness. Resulting in the reduction of disparity from 10.1% in 2022 to 7.1% in 2023.
There has been an increase in the percentage of staff with a LTC or illness, saying that their employer has made adequate adjustment(s) to enable them to carry out their work (WDES indicator 8) from 77.6% in 2022 to 78.4% in 2023.
The staff engagement score for Disabled staff, compared to nondisabled staff (WDES Indicator 9a) has increased for both groups of staff from 6.66 in 2022 to 6.87 in 2023 for staff with a LTC or illness and 7.18 in 2022 to 7.32 in 2023 for staff without an LTC or illness. This has reduced the disparity gap by .45 between the two groups of staff.

The Workforce Race Equality Standard data

The percentage of white staff who have *experienced bullying and harassment or abuse from patients, relatives, or the public the last 12 months* (WRES indicator 5) continues to reduce, from 23.9% in 2022 to 18.8% in 2023. However, the percentage of all other ethnic groups has increased from 16.3% in 2022 to 17.7% 2023.
Analysis indicates that is increase is attributable to the results from Wharfedale Recovery Hub, support from EDI, ODI and Health Equity is now in place to assist in reducing the disparity of experience between white staff and those from other ethnic groups.

Whilst the Percentage of white staff *who have experienced bullying, harassment or abuse from other staff in the last 12 months* (WRES indicator 6*)* continues its downward trajectory from 12.8% in 2022 to 11.7% in 2023 the percentage of other ethnic groups has risen for the first time in 5 years from 12.9% in 2022 to 15.2% in 2023.
Analysis indicates that is increase is attributable to the results from Wharfedale Recovery Hub, support from EDI, ODI and Health Equity is now in place to assist in reducing the disparity of experience between white staff and those from other ethnic groups.

The percentage of staff who have experience bullying, harassment or abuse from Managers/Team Leaders or other colleagues (WRES indicator 8) has reduced for both white staff, 4.2% in 2022 to 2.7% in 2023 and for staff in other ethnic groups from 12.1% in 2022 to 11.3% in 2023.

Analysis of WRES indicators 5,6 and 8 indicate the increase is attributable to the results from Wharfedale Recovery Hub. Support from EDI, ODI and Health Equity is now in place to assist in reducing the disparity of experience between white staff and those from other ethnic groups.

There has been a percentage increase of respondents from both white (62.9% in 2022 – 66.7% 2023), and other ethnic groups (49.8% 2022 – 50.4% 2023) *believing that the trust provides equal opportunities for career progression or promotion believing the organisation provides equal opportunities for career progression and promotion* (WRES indicator 7).
A significant disparity of experience between white and other ethnic staff remains, the recently launched BME Talent Management and the Fair Recruitment Panel member WRES action, together the Health Equity Strategy Cultural Conversation action are designed to make a positive impact on this metric.

Appendix 5- 2023 Results Infographic


2023 Staff Survey
Results
NHS
Leeds Community Healthcare
NHS Trust
HEADLINES
62%
of substantive staff joined the conversation (2,038 people)
Comparison to last year: 58% (1,847 people)
27%
of bank colleagues also took part (72 people)
This was the first year that our bank staff were invited to have their say, and many took the opportunity
7.19 out of 10
Staff Engagement Score
Comparison to last year: 7.05 out of 10
6.13 out of 10
Staff Morale Score
Comparison to last year: 5.86 out of 10
PEOPLE PROMISE THEMES
We are compassionate and inclusive
7.7 out of 10
Comparison to last year: 7.6
We are recognised and rewarded
6.5 out of 10
Comparison to last year: 6.3
We each have a voice that counts
7.1 out of 10
Comparison to last year: 7.0
We are safe and healthy
6.3 out of 10
Comparison to last year: 6.1
We are always learning
6.0 out of 10
Comparison to last year: 5.7
We work flexibly
6.9 out of 10
Comparison to last year: 6.6
We are a team
7.1 out of 10
Comparison to last year: 6.9
AREAS TO CELEBRATE
92%
...of staff say our organisation encourages us to report errors, near misses or incidents
Comparison to last year: 91%
68%
...of staff say our organisation takes positive action on health and wellbeing
Comparison to last year: 66%
77%
...of staff say they have opportunities to improve their knowledge and skills
Comparison to last year: 73%
87%
...of staff say they enjoy working with the colleagues in their team
Comparison to last year: 86%
62%
...of staff say our organisation is committed to helping us balance our work and home life
Comparison to last year: 56%
80%
...of staff say they can approach their immediate manager to talk openly about flexible working
Comparison to last year: 75%
69%
...of staff say they would recommend our organisation as a place to work
Comparison to last year: 64%
78%
...of staff say their immediate manager is interested in listening to them when describing the challenges they face
Comparison to last year: 75%
AREAS TO IMPROVE
26%
...of staff say they have realistic time pressures
Comparison to last year: 23%
31%
...of staff say there are enough staff at this organisation for us to do our jobs properly
Comparison to last year: 23%
19%
...of staff say they rarely find their work emotionally exhausting
Comparison to last year: 17%
20%
...of staff say their work rarely frustrates them
Comparison to last year: 19%
WANT TO KNOW MORE?
Check out the Staff Survey Hub on My LCH or speak to your line manager about local results and action plans.
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Trust Board Meeting Held in Public: 28 March 2024
Agenda item number: 2023-24 (131)

Title: Engagement Principles

Category of paper: For assurance
History: Quality Committee

Responsible director: Executive Director of Nursing and AHPs
Report author: Patient Engagement and Experience Co-ordinator

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Executive summary (Purpose and main points)

This paper provides an update on the LCH Engagement Principles and work that has been completed to begin embedding these across the organisation. The six principles were developed following a review of the evidence base and a stakeholder engagement event with professionals in 2022. The principles describe what we expect to see in each service, in each interaction with patients, carers, communities and citizens. The principles reflect the city's aspirations around patient experience in relation to co-ordination, communication, and compassion. It is intended that the Engagement principles will provide a more responsive, sophisticated, and useful approach to patient engagement.

An update is provided on the development and implementation of the Engagement Principles and includes:

- Work with patients and carers to make the principles real. The outcome of initial engagement with patients and communities tells us that there is still work to be done to make the principles meaningful, clear and accessible.

Next steps for development and implementation of the engagement principles will include:

- Redrafting the principles into clearer language based on feedback from initial engagement with patients and communities.

- Running a further round of engagement with patients, carers and communities based on the redrafted principles to ensure they are accessible and have a clear target audience.

- Using the next round of engagement to develop a series of "I" statements with people and communities that will help to make the engagement principles real for staff and will provide a basis for patients and carers to hold services to account in 'living' the principles.

- Working with patients and services to understand how we will measure the principles.

The Board is recommended to:

- Note the progress so far to embed the Engagement Principles across the organisation.
- Agree the updated aims for the next six months.

1. Introduction

1.1 This paper provides an update on the LCH Engagement principles and how these are being embedded across the organisation and in every interaction with every patient and carer.

2 Background

2.1 In November 2022 the Quality Committee agreed that LCH would develop Engagement Principles rather than a revised strategy with the aim being to focus on actions that would achieve true and meaningful engagement. The timeline included in that paper proposed that between December 2022 and March 2023, LCH would engage further on defining the principles that were coproduced during a summer workshop in 2022.

2.2 Initial engagement has taken place with key stakeholders, staff and patients and we continue to review on an ongoing basis feedback received through complaints, accessibility, service specific surveys and friends and family. This has led to the development of the LCH Engagement principles, and a greater understanding of what these mean for LCH, our patients, carers and the communities we serve.

2.3 An updated timeline was approved by Quality Committee in March 2023 due to significant pressures within the Patient Experience Team and the wider system.

2.4 It was agreed that an update would be provided in March 2024 on the following area:

Making sure the principles are accessible for all communities, developing "I" statements. Working with learning disability, health equity and third sector colleagues we will work with people to develop a list of "I" statements that will underpin the culture of engagement with LCH. These "I" statements will help to make the engagement principles real for staff and will provide a basis for patients and carers to hold services to account in 'living' the principles.

3. LCH Engagement principles

3.1 Our principles set out what good engagement looks like in LCH; they are designed to put people at the centre of our engagement work, improve how we deliver our care and services, and create an organisation wide culture of engagement. The principles will outline how we work with people, how we ensure that we are listening to all voices, in particular community groups experiencing inequalities, and that we act on feedback we receive. These principles will underpin everything we do and support LCH in being good partners in the city's ambition to deliver care that is co-ordinated, well communicated and compassionate.

4. Progress so far

4.1 Progress with embedding the engagement principles has been impacted by the Patient Experience and Engagement Lead leaving in October 2023. Interim arrangements are in place until a new Lead is recruited this year. It has meant that during the handover and induction phase, progress on taking forward work with the principles slowed as the Patient Engagement Team supported the complaints function, including support for a newly recruited Complaints, Claims and Patient Experience Officer and an increase in the complexity of complaints that are being received.

4.2 Despite pressures within the workstream, work has begun with communities to make sure that the Engagement Principles are accessible. An infographic has been produced to make the principles visual (see Appendix 1). These will be further developed with a series of “I” statements.

4.3 A detailed progress summary is included in Appendix 2.

4.4 A Patient Safety Partner provided early feedback on the first iteration of the Engagement Principles; this supported where early improvements were required before sharing more broadly with members of the public.

4.5 A refined version of the Engagement Principles (version 2) was shared with members of the public in two workshops in February 2024, seeking broader feedback and with a view to develop a series of ‘I’ statements from the principles. The Patient Safety Partner was also included in facilitating the workshops.

4.6 Feedback from the public at the workshops told us:

- Some of the language in the engagement principles was difficult to understand and could be made simpler and clearer.
- It wasn’t clear who the intended audience was and what some of the principles would mean in practice.
- Once they understood them and their aim, people were positive about having a visual series of engagement principles on a page rather than a long strategy. There was consensus that this was a positive step forward.
- The principles must be made clear and accessible before the ‘I statements’ can be developed.
- An initial focus for the ‘I statements’ included feeling happy and trusting.

4.6 Ongoing engagement work supported and facilitated by the Patient Experience Team has contributed to continued awareness raising of the principles across the organisation.

4.6 The principles were discussed as a standing item on the bi-monthly Engagement Champion meeting agendas where they have focused on related themes such as carers voice, health inequalities, accessible information, translation, and sharing learning and good practice between services. This has helped to make the principles real for staff, so they develop ownership of how people experience our services.

4.7 The engagement principles infographic is now on the myLCH staff intranet and we have received positive feedback from staff.

4.8 Development of the engagement proforma used with services to plan engagement work to bring it more in line with the engagement principles. This included introducing more focus on considering health inequalities, the Accessible Information Standard, measuring outcomes and impact and sharing learning.

5. Next six months

5.1 Based on feedback from the workshops, we have identified the following as a focus for the next six months:

- Redrafting the principles into clearer language based on feedback from initial engagement with patients and communities.

- Running a further round of engagement with patients, carers and communities based on the redrafted principles to make sure they are accessible and have a clear target audience.

- Using the next round of engagement to develop a series of "I" statements with people and communities that will help to make the engagement principles real for staff and will provide a basis for patients and carers to hold services to account in adhering to the principles.

- Working with patients and services to understand how we will measure the principles.

6. Recommendations

6.1 The Board is recommended to:

- Note the progress so far to embed the Engagement principles across the organisation.
- Agree the updated aims for the next six months.

Appendix 1: Engagement Principles infographic (version 2)

Appendix 2: Progress summary

Work to make the principles real

Publicising our principles with patients, carers and communities to raise awareness about what they can expect.

- Two workshops were held in February:
  (i) A women's group at Wortley community centre
  (ii) A drop-in community wounds clinic at OPAL an older people's organisation in LS16.
- We received feedback from 20 people about the engagement principles and how we can make them more accessible for communities.

Making sure the principles are accessible for all communities, developing "I" statements.

- Initial engagement around 'I statements' was carried out at the workshops detailed above. The workshops identified a need for more clarity around the principles before we can develop the 'I' statements further. More engagement planned over the next six months to further develop the 'I statements'.

Working with patients and carers to help them hold services to account in delivering the principles.

- 'I' statements to be developed with people and communities over the next six months.

Work to embed in services

Build the capacity to support good engagement through training, champion networks, resources and alignment with organisational and professional values and behaviours.

- Guides have been created for Civica (Membership Experience System, MES) for staff including how to extract reports, survey results, and create 'you said, we did' posters. Bespoke training has been delivered to services on extracting reports and analysing themes.
- Friends and Family Test demographic questions are in the process of being updated to enable better analysis of information by factors relevant to health inequalities such ethnicity or postcode area.
- The carer engagement work has been rebranded and relaunched as a 'Carers Champions' network with the aim of making it easier and more attractive for staff to get involved. Response so far has been encouraging with ten new carer champions from across the business units signed up to attend the relaunch meeting.
- An easy read complaints form has been created to make the complaints process more accessible.
- Internal staff intranet 'Making information accessible' pages are regularly monitored and updated to ensure there is good quality and up to date information and advice for staff to help them provide information to patients in accessible formats dependant on their communication needs.
- The patient experience pages on MyLCH staff intranet are regularly monitored and updated to ensure there is good quality and up to date information and advice for staff. These include an engagement toolkit, key

resources, information on accessibility (Accessible Information Standard, AIS), and training dates,

Trust Board Meeting Held In Public Board Meeting: 28 March 2024

Agenda item number: 2023-24 (132)

Title: Waiting List 'Deep Dive' Findings Report

Category of paper: For information and assurance

History: Business Committee and Board

Responsible director: Interim Director of Operations
Report author: Interim Director of Operations

Executive summary

This paper provides information on the findings from a ‘deep dive’ into waiting times across services in LCH.

Concerns had been raised that reports on service waiting times did not accurately reflect the position within services. This resulted in a proposal to undertake a ‘deep dive’ to establish whether the organisation could have reasonable confidence and assurance in the data being presented to Business Unit Performance Panels, Business Committee and Board.

The purpose of the deep dive was to establish what systems and process were in place and whether these were standardised and effective across the business units and services.

A series of workshops were held involving the Interim Director of Operations, representatives from the Business Intelligence (BI) Team an individual business units.

As a result, 4 key themes identified;

- Waiting list validation processes require strengthening.
- There is a misalignment between clinical systems and clinical pathways, resulting in a lack of transparency.
- There are a small number of pathways that should be excluded from the Trust waiting list position.
- There is a requirement for a more standardised process across business units to ensure robust scrutiny of waiting lists and provide assurance to Business Committee and Board.

It quickly became apparent that well-established processes in place pre-Covid, had not been consistently reinstated post pandemic and service leaders welcomed the opportunity to re-base their service waiting times reporting.

The paper outlines the findings from the ‘deep dive’, the actions taken to address the issues identified and provide assurance to Business Committee and Board.

Recommendations

Business Committee and Board is asked to note the findings from the Waiting List Deep Dive.

Business Committee and Board monitor the changes to the ‘responsiveness’ section of the Performance Report and provide feedback regarding the level of assurance received in relation to waiting times to enable on-going improvement as required.

Waiting List 'Deep Dive' Findings Report

1 Introduction

This paper details the 'deep dive' methodology used to understand what systems and processes were in use across the 3 business; Adult Business Unit (ABU) Children's Business Unit (CBU) and Specialist Business Unit (SBU) to manage access to services and validate waiting times.

It outlines the action taken to address inconsistencies, provides assurance that data validation will be completed across business units by the end of March 2024, a new standardised approach to waiting list management will be in place for the new financial year 2024/25 and to provide an accurate baseline on waiting times in preparation for the Quality and Value Programme.

2 Background

Timely access to services is important to patients and to staff. Waiting times are monitored through business unit performance panels, the organisation performance panel, Business Committee and Trust Board.

- Regular reporting processes were disrupted during Covid.
- Services had reported a loss of confidence in waiting list reports produced by the Business Intelligence Team.
- Services regularly challenged the numbers of patients reported as waiting over 18 weeks and 52 weeks as being inaccurate.
- Many services were maintaining separate records which differed from those produced centrally.
- Usual reporting processes were suspended during the pandemic and the differential impact on services contributed to variation in the recovery and management of waiting lists across teams, services and business units.
- Inconsistencies in waiting list reporting was identified at Business Committee and Board resulting in a loss of confidence in performance data and service delivery.

In response to the lack of confidence across the system it was proposed to undertake a 'deep dive' to understand the systems and processes in place across business units and make recommendations for improvement.

3 Current position

In January and February 2024 each business unit participated in a workshop supported by the Interim Director of Operations and corporate colleagues. The purpose of the workshops was to establish what processes were in place for waiting list management and how they were applied across teams, services, and business units.

Methodology- Business Unit leads prepared information in advance of their workshop identifying those services reporting on waiting times and their current performance, those services where waiting lists don't apply, and any issues or concerns relating to performance or reporting.

In the workshop each service line was reviewed individually, comparing pre-prepared data with live PiP data. Issues were identified along with opportunities for improvement.

Findings - There was a surprising level of consistency of issue across the 3 business units leading to the emergence of 4 key themes;

- Waiting list validation processes require strengthening.
- There is a misalignment between clinical systems and clinical pathways, resulting in a lack of transparency.
- There are a small number of pathways that should be excluded from the Trust waiting list position.
- There is a requirement for a more standardised process across business units to ensure robust scrutiny of waiting lists and provide assurance to Business Committee and Board.

Waiting list validation processes require strengthening

During the workshops, it became evident that there was variation in approach across teams, services, and business units. There was evidence of more robust processes having been in place pre-covid with some teams and services reinstating these as we came out of the pandemic. From the information gathered at the workshops it is reasonable to conclude that covid caused significant disruption which has negatively impacted on waiting list reporting post-pandemic.

Some services were impacted more than others, with some closing altogether during the pandemic which resulted in backlogs when they re-opened. Staffing changes during the pandemic also meant that staff entering new roles did not always get the induction they should have, and roles and responsibilities were not always clear and consistently understood.

An immediate need to reinstate a weekly process of validation was quickly identified.

There is a misalignment between clinical systems and clinical pathways, resulting in a lack of transparency.

As individual service lines were reviewed it was clear that many of the service lines reported as waiting lists did not align to the way data is inputted onto the system or the way the service operates. Some services report waiting times at a service level, others have developed individual clinical or profession specific pathway reporting. The reporting of waiting times is therefore inconsistent and undermines confidence in its accuracy.

The BI Team has started to capture the work required to address the misalignment issues, but it is complex and will require input from clinicians, managers, clinical system developers and BI colleagues. Services will be prioritised to ensure alignment with the Quality and Value Programme to ensure optimal impact.
Over time all services will develop pathway-level reporting which will be a significant improvement and provide greater assurance of responsiveness at a pathway rather than service level and thus removing what are often referred to as ‘hidden waits’.

There are a small number of pathways that should be excluded from the Trust waiting list position.

There was evidence that for a small number of services waiting times had been reported where it was inapplicable as they don't offer waiting list models of care eg Hannah House was reporting waits over 18 and 52 weeks however the service is offered on an 'opt in' basis at a time of preference and therefore waiting times do not apply.

The services identified are currently applying for waiting list exemptions via usual processes, to be signed off by the Director of Operations. This will lead to the removal of these services from the waiting list report however, the Business Intelligence Department is developing alternative measures to maintain visibility of any emerging data quality trends and any responsiveness measures for these pathways.

There is a requirement for a more standardised process across business units to ensure robust scrutiny of waiting lists and provide assurance to Business Committee, Quality Committee and Board.

Within, and across, business units there was significant variation in understanding of the importance of waiting list management and lack of consistency in roles and responsibilities. This resulted in variable data quality and a lack of confidence and assurance. In services that have introduced clinical or profession specific pathway reporting patients are often waiting on more than one pathway waiting list at the same time. The BI team is looking to use unique identifiers for patients in order to get a more accurate position on the number of people waiting for each service.

Complaints

As part of the investigation, complaints received between 01/01/2023 and 31/12/2023 regarding waiting lists were reviewed.

6 of these are for CBU. 2 for SBU.

CBU

- CAMHS x4
- ICAN Central Admin x1
- ICAN East x1

SBU

- LMWS x1
- Podiatry x1

Breakdown:

C35079 – ICAN Central Admin

- Assessment withdrawn after 18 months of being on waiting list. Queried why friends child got an appointment after a shorter period of time on waiting list.

C34797 – CAMHS

- Concerns regarding waiting list for complainants sons complex needs assessment for possible dual diagnosis

C34675 – Podiatry

- Patient had been on waiting list for 3 months and health issue caused him to be hospitalised, appoint had been arranged but was cancelled by service.

C34649 – CAMHS

- Patient was on CAMHS waiting list for Autism assessment for over 12 months, but then got admitted to LGI where she was later diagnosed with Autism. If she had been seen sooner by CAMHS and had diagnosis, she would have started to receive the right treatment for her eating disorder and could have prevented admission to LGI.

C34054 – CAMHS (Mindmate SPA)

- Service not giving patients mum a clear answer on waiting list times.

C34030 – ICAN East

- Patient had a referral from one service to another, family assumed patient had been placed on waiting list following the referral, and had recently been made aware by the service that a referral was never received by them. Patient has had a variety of tests and family have been advised the tests/samples/results have gone missing.

C33864 – LMWS

- Patient was told he had a 6 month waiting time, he has been on waiting list since October 2021 (complaint made in January 2023). Each time he contacts service, the length of waiting time increases.

C33754 – CAMHS

- Patient unhappy with lack of communication and support by the service, and was told they would be on waiting list for 18 months before they access the support they need.

Overall, the level of formal complaints relating to waiting times is low, these figures do not include informal concerns raised directly with services.

4 Next steps

A number of actions were identified in response to the findings in order to restore confidence in waiting list management processes and the validity of data reporting;

- The BI Team to work with services to ensure an immediate cleanse of service lines to ensure waiting list exclusions are appropriately applied.
- Business units to identify named individuals per service responsible for data cleansing and validation, and those responsible for managing waiting times and performance.
- The validation process was to be re-instated immediately (February 2024) across services.
- Business units to ensure a standardised approach across services through weekly validation by named individuals.
- Training and support is available from the BI and Clinical Systems Teams on an individual level, team level and using written guides.

- Service line reports are being reviewed individually by business units and BI to ensure consistency in reporting.
- The BI Team is working with a small number of services to apply for a waiting list exclusion via the usual process and working with them to develop alternative responsiveness measures.
- Changes have been introduced to the Responsiveness section of the Performance Report from February 2024 to provide greater visibility and assurance to the committees and Board.
- The revised report will include individual service line reporting for all services where waiting times are of concern. Where waiting times are within normal range they will be monitored and reported locally through Performance Panels and escalated if the position changes to one of concern.
- A full list of services where waiting times apply to their service delivery model is included in Appendix 1.
- The BI Team is looking to use unique identifiers to understand the true number of people waiting for each service.

Following on from the workshops, it has been agreed to establish a monthly Patient Access Meeting, to include all pathways that manage access to care via a waiting list. This group will sit alongside the established Performance Management processes, and provide an additional level of scrutiny, analysis, and assessment of waiting lists and waiting times, allowing a shared understanding of current pressure areas and agreed actions and improvement. It will monitor and ensure consistency of approach across business units, and is being jointly developed between Business Units and the Business Intelligence and Performance Department, with the first meeting scheduled for April 2024.

Conclusion

The ‘deep dive’ was effective in exposing inconsistencies in waiting list management across the Trust that have resulted in a lack of trust and confidence in the data produced, from service to Board level.

Service leaders were correct in raising concerns regarding the accuracy of waiting list data, however some had become passive in their role in managing the process and recognising their own responsibility and accountability.

The actions outlined in response to the findings will address the inconsistency of approach, ensure appropriate reporting, and offer assurance to Business Committee and Board that the data they receive is accurate.

As services participate in the Quality and Value Programme we can be assured that they will start with a validated baseline in terms of patient access and waiting times.

Confidence that the data is accurate will enable service leaders to analyse and understand the demand, the demographic of people using the services and to target resources to address health inequalities.

6 Recommendations

Business Committee and Board is asked to note the findings from the Waiting List Deep Dive.

Business Committee and Board are asked to monitor the changes to the 'responsiveness' section of the Performance Report, provide feedback regarding the level of assurance received in relation to waiting times to enable on-going improvement as required.

Appendix 1

The following list is the full list of LCH services with a service services delivery model that operates on a waiting list basis.

ABU;
Continence, Urology & Colorectal (CUCS) – whole service, but think concern is in bowel care
Neighbourhood Teams - Therapy waits

CBU;
CAMHS – Whole service
Child Development Centres (CDC) - CDC: Complex Communication & Autism Assessment - Citywide
Children's Audiology – whole service
Children's Community Nursing Team – whole service (inc. Hannah house, short breaks, nursing at home)
Children's Occupational Therapy
Children's Speech & Language Therapy - Communication Aids Service
Looked After Children - iHNAs
Paediatric Neuro Disability Clinics – ND waits

SBU;
Cardiac Services – Whole service
Community Gynaecology
Community Neurological Rehabilitation Service – whole service
Community SLT (Speech & Swallowing) - Community SLT (Speech & Swallowing)
Community Stroke Team – whole service
Diabetes Services – whole service
Leeds Community Pain Service – whole service
MSK – whole service
Tier 3 Specialist Weight Management
Community Dental Service

From March 2024 any service with waiting times over 18 weeks or those with a service specific KPI that is not being achieved will be included in the Performance Brief presented to Business Committee, Quality Committee and Board.

Trust Board Meeting Held in Public: 28 March 2024

Agenda item number: 2023-24 (133a)

Title: Operational Plan Priorities 2024/25

Category of paper: For Approval
History: TLT 24 January 2024, February Committees, TLT 20th March 2024

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

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

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Executive summary

The purpose of this report is to present the 2024/25 operational plan which outlines the strategic framework for 2024/25. This includes the Trust vision, strategic goals and priorities for 2024/25 the achievement of which are underpinned by the 2024/25 business unit business plans and Quality and Value Programme (see Appendix 1).

The Trust priorities for 2024/25 have been developed within the context of what will be another challenging year for the NHS against a national and local backdrop of waiting list backlogs, system pressures and significant financial efficiency targets.

Consideration has been given to the draft operational planning guidance that NHS England published in mid February 2024 when setting the Trust Priorities. Please note: The interim draft planning assumptions are not agreed with Government and are subject to change. Agreed expectations and priorities for 2024/25 will be set out in the published priorities and planning guidance document.

Our Trust vision is that '**we provide the best possible care in every community'**.

Our five Strategic Goals with the underpinning 2024/25 Trust Priorities are:

Strategic Goal - Work with communities to deliver personalised care

- *Trust Priority: We will provide proactive and timely care that is person centred by ensuring the right service delivers the right care at the right time by the right practitioner.*

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

- *Trust Priority: To have a well led, supported, inclusive and valued workforce*

Strategic Goal – Collaborating with partners to enable people to live better lives

- *Trust Priority: We will develop a Leeds Community Collaborative in partnership to amplify the community voice and facilitate care closer to home.*

Strategic Goal - To embed equity in all that we do

- *Trust Priority –To ensure that the Quality and Value Programme has the least negative impact on those with the most need and positively impacts where possible.*

Strategic Goal - Use our resources wisely and efficiently both in the short and longer term

- *Trust Priority: To achieve the 2024/25 Trust's financial efficiency target through delivery of an effective Quality and Value Programme*

Recommendations

Board is asked to approve the 2024/25 Trust Priorities.

2024/25 Operational Plan

1 Introduction

The Trust priorities for 2024/25 have been developed within the context of what will be another challenging year for the NHS against a national and local backdrop of significant waiting list backlogs, system pressures and significant financial efficiency targets.

2 2024/25 Operational Plan

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

Consideration has been given to the draft operational planning guidance that NHS England published in mid February 2024 when setting the Trust Priorities. Please note: The interim draft planning assumptions are not agreed with Government and are subject to change. Agreed expectations and priorities for 2024/25 will be set out in the published priorities and planning guidance document.

The priorities and objectives set out in the 2023/24 planning guidance will not fundamentally change with retained focus on:

- recover our core services and improve productivity
- making progress in delivering the key NHS Long Term Plan ambitions and
- continuing to transform the NHS for the future

2024/25 key requirements will be for systems to

- maintain the increase in core UEC capacity established in 2023/24,
- complete the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients
- maximise the gain from the investment in primary care in improving access for patients, including the new pharmacy first service
- continue to target a reduction in the cost of temporary staffing.

We anticipate NHSE will be asking for 2024/25 Forecast outturn positions and will be comparing plans to 2023/24 FOT rather than looking back to 2019/20 and the following proposed metrics

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Continue to expand/maximise Virtual Ward capacity

Our five Strategic Goals, Trust priorities and underpinning objectives are detailed below. The achievement of these are supported by the 2024/25 business unit business plans and Quality and Value Programme (see Appendix 1).

Strategic Goal - Work with communities to deliver ~~right quality~~ personalised care

There is a proposal, following discussion at TLT on 17 January 2024 to replace 'right quality' in this strategic goal to 'personalised'. There are various and consecutive

national guidance where the NHS is challenged to provide ‘high’ quality care or where reports articulate the need to provide high quality care . For example, High Quality Care for All 2008 or the NHS Long Term Plan 2019.

In addition, the CQC state ‘we make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve’. It is suggested to update the strategic goal to personalised care in recognition that we will continue to aim to provide high quality care within the constraints of the 2024/25 financial envelope, and that right quality care could be misinterpreted externally as a change in our expectation of the quality of our care delivery.

Trust Priority: We will provide proactive and timely care that is person centred by ensuring the right service delivers the right care at the right time by the right practitioner.

- We will ensure our care pathways are robust to ensure our patients receive the most appropriate intervention to meet their needs.
- We will utilise a digital technology to ensure we optimise our service provision for those patients able to engage with digital interventions and work to improve digital inclusion.
- We will work in partnership with patients, families, patient representatives and our diverse communities and our professional partners to maximise our service delivery.

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

Trust Priority: To have a well led, supported, inclusive and valued workforce

- Enhance leadership capacity and capability ensuring leaders of teams understand their roles and responsibilities in relation to people management, with a particular focus on staff health and wellbeing and supporting attendance.
- Support our staff to be as efficient and productive as possible through better use of digital and technology
- Increase staff retention through targeted response to staff survey/workforce data, continuing to pursue our EDI agenda and promoting our staff health and wellbeing offer

Strategic Goal – Collaborating with partners to enable people to live better lives

Please note TLT reworded the Strategic Goal from ‘Working together to enable people to live better lives’ to the above to emphasise the partnership element of this goal.

Trust Priority: We will develop a Leeds Community Collaborative in partnership to amplify the community voice and facilitate care closer to home.

- Explore opportunities for care closer to home (the full spectrum from acute care to self-management) as part of the Quality and Value Programme
- Aim for the collaborative* (Alliance* plus third sector and primary care partners) to become the single provider of a range of intermediate care services.

- Engage with the universities and business community to utilise their capacity and capability in innovation.

Strategic Goal - To embed equity in all that we do

Please note TLT reworded the Strategic Goal from 'To ensure equity is a core consideration in all that we do' to the above to emphasise our aim of ensuring equity is core to all we do.

Trust Priority –To ensure that the Quality and Value Programme has the least negative impact on those with the most need and positively impacts where possible.

- To improve access to, and use of data to understand and promote equity in access, experience and outcomes.
- Collaborate with people and diverse communities to ensure their experiences influences equitable approaches to change, such as for the Quality and Value Programme.
- Demonstrably utilise the Equity and Quality Impact Assessment (EQIA) process and outputs to ensure all changes are inclusive of an equity focus.

Strategic Goal - Use our resources wisely and efficiently both in the short and longer term

Trust Priority: To achieve the 2024/25 Trust's financial efficiency target through delivery of an effective Quality and Value Programme

- Make the best use of all Trust resources by maximising productivity and efficiency through service offers and pathway redesigns
- Maximise our opportunities for IT, digital and estates transformation
- Explore commercial income generation and review corporate running costs

3 Feedback from Engagement

The Patient Engagement Officer has supported engagement from staff, patients and our Third Sector colleagues for feedback on the proposed Trust Priorities for 2024/25. The following feedback is included for the Board's consideration and review.

The request for feedback on our proposed Trust Priorities was shared with 74 individuals, including third sector organisations, staff, and patients. Patient's who had shared patient stories and those recorded as 'Friends of LCH' were contacted but did not respond. The ICB led Trackivity stakeholder engagement system is being assessed for the potential to provide patient feedback for future feedback.

Third Sector Feedback

"My only comment would be to be more explicit about engaging/working in partnership with children and young people – there is mention of families but when supporting an adult often people see working in partnership with families as considering the needs of the other adults and this is where 'young carers' get lost/missed?"

"Is there something about co-production/more of an emphasis on the patients/families' voice to shape services – just thinking it mentions in regards to staff retention getting feedback from surveys but is there something about how that works for patients/families who use your services? I know in my service and charity service user involvement is huge and something we need to demonstrate all the time". Family Action.

Staff Feedback

"I think it all looks fabulous".

"Just now getting people to honour it and stick to it. But it all reads correctly, and I think pretty easy to follow".

"My only feedback is that I think we should have something in there about sustainability and being more green focussed".

There were also comments from staff and the Committee members around the need to focus on reducing waiting times. The Committees acknowledged this will be a challenge in the light of the financial position going into 2024/25. The Trust is currently developing a revised waiting times report to evidence performance against the responsiveness domain to the Committees and Trust Board. ICB colleagues are working with us to ensure we have a collective understanding and focus our efforts on reducing the longest waits and thereby improve access for patients.

4 Next Steps

How to measure achievement against the Priorities will be assessed once the Priorities are approved. Some initial measures were suggested at the Board workshop which will inform the basis of initial scoping meeting planned for April 2024 with the Interim Director of Finance and Resources, Senior Business Manager, and Head of Clinical Governance. The measures will be considered in the broader context of the Board Assurance Framework and Performance Brief.

5 Recommendations

Board is asked to approve the 2024/25 Trust Priorities.
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6 Appendices

Appendix 1 – Business Unit Business Plans and Quality & Value Programme Overview

2024-25 CBU Business Change Plan

ABU 24-25 Business Plan v4.0 160124.xlsx

Copy of 2024-25 SBU Business Change

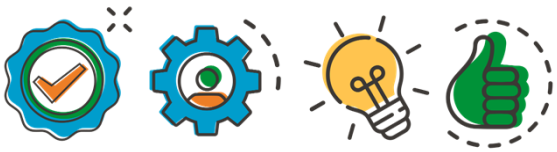
NHS
Leeds Community Healthcare
NHS Trust

Making Stuff Better

Quality and Value Programme 24-27

To use our resources wisely and by:
- ensuring optimal and costeffective delivery of quality services with partners and service users,
- whilst ensuring our statutory duty of remaining within financial balance

A three year efficiency programme, with a focus on year one and pipeline ideas for future years



Quality and value programme overview

Proposed workstreams

A. Service offers and pathway redesigns
B. Digital enablers
C. Business development
D. Corporate review and business processes
E. Estates strategy

Also – clarity on what we expect of all services

Trust Board Meeting Held in Public: 28 March 2024

Agenda item number: 2023-24 (133b)

Title: 2024/25 Financial Plan

Category of paper: For information
History: Extraordinary Trust Board 14th March 2024

Responsible director: Interim Executive Director of Finance and Resources
Report author: Interim Executive Director of Finance and Resources

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Executive summary (Purpose and main points)

The financial planning process continues to be extremely challenging for all NHS organisations. Final planning guidance has yet to be issued and an updated timetable has recently been issued by NHS England that sets out the key milestones for a final plan submission on the 2nd May 2024

In accordance with the timetable, the attached slides present the full revenue and capital plan for 2024/25 as submitted to NHS England on the 21st March 2024

They reflect the position as set out in the extraordinary Trust Board on the 14th March where, after careful consideration of the financial plan, risks and mitigations the Board agreed to develop a break-even plan, underpinned by an efficiency programme of £15.8m (7.2% of income) that signalled the Trusts intention and commitment to delivery of a balanced financial position throughout 2024/25.

Key issues noted:

1. There remains a considerable financial gap both within the Leeds Place and the WY ICB. As a result:
    a. the prior year commitment to commission growth arising during 23/24 (£1.4m) has not been funded.
    b. The ICB in Leeds is currently unable to fund any new growth in demand / forecast financial pressures in LCH services for 2024/25.

2. The efficiency requirement is extremely challenging and whilst the foundation of the Quality & Value Programme has been established, keys aspects of the programme centre on service transformation which will take time to develop and therefore release of savings in-year will be challenging. A range of immediate cost control measures are being introduced with the focus on tighter grip and control of all expenditure however full delivery in year remains a risk.

3. The capital plan is deliverable however is predicated on the WY ICS receiving the full CDEL envelope. This may be at risk given the scale of financial challenge on revenue plans. The Interim Executive Director of Finance is establishing a new capital planning group which will oversee the capital programme and support responding to any changes in the system envelope and/or new national funding streams that may become available during the year.

Recommendations

The Board is asked to note the 2024/25 revenue and capital plan submission as made on the 21st March 2024

NHS
Leeds Community Healthcare
NHS Trust

Final 2024-25 Financial Plan

Andrea Osborne,

Interim Executive Director of Finance and Resources

Trust Board 28th March 2024

Leeds Community Healthcare NHS Trust

Context

Interim Planning Assumptions

System Position

Statutory and Regulatory Framework

Interim Planning Assumptions (1)

Leeds Community Healthcare NHS Trust

Interim draft planning assumptions issued, not agreed and therefore subject to change , final guidance not expected until mid March. **Headlines from interim guidance :**

Primary and community services

- Continue to improve access to primary care and improve community services waiting times, focusing on reducing long wait.
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels. Dental funding will be subject to a strict ringfence.

Urgent and emergency care

- Maintain the peak increase in capacity agreed through operating plans in 2023/24. This includes acute G&A beds, virtual ward beds, intermediate care (rehabilitation, reablement and recovery services that are either bedded and non-bedded)

Mental health

- Continue to improve access and quality in line with the priorities set out for 2023/24, increase delivery of full annual physical health checks. Further expand access to NHS talking therapies and Individual Placement and Support (IPS) services
- Improve patient flow to reduce pressure in crisis and acute care and continue to improve the quality of care for patients,
- Meet the Mental Health Investment Standard

Prevention and health inequalities

- Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and for children and young people

Interim Planning Assumptions (2)

Leeds Community Healthcare NHS Trust

Workforce

- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
- Implement actions for 2024/25 from the Long Term Workforce Plan, including the agreed increase in education places in 2024/25 for Nursing Associates, Advanced Clinical Practitioners and Physician Associates
- System workforce numbers must be aligned to the financial resources available. Substantive staffing growth should come with commensurate and demonstrable reductions in temporary staffing use

Digital & Data

- Continue to level up the digital maturity of providers across all sectors, with a focus on deploying and upgrading electronic patient record systems in line with the What Good Looks Like guidance, as part of delivering the wider commitments set out in 'A Plan for Digital Health and Social Care', and 'Data Saves Lives'.
- Support and prioritise the implementation of the Federated Data Platform (FDP) to support elective recovery, care coordination (including optimising discharge), population health management and vaccinations.
- Continue to connect services to and champion use of the NHS App and website as the digital front door to the NHS

Use of resources

- Deliver a balanced net system financial position for 2024/25, including any repayments of 2022/23 overspends
- Improve productivity consistent with the planning assumptions and allocated resources.
- 0.6% growth on acute and ambulance services

Timelines

Leeds Community Healthcare NHS Trust

Date	Key Milestone
21 March	- **Full plan submission**
2 – 12 April	- Plan assurance meetings with system leaders
15 - 26 April	- Targeted follow up meetings
2 May	- **Final plan submission**
wc 13 May	- Plan close-down meetings with NHSE CEO/CFO/COO and RDs
By end of May	- Plan close-down letters issued
By end of June	- **Share and publish updated JFPs and capital resource plans**
By end of July	- **Develop system infrastructure strategies**

More recently, NHS England have published the above timelines. The LCH Financial Plan presented reflects the full plan submission however recognises a revised submission timeline that now incorporates a final plan submission on the 2nd May so may still be subject to change

Leeds Community Healthcare NHS Trust

LCH Financial Plan

Budget Setting Assumptions

Latest Plan

Risk & Mitigations

24/25 Finance Assumptions

Leeds Community Healthcare NHS Trust

CIP
- 7.2% turnover = £15.8m

Clinical Income
- WY ICB Clinical Income Net Deflator -0.17%
- FYE Prior Year Commitments incl Wharfedale funding for 24/25 ; Community Capacity funding £1.5m, Mental Health Support Teams £0.6m
- No growth / MHIS funding for 24/25 + withdrawal of commitment to fund costs associated with 23/24 growth.

Other Income
- Education & Training funding based on HEE assumed 2.1% in line with estimated pay inflation
- LA / Other contracts in line with agreed contracts

Pay
- Assumes 2.1% inflation as per national guidance

Non Pay
- Inflation assumptions, 1.7% Non-Pay, 0.6% drugs
- CNST premium inflation as per schedule advised from NHSLA
- Subcontract uplifts applied

Other
- IFRS 16 and Depreciation impact – increased for frontline digitisation, additional leases and CHP RPI uplift
- PDC / loan interest amended to reflect current financing assumptions

As a result of changes in the national assumptions on inflation, NHS England have recently signalled a reduction in the cost uplift factor of 0.2% noting that all providers should plan for a reduction in income with an equal reduction in inflation costs. This assumption has not yet been factored into WY commissioner and provider plans. There remains a risk that this action may not be cost neutral

24/25 Cost Pressures

Leeds Community Healthcare NHS Trust

Themes	Recurrent	Non Recurrent	Total	Planning Assumptions
	£k	£k	£k	
23/24 Local Cost Pressures		284	**284**	Full review required manage within budgets
New pressures	271	26	**297**	Business case required
Activity & Demand	266	621	**887**	Reduce capacity
Secondment	106		**106**	Full review required manage within budgets
Subtotal UnFunded Cost Pressures	**643**	**931**	**1,575**	
Inflationary pressures above national assumptions	2,262		**2,262**	Agreed
Activity & Demand	4,096		**4,096**	Further full review required
Depreciation & PDC Impact	731		**731**	Agreed
Loss of Income from Contracts	300		**300**	Agreed
Subtotal Funded Cost Pressures	**7,389**	**0**	**7,389**	
Total Cost Pressures Reviewed	**8,033**	**931**	**8,964**	

Essential cost pressures only supported by Trust Leadership Team including inflation, technical items and unavoidable as identified by business units including medical agency pressures within CAMHs, increased costs associated with expenditure on enteral feeds and continence products, PPE, IT Contracts, speech language therapists, real living wage.

A further review of all funded cost pressures will be undertaken to identify opportunity for costs to be avoided / deferred and therefore budgets to be released to deliver the efficiency programme.

£1.6m of cost pressures have not been supported and will need to be managed within existing delegated budgets

24/25 Quality & Value Programme

Leeds Community Healthcare NHS Trust

Scheme	£'000	Recurrent / Non Recurrent	Category	Status	Risk Status
Vacancy factor/removal of posts was NR in 23/24	4,000	Recurrent	Pay	Plans in Progress	Medium
Service transformation	6,155	Recurrent	Pay	Plans in Progress	High
Corporate transformation	1,320	Recurrent	Pay	Plans in Progress	High
Total Pay	**11,475**				
Estates	1,000	Recurrent	Non pay	Plans in Progress	Medium
Non pay expenditure controls - cost reduction	500	Recurrent	Non pay	Plans in Progress	Low
Procurement Management of price increases	225	Recurrent	Non pay	Plans in Progress	Low
Total Recurrent Efficiency	**13,200**				
Unidentified	1,378	Non Recurrent	Non pay	Opportunity	High
Interest receivable	1,200	Non Recurrent	Non pay	Fully developed	Low
Total Non Recurrent Efficiency	**2,578**				
Total Efficiency	**15,778**				

Income	**(219,284)**
% Efficiency	**-7.2%**

- Allocation methodology for efficiency targets linked to service and corporate transformation (high risk status) has been agreed by the Trust Leadership Team and will form part of the 2024/25 delegated budgets issued to business units
- £1.4m , linked to unfunded 23/24 growth, remains unidentified however short-term mitigation plans have been developed and work with commissioners to assess the impact will need to take place.
- Further detail of the Quality & Value Programme will be provided in the private Board Meeting

Bridge 3/24 Forecast outturn to 24/25 plan

Leeds Community Healthcare NHS Trust

	£'m	£'m
23/24 Surplus / (Deficit)		0.3
Non Recurrent		
Efficiency	(4.6)	
Balance Sheet Mitigations	(1.8)	
Additional Interest Received	(1.4)	
ICB Local Authority Pay Award Funding	(0.7)	
ICB "refund"	1.00	
Subtotal Non Recurrent		(7.5)
FYE cost pressures net of non recurrent budget underspends		(1.7)
23/24 Underlying Surplus / (Deficit)		(9.0)
Inflation		
Cost of inflation	(6.5)	
Income Uplifts	0.8	
Subtotal Inflation		(5.7)
24/25 Cost Pressures		(1.1)
Efficiency Target		15.8
Current Plan at 21/03/24		(0.0)

Current year performance underpinned by non-recurrent flexibilities, including high levels of interest receivable and release of balance sheet flexibility.

National Efficiency is 1.1% , LCH target is 7.2%, (as % of turnover) increase driven by :

- Significant use of NR resources to deliver 23/24 out-turn
- Cost inflation above nationally expected levels (£2.7m).
- Global application of WY convergence adjustment (£1.6m) , no sensitivity to “place”
- Cost pressures= e.g. reduction / loss of income contribution from tendered services, dividend and depreciation cost pressures along with the cost of activity growth delivered in 2023/24 that remains unaffordable to the Leeds system.

Summary Income & Expenditure

Leeds Community Healthcare NHS Trust

Income & Expenditure Summary	2023/24		2024/25
	Annual Budget	M10 Forecast	Headline Plan
	£k	£k	£k
Income			
Income from Patient Care Activities	(204,949)	(204,812)	(206,349)
Other Operating Income	(13,571)	(13,565)	(12,935)
Total Income	**(218,520)**	**(218,377)**	**(219,284)**
Expenditure			
Pay	154,488	153,443	150,646
Non pay	63,833	65,930	68,658
Total Expenditure	**218,321**	**219,373**	**219,304**
Operating (Surplus) / Deficit	**(199)**	**996**	**20**
Public Dividend Capital	460	461	698
Profit/Loss on Asset Disp	0	(12)	0
Interest Payable	676	658	819
Interest Received	(922)	(2,353)	(1,522)
(Surplus) / Deficit	**15**	**(250)**	**15**
Less: Donated Asset Depreciation	(15)	(15)	(15)
Less: Capital Donations and Grants	0	15	0
Adjusted (Surplus) / Deficit	**0**	**(250)**	**0**

- Break-even plan predicated on release of £15.8m cost reduction / efficiency savings programme.
- Pay expenditure to reduce in real terms back to 22/23 levels equating to an estimated establishment reduction of c.200 wte. Within this agency expenditure is planned to be 2.5% of total pay costs
- Growth in non pay is due to inflation and suppressed expenditure in 23/24 following a review of prior year accruals no longer required
- Interest receivable expected to fall as a result of lower cash balances and interest rates

Capital Plan

Leeds Community Healthcare NHS Trust

NHS England published the NHS capital guidance 2022 to 2025 in March 2022, and subsequently supplementary guidance for the 2023/24 financial year. Both still apply and set out the basis of the capital framework and allocations for the period 2022/23 to 2024/25.

	2024/25	2025/26	2026/27
Capital Scheme	**Plan £k**	**Plan £k**	**Plan £k**
Estate Maintenance	1,473	1,223	1,223
Clinical Equipment	400	400	400
IT Hardware	300	500	500
IT - National Cyber Security	300	350	350
Sub-Total Internally funded	***2,473***	***2,473***	***2,473***
PDC Capital - Frontline Digitisation	*1,306*	*0*	0
Sub-Total Capital Expenditure	***3,779***	***2,473***	***2,473***
Lease Cars IFRS 16	500	500	500
Property Leases IFRS 16 - Additions	4,723	1,724	0
Property Leases IFRS 16 - Remeasurement	5,886	6,000	6,000
Sub-Total Finance Lease Expenditure	***11,109***	***8,224***	***6,500***
Total Capital Expenditure	**14,888**	**10,697**	**8,973**

- Capital plans updated for the second year of frontline digitisation funding and leases updated for inflation and new leases.
- c7% of operational capital envelopes at a system level remain linked to performance (now split 50% financial i.e. submission of a balance system plan and 50% Urgent Emergency Care) – this may affect the overall capital envelope and therefore provider distribution.
- A new capital planning group is being established within LCH to monitor delivery of the 24/25 capital programme across both Estates and Informatics and to oversee the development of new pipeline capital proposals in readiness for new national funding streams / programme slippage

Summary Balance Sheet

Leeds Community Healthcare NHS Trust

Statement of Financial Position	2023/24 M10 £'m	2024/25 Plan £'m
Property, Plant and Equipment	38.3	40.6
Intangible Assets	0.1	0.0
Right of Use Assets	58.5	64.0
Total Non Current Assets	**96.9**	**104.6**
Current Assets		
Trade and Other Receivables	10.1	9.7
Cash and Cash Equivalents	45.9	39.9
Total Current Assets	**56.0**	**49.7**
Total Assets	**152.9**	**154.3**
Current Liabilities		
Trade and Other Payables	(31.1)	(26.7)
Borrowings	(6.9)	(7.2)
Provisions	(1.0)	(0.6)
Total Current Liabilities	**(39.0)**	**(34.6)**
Net Current Assets/(Liabilities)	**17.0**	**15.1**
Total Assets less Current Liabilities	**113.9**	**119.7**
Non Current Borrowings	(51.0)	(55.5)
Non Current Provisions	(0.0)	(0.4)
Total Non Current Liabilities	**(51.1)**	**(55.9)**
Total Assets less Liabilities	**62.9**	**63.8**
TAXPAYERS EQUITY		
Public Dividend Capital	2.5	3.8
General Fund	44.4	44.3
Revaluation Reserve	15.9	15.7
Total Equity	**62.8**	**63.8**

Cash balances forecast to remain healthy at £39.9m however will be dependant on efficiency savings being cash releasing

Working capital balances are expected to fall by c£1.9m leading to a reduction in the liquidity ratio from 1.55 to 1.44

Key Risks & Mitigations (1)

Leeds Community Healthcare NHS Trust

Headline Risk	Planned Mitigation
Workforce : There is a risk that the scale of challenge will impact adversely on our workforce creating further unplanned cost pressures in order mitigate quality and safety risks	Continued staff engagement programme and listening events planned. Workforce measures monitored closely through existing governance.
Inflation : Final pay settlement could be higher than currently planning assumptions (2.1%) ; as a result of a recent change in the national assumptions on inflation, NHS England have signalled a reduction in the cost uplift factor of 0.2% noting that all providers should plan for a reduction in income with an equal reduction in inflation costs. This assumption has not yet been actioned and there is a risk it may not be cost neutral	Any financial pressure is likely to be system wide ; the Trust will continue to engage with Leeds Place and ICS to determine an approach to manage.
System Financial Plans : There is a risk that the WYICS / Leeds Place cannot develop a balanced plan and that further efficiency contributions to the system gap are required .	Continue to engage and support development of measures to achieve financial balance at a system level.
Cost Pressures : There is a risk that known costs pressures will not be managed creating further financial challenge.	Strong financial management with regular challenge from the finance team at key business meetings with budget holders will continue to take place. Detailed run rates and forecast reported through Performance Management Process. Expenditure controls to be in place to manage non urgent / discretionary spend
Capital : There is a risk that the capital envelope will be further constrained which could adversely impact on our ability to transform and release efficiency savings	Aligned to digital and estates strategies aim to develop oven ready schemes, to : • minimise internal slippage and utilise external CDEL cover if possible • ensure readiness for bids against national capital programmes
Quality & Demand : There is a risk that the Trust cannot meet the demand for services resulting in increased waiting times and/or the quality of service provision may be adversely affected as focus shifts to value and efficiency	Q&V programme focus on review of service offer and scope for increasing productivity, all proposals will be subject to EQIA's , quality walks and monitoring of patient safety indicators will continue to be a key focus.

Key Risks & Mitigations (2)

Leeds Community Healthcare NHS Trust

Headline Plan Submission	Best £'m	Likely £'m	Worst £'m
		0.0	
Risks:			
Efficiency	(3.3)	(5.2)	(8.9)
% Share of ICB cost pressure			
Inflation above levels provided for			
Continued activity growth / generic cost pressures	0.0	(0.7)	(2.2)
Unplanned Income Risks	0.0	(0.3)	(1.2)
Total Risks to be managed	**(3.3)**	**(6.1)**	**(12.3)**
Mitigations:			
NR Vacancy Freeze / Expenditure Controls	1.0	2.7	3.6
Further national allocations	0.4	0.4	0.0
Additional ICS Income- negotiation / Cost Control Measure for unfunded growth	1.3	0.0	0.0
Interest receivable	0.6	0.3	0.0
Total Mitigations	**3.3**	**3.4**	**3.6**
24/25 Surplus/ (Deficit)	**0.0**	**(2.8)**	**(8.7)**

At this stage in the financial planning process delivery of a break-even plan represents the Trusts best case scenario.

There remains considerable risk with the timely delivery of efficiency savings and a series of mitigation plans around expenditure control continue to be developed and enacted. Clarification on national allocations for depreciation have yet to be confirmed and interest receivable above the plan assumes a rate of 5% under the best-case scenario.

Routine reporting of risks and mitigation plans will continue throughout 2024/25

Conclusion

Leeds Community Healthcare NHS Trust

Conclusion:

Full consideration of the financial plan noting risks, sensitivity and triangulation with operational and workforce plan submissions took place at an exceptional meeting of the Board on the 14th March 2024

Whilst mindful of the risks the Board agreed to signal intent to deliver a breakeven position following which a balanced financial plan was submitted to NHS England on the 21st March.

Following recent notification of an updated planning timetable we will continue to develop the work with system partners with any changes prior to a final plan submission on the 2nd May being presented in a future board meeting.

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 28 March 2024

Agenda item number: 2023-24 (133c)

Title: Revised High Level Indicator List for 2024/25

Category of paper: for approval

History:
TLT 10 Jan, Quality Committee 22 Jan, Business Committee 24 Jan
TLT 13 March, Quality Committee 25 Mar, Business Committee 27 Mar 2024

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

Executive Summary (Purpose and main points)

The paper proposes the high level indicators that will be measured in the Performance Brief for 2024/25.

This review takes account of changes in contracts, NHS Standard Operating Framework and other relevant requirements. Where national guidance on measures exists we align to this.

By domain the following changes have been made:

	Remains the same	Amended	Removed	New Measure	For Development	Total Measures After Review
Overall	0	2	0	0	0	2
Safe	8	1	9	6	0	15
Caring	2	0	0	1	0	3
Effective	7	0	0	0	2	9
Responsive	16	2	0	2	1	21
Well Led	13	1	2	6	0	20
Finance	3	0	0	0	0	3

Recommendations

- The Board is asked to approve the proposed changes to the indicators and consider whether these will provide the assurance from the Performance Brief through 20245/25.

Revised High Level Indicator List for Performance Brief 2024/25

This document provides the list of indicators that will be examined within the Performance Brief. This list has been bought in line with the System Oversight Framework (https://www.england.nhs.uk/publication/nhs-oversight-framework-22-23/). Additional indicators from local performance processes and national planning requirements have also been considered for inclusion.

Key:

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

CE: Chief Executive
DoF: Director of Finance and Resources
DoO: Director of Operations
MD: Medical Director
DoNA: Director of Nursing and Allied Health Professionals
DoW: Director of Workforce

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

Safe - people are protected from abuse and avoidable harm	Resp. Dir.	Target - Annual	Frequency	Notes	Action
Safer Staffing – Inpatient Services	DoNA	TBC	M	Reinstated for Hannah House and Wharfedale Recovery Hub	
Safer Staffing – Community Services	DoNA	TBC	TBC	Work is ongoing to provide additional and improved information to the twice yearly safer staffing report. Propose that this measure is removed whilst that work progresses.	
Patient Safety Incidents Reported in Month Reported as Harmful per 1000 contacts	DoNA	Value between UCL and LCL Variation outside that investigated and explained	M	To be replaced by new measures reflecting PSIRF*	
Serious Incident Rate	DoNA	Value between UCL and LCL Variation outside that investigated and explained	M		
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	DoNA	TBC	M		

Validated number of Patients with Avoidable Category 4 Pressure Ulcers	DoNA	0	M		
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	DoNA	TBC	M		
Number of Falls Causing Harm	DoNA	TBC	TBC		
Number of Incidents Involving Medication Causing Harm attributable to LCH	DoNA	TBC	TBC		
Reduction in Gram Negative Infections	DoNA	7%	TBC		
Compliance in Level 1 and 2 Patient Safety Training*	DoNA	95%	M		
Number of Patient Safety Incident Investigations (PSII)*	DoNA	N/A	M	Target not available as this is a new process being embedded. Any emerging trends will be commented upon in narrative.	
Number of overdue PSII actions*	DoNA	N/A	M		
Number of incidents by PSIRP priority*	DoNA	N/A	M		
Number of teams who have completed Medicines Code Assurance Check since 1 April 2023 versus total number of expected returns	MD	100%	Q		
Compliance with statutory Duty of Candour	DoNA	100%	M	Wording updated. No longer reported by exception	
Attributed MRSA Bacteraemia - infection rate	DoNA	*0*	*RbE*		
Clostridium Difficule - infection rate	DoNA	*3*	*RbE*		
Never Event Incidence	DoNA	*0*	*RbE*		
Incidents of E.Coli, bacteraemia	DoNA	*0*	*RbE*		
CAS Alerts Overdue	DoNA	*0*	*RbE*		
Data Quality Maturity Index (DQMI) - CSDS dataset score	*DoF*	*TBC*	*RbE*		
Data Quality Maturity Index (DQMI) - IAPT dataset score	*DoF*	*>=95%*	*RbE*		
Data Quality Maturity Index (DQMI) - MHMDS dataset score	*DoF*	*>=95%*	*RbE*		

* The transition to the Patient Safety Incident Response Framework (PSIRF) is a significant change from the Serious Incident Framework we have worked to over the past 10+ years. We are at the very infancy of this transition which will involve a significant change in the way we capture and analyse safety data in the organisation. Delivering improvement is the new focus of the work and the premise is to move beyond a narrow set of metrics. Therefore, a comprehensive suite of quantitative measures is not possible and four contextual measures are proposed for inclusion in this year's indicators to provide some degree of quantification. We understand this provides a level of uncertainty however, within this process we can provide some assurances:

- PSIRF brings a commitment to more collaborative working and system approaches to improve safety and care
- PSIRF brings an increased patient and staff voice to how we learn and improve, alongside the involvement of our two patient safety partners
- PSIRF brings a focus on 'Just Culture' to improve the psychological safety for staff to speak up, and we are already ensuring staff involved in patient safety incidents are supported through the Trust wellbeing offers

- PSIRF may identify resource implications going forward and therefore this needs to remain a key focus in financial, operational and workforce planning
- PSIRF equally requires a significant culture change – and this starts with the undertaking of the Level 1 and 2 patient safety training as part of the national syllabus (and is an area we can measure with immediate effect)

We are not alone in this position. Other trusts, even early adopters are still grappling with this transition.

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Resp. Dir.	Target - Annual	Frequency	Notes	Action
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	DoNA	>=95%	M		
Total Number of Formal Complaints Received	DoNA	No Target	M	Health equity analysis of complaints carried out every 6 months and reported separately	
Mixed Sex Accommodation Breaches	DoNA	*0*	*RbE*	*Reinstated for Wharfedale Recovery Hub*	

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Resp. Dir.	Target - YTD	Frequency	Notes	Action
Difference in access to services for patients living in IMD1 vs IMD2-10.	MD	TBC	M	We will develop measures that highlight any statistically significant variation between the waiting times experienced by patients living in IMD1 and IMD2 to 10. Initially this will include the following measures: • Percentage of patients currently waiting under 18 weeks (Consultant-Led) • Number of patients waiting more than 52 Weeks (Consultant-Led) • Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01) • % Patients waiting under 18 weeks (non reportable)	
Differences in patient safety for patients living in IMD1 vs IMD2-10	MD	TBC	M	We will develop measures that highlight any statistically significant variation between the number of Patient Safety Incident Investigations (PSII) completed in relation to	

				patients living in IMD1 and IMD2 to 10.	
Number of NICE guidelines with full compliance versus number of guidelines published in 2022/23 applicable to LCH	MD	100% by year end	Q		
Number of NICE guidelines with full compliance versus number of guidelines published in 2023/24 applicable to LCH	MD	No Target	Q		
*Number of Unexpected Deaths in Bed Bases**	MD	*No Target*	*RbE*	Monthly	
*Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload**	MD	*No Target*	*RbE*	Monthly	
NCAPOP audits: number started year to date versus number applicable to LCH	MD	100% by year end	Q		
Priority 2 audits: number completed year to date versus number expected to be completed in 2024/25	MD	100% by year end	Q		
Total number of audits completed in quarter	MD	No Target	Q		

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	**Resp. Dir.**	**Target - YTD**	**Frequency**	**Notes**	**Action**
Percentage of patient contacts where an ethnicity code is present in the record	DoO	>=95%	M	New target proposed	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)**	DoO	>=92%	M		
Number of patients waiting more than 52 Weeks (Consultant-Led)**	DoO	0	M		
Zero tolerance RTT waits over 78 weeks for incomplete pathways**	DoO	0	M	Added 28/12 from National Contract	
Zero tolerance RTT waits over 65 weeks for incomplete pathways**	DoO	0	M	Added 28/12 from National Contract	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)**	DoO	>=99%	M		
% Patients waiting under 18 weeks (non reportable)**	DoO	>=95%	M		
Number of children and young people accessing mental health services as a % of trajectory**	DoO	TBC	M		
% CAMHS Eating Disorder patients currently waiting less than 1 week for urgent treatment**	DoO	>=95%			
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment**	DoO	>=95%			
% CAMHS ACBI & Neurodevelopmental Initial Assessment	DoO	No Target			

patients currently waiting less than 12 weeks for treatment**					
LMWS – Access Target; Local Measure (including PCMH)**	DoO	TBC	M	Target for 2024/25 to be defined with ICB	
IAPT - Number of patients starting screening within two weeks of referral **	DoO	No Target	M		
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral**	DoO	>=75%	M		
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral**	DoO	>=95%	M		
Neighbourhood Team Face to Face Contacts**	DoO	No Target	M		
Neighbourhood Team Referrals (SystmOne only)* *	DoO	No Target	M		
Neighbourhood Team Productivity (Contacts per Utilised WTE)	DoO	No Target	M		
Community health services two-hour urgent response standard **	DoO	>=70%	M	Wording updated to match national contract	
Available virtual ward capacity per 100k head of population	DoO	TBC	M		
Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted**	DoO	TBC	M	To be developed through 2024/25 as Dental EPR rolled out	

** NB the System Oversight Framework metrics state that "for all relevant metrics … providers must consider how inequalities of access and outcome are being reduced". The Trust must be assured that this process is in place and is active. Specific measures will be developed for an initial set of key responsive and safe measures (see effective domain). Additional monitoring mechanisms are available outside the Performance Brief process.

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	**Resp. Dir.**	**Target - YTD**	**Frequency**	**Notes**	**Action**
Staff turnover	DoW	<=14.5%	M		
Staff turnover amongst staff from a minoritised ethnic group	DoW	<=14.5%	M	Breakdown by ethnicity to be provided as an appendix and where relevant commented upon in narrative	
Reduce the number of "other not known" reasons for leaving	DoW	TBC	M	Target will be a reduction on the 2023/24 year end figure	
Reduce the number of staff leaving the organisation within 12 months of starting with LCH	DoW	<=20.0%	M		
Short term sickness absence rate (%)	DoW	<=3.0%	M	Narrative on short term sickness will be provided.	
Long term sickness absence rate (%)	DoW	<=3.5%	M	Narrative on long term sickness will be provided.	
Total sickness absence rate (Monthly) (%)	DoW	<=6.5%	M		
AfC Staff Appraisal Rate	DoW	>=90%	M		
Statutory and Mandatory Training Compliance	DoW	>=90%	M		

Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	DoW	>=60%	Q		
Percentage of staff who are satisfied with the support they received from their immediate line manager	DoW	>=52%	Q		
The overall percentage of staff who have identified as BME (including exec. board members)	DoW	14%	M	Previously agreed targets of 14% by 31/05/25 and 18% by 2028/29. Wording updated	
Proportion of staff in senior leadership roles (8a and above) filled by staff who have identified as BME	DoW	TBC	M	Target will be an improvement on the 2023/24 year end figure	
Proportion of staff in senior leadership roles (8a and above) who are women	DoW	TBC	M	Target will be an improvement on the 2023/24 year end figure	
Proportion of staff in senior leadership roles (8a and above) who have a disability	DoW	TBC	M	Target will be an improvement on the 2023/24 year end figure	
Proportion of staff in senior leadership roles (8a and above) who have identified as LGBTQIA+	DoW	TBC	M	Target will be an improvement on the 2023/24 year end figure	
Neighbourhood Team Vacancies, Sickness & Maternity WTE	DoW	No Target	M		
Neighbourhood Team Percentage of Funded Posts Utilised	DoW	No Target	M		
Starters / leavers net movement	DoW	>=0 in favour of starters	M		
'RIDDOR' incidents reported to Health and Safety Executive	DoF	No Target	M		
Total agency cap (£k)	DoF				
Percentage Spend on Temporary Staff	DoF	No Target	M		

Finance	Resp. Dir.	Target - YTD	Frequency	Notes	Action
Net surplus (-)/Deficit (+) (£m) - YTD	DoF	TBC	M		
Capital expenditure in comparison to plan (£k)	DoF	TBC	M		
CIP delivery (£k)	DoF	TBC	M		

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held In Public: 28 March 2024

Agenda item number: 2023-24 (134a)

Title: Going Concern Consideration

Category of paper: for approval
History: Audit Committee 8 March 2024

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

Executive summary (Purpose and main points)
In preparing the annual accounts those charged with governance are specifically required to consider whether the Trust is a going concern so that financial statements are prepared on that basis. This report has been prepared to assist the Board with this consideration.

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

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

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

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

The Trust is in the process of agreeing the income allocation for 2024/25 with partners from the West Yorkshire Integrated Care Board (ICB). This work is expected to conclude to enable the ICB and provider organisations to submit the final plan to NHS England in March 2024. The plan will include both revenue and capital plans. These plans will need to affordable within the ICB financial envelopes; this is a joint responsibility for all organisations within the Integrated Care Board (ICB).

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

Recommendations

The Board is recommended to:

- approve the preparation of the 2023/24 annual accounts on a going concern basis.

Going Concern Consideration

1.0 PURPOSE OF THIS REPORT

1.1 This report provides information to the Board upon which the assessment of the concept of going concern can be made. The accounts to be approved by the Board will be prepared on a going concern basis subject to an assessment by the Audit Committee.

2.0 BACKGROUND

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

2.2 NHS trusts are considered to be going concerns unless there are plans to dissolve them. There are no plans to dissolve Leeds Community Healthcare and therefore the 2023/24 accounts should be on the basis of a going concern.

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

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

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

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

3.0 CONTENT

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

3.2 The Trust's financial monitoring throughout 2023/24 provides evidence that financial duties and targets will be met. The Trust is forecasting to meet the £250k surplus agreed with WYICB by the end of March. Historically, the Trust has achieved all its regulatory financial duties.

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

3.3 The Trust expects to have a detailed income and expenditure revenue budget for the year approved by the Board by 31st March 2024. A source an application capital plan will also be presented to the Board for approval.

3.4 The Trust's liquidity remains very strong with circa £40m forecast to be in the bank at year-end; £41.6m was held at the end of January 2024. The Trust is confident it has sufficient cash resources to meet all its liabilities in 2024/25.

3.5 During 2023/24 there has been a number of changes in the Trust Leadership team with interim arrangements in place whilst competitive recruitment processes were undertaken. The Trust has appointed a substantive Chief Executive to commence in April 2024 and is in the process of recruiting a substantive Executive Director of Finance and Resources.

3.6 The Board has inherently considered the matter of the Trust as a going concern, through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future.

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

3.8 The NHS has resumed its planning and contracting processes for 2024/25. These are being led by West Yorkshire ICB and the Trust is participating fully in the revenue and capital planning for 2024/25. NHS contracts are due to be signed with Commissioners by the end of March 2024. Whilst we remain in a recurrent financially challenged system, and face a number of risks and uncertainties, there is clear evidence of continued provision of services being planned by Commissioners.

3.9 A four year extension has been agreed with the Local Authority commencing 1st April 2023 for the Children's 0-19 service until the end of March 2027.

3.10 The current contract with the Local Authority for Sexual Health services ends on 30th June 2024. The Trust successfully won the tender and is in the process of finalising the contract due to commence 1st July 2024 until 31st March 2030.

3.11 The contract with the Police Commissioners was extended in 2022/23 for three years until the 25th March 2025. The North Yorkshire element of the contract has been decommissioned from 26th March 2024. We are awaiting details of the tender process for the remaining elements of the contract.

3.12 The contract for public health school immunisations was awarded to the Trust by Locala from 1st September 2023 until 31st August 2028.

3.13 The contract for dental services with WYICB has been extended until 31st March 2025.

3.14 Other small contracts for public health and health and justice services are under negotiation with NHS England.

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

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

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

4 CONCLUSION

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

4.2 The final version of management's assessment of going concern will be presented to the Board at the meeting at which the accounts and annual report are approved.

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

5 RECOMMENDATIONS

5.1 The Audit Committee reviewed the consideration on 8 March 2024 and recommends to the Board that it approves the preparation of the 2023/24 annual accounts on a going concern basis.

Trust Board Meeting Held in Public: 28 March 2024

Agenda item number: 2023-24 (134b)

Title: Compliance with the new Code of Governance

Category of paper: For assurance
History: N/A

Responsible director: Chief Executive
Report author: Company Secretary

Executive Summary

This report sets out the requirements of the new Code of Governance which came into force on 1 April 2023 and reports the Trust's compliance against the standards.

Main issues for consideration

At the end of October 2022 NHS England issued the Code of Governance (the Code) for provider Trusts, which set out a series of standards based on best practice of corporate governance from the private sector and replaced the Monitor Code of Governance establish some years ago for NHS Foundation Trusts. This also reflects the developments of governance across Integrated Care Systems (ICSs). The updated Code applies to all providers – both NHS Trusts and Foundation Trusts.

The Code sets out a series of standards whereby the Trust is required to include information within the Annual Report or via a comply or explain statement (as set out within the supporting Appendix to this report) which by means of this report to public Board can also be referenced within the Annual Report. As part of the yearend processes, External Audit are required to review the Annual Report to ensure the content reflects the specified requirements.

NHS England recognises that departure from the specific provisions of the code may be justified in particular circumstances. Reasons for non-compliance with the code should be explained, with the Trust illustrating how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the Trust should indicate when it expects to conform to the provision.

There is one statement, D 2.5, relating to the Trust having a policy on its purchase of non-audit services from its external auditor, for which an explanation has been provided. Although the Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports, work needs to be undertaken to develop this specific policy. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust. This provision has therefore been marked as non-compliant but the intent to comply confirmed and a policy will be developed during 2024/25.

Further to this, in order to remain compliant with provision C 4.7, Trusts being strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, it is recommended that an external review be commissioned during 2024/25.

The Code, with the comply or explain statements and publication requirements within the Annual Report, although not a specific KLOE defined within the current requirements of the CQC Well-led, will be a key tool to assess corporate governance practices within the Trust.

Schedule A of the code sets out which provisions fall into which category.

Recommendations

The Board is requested to:

- Note the new requirements of the Code of Governance for provider trusts, and the assurance that will be provided in due course by External Audit against the publication within the Annual Report.
- Reflect on the self-assessment of the comply or explain against the statements of the Code and approve this as an accurate reflection of the Board and practices at LCH.
- Note the recommendation for an external Well-led review to be undertaken during 2024/25.
- Approve the inclusion of a declaration within the Annual Report as below: *The Board recognises the importance of the Code of Governance and has undertaken a review of compliance. There have not been any contraventions of the Code but there is one area where further work is indicated to declare full compliance going forwards. (This is highlighted amber within Schedule A).*

Appendix 1

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for Foundation Trusts in the NHS foundation trust annual reporting manual and for NHS Trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a Trust's annual report, even in the case that the Trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

NB Blue text is only applicable to NHS Foundation Trusts

Provision	Requirement	Evidence	Comply
Section A, 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Annual Report Quality Account Third Sector Strategy	Annual Governance Statement

Section A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Annual Report NHS Staff Survey Quarterly Pulse surveys	Accountability Report, Annual Governance Statement, Performance Overview and Analysis Report
Section A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision- making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Annual Report Standards of Partnership Governance Individual Partnership arrangements	Performance Overview and Analysis Report
Section B, 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent.	Annual Report - NEDs described in Board structure	Accountability Report (Directors' Report)
Section B, 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Annual Report Minutes of Board and	Accountability Report (Directors' Report), Annual Governance Statement (Directors' attendance tables)

		Committee meetings	
Section B, 2.19	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.		N/A
Section C, 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.		N/A
Section C, 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.		N/A
Section C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Annual Report Trust website – About the Board	Accountability Report (Directors' Report)

Section C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Gatenby Sanderson development review 2022	Compliant for 2023/24. The last development review was undertaken in 2022. It is recommended that an external Well-led review be undertaken during 2024/25.
Section C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served	Annual Report Nominations and Remuneration Committee Annual Report Annual Equality, Diversity & Inclusion Report that evidences compliance with the Public Sector Equality Duty (evidenced through Business Committee and Board minutes)	Annual Governance Statement – Nominations and Remuneration Committee summary, and Equality and Diversity section

	• the gender balance of senior management and their direct reports.		
Section C, 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.		N/A
Section D, 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Annual Report Process for appointment of auditors	Annual Governance Statement

Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Annual Report	Statement of Directors' responsibilities
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Report Board Assurance Framework Process	Annual Governance Statement
Section D, 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Report Audit Committee risk management reports	Annual Governance Statement
Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will	This is described in the Annual Accounts - Finance	Going Concern Statement

	continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.		
Section E, 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings	Requirement noted - should this ever be the case this would be described in the Annual Report and Accounts	N/A

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Provision	Requirement	Comply
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	Trust vision and values agreed for 2023/24. The Board also agreed its four strategic goals and a number of priorities that are aimed at supporting the delivery of the strategic goals. The strategic goals inform the Trust's Strategic and Operational plans. The Board receives quarterly reports on progress towards achieving its priorities. When setting its strategic priorities, the Board will take account of the ICB's strategic priorities, both at ICB and Leeds Place level.
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Board regularly review performance using the Performance Brief in Board Committees and within the Board meeting to measure and monitor the quality, effectiveness and efficiency of healthcare delivery.

Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	All executive directors and non-executive directors, through the Board sub-committees have an opportunity to receive and influence the Internal Audit Plan for areas of high risk prior to it being signed off by the Audit Committee. Should the Board require, the internal auditors can be asked to look at any areas of concern for the Board; internal auditors can be commissioned by the Audit Committee where the Board or NEDs have concerns about areas of performance. The Business Committee and the Board of Directors receives annual performance reports which show data relating to WRES and WDES.
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	The Board has formally approved its Board sub-committee structure including the Quality Committee which receives assurance on clinical governance and quality matters. Assurances on clinical governance and clinical quality are made to the Board of Directors through reports made by the chair of the Quality Committee. The Trust produces a Quality Report which sets out progress against the Trust's quality improvement priorities.
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear	Engagement with stakeholders is reported to Public Board via the Chief Executive's report and within the Annual General Meeting.

	understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	The Trust has a Freedom to Speak Up Guardian (FTSUG) and FTSUG Ambassadors. The Board receives a six-monthly report from the FTSUG. There is a nominated FTSU Board Champion who meets regularly with the FTSUG.
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	The Trust has a Managing Conflicts of Interest Policy and Procedure which includes Standards of Business conduct. Registers are in place and available on request. Registers of Director interests are published within the Annual Report.
Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Requirement noted. If and when applicable resignations would be reported to Board.
Section B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that	Agendas for the Board are prepared by the Chair, CEO and Company Secretary.

	adequate time is available for discussion of all agenda items, in particular strategic issues.	
Section B, 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	The Chair takes an active role in specifying the format of the information provided to directors. The Chair is clear as to the timeframe in which information should be distributed to the Board of Directors.
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	The Chair ensures that there is effective contribution from all members of the Board, in particular the non-executive directors and the opportunity to challenge the executive directors. The Code of Conduct contains information about our values and makes reference to the Nolan Principles. The Chair allows sufficient time for discussion at Board meetings. The Board encourages its sub-committees to look at areas in detail where needed. Board and sub-committee meetings run in accordance with Trust values.
Section B, 2.4 (NHS foundation trusts only)	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	N/A

Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	The Chair of the Trust and the Chief Executive abide by the division of responsibilities as set out in the standing orders and standing financial instructions. The roles of the Chair and Chief Executive are undertaken by two different individuals. The Chair of the Trust has completed a declaration as to their independence. Whilst the Chair is required only to do this on appointment we test this (as for all other NEDs) on an annual basis. The Chair of the Trust has not previously been the Chief Executive of the Trust. The Board has identified a deputy chair and a senior independent director. The Audit Committee is not attended by the Chair of the Trust on a regular basis; however, an invitation is extended for them to attend once a year.
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	The Board comprises 5 non-executive directors excluding the Chair in comparison to 5 executive directors, therefore, at least half the Board comprises non-executive directors. On appointment and annually thereafter the NEDs are required to declare their independence. All the non-executive directors have been determined to be independent.
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	This is evidenced through the annual declaration of interest forms.

Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	The Board has made a clear determination as to the membership of the committees in the agreed terms of reference. The Trust has two NEDs with clinical backgrounds, other NEDs have a diverse range of skill sets.
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Requirement noted and included within the Terms of Reference.
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.	The Senior Independent Director undertakes the annual appraisal of the Chair.

Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	The CEO reports directly to the Chair, with Executive Directors reporting to the CEO. Appointment of Executive Directors include the relevant NED on the interview panel and inclusion of others with the assessment centre process. Annually the CEO reports formally to the Nominations and Remuneration Committee on his appraisal meetings and objective setting with each Executive. The Chair holds a quarterly meeting with the non-executive directors as a group without the executive directors present.
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	The expected time commitment is set out in the letter of appointment and in accepting the appointment Directors confirm that they are able to allocate sufficient time to the role.
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply – Company Secretary in post.

Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.
Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	The Board acts as a unitary Board, with Executive and Non-Executive Directors sharing the same liabilities and joint responsibilities for all decisions taken by the Board. A schedule of matters reserved for the Board is in place.
Section B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.
Section B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	The Board meets in public seven times per year and meets privately for Board development sessions or workshops six times per year. There are also extraordinary meetings held when required. A schedule of matters reserved for the Board is included in the standing orders and standing financial instructions, and

		this is reviewed annually by the Audit Committee and agreed by the Board to ensure it remains fit for purpose.
Section C, 2.1 (NHS foundation trusts only)	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.	Comply – use of external recruitment and adherence to recommendations for selection panel. Nominations and Remuneration Committee has received reports on succession planning.
Section C, 2.2 (NHS foundation trusts only)	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of	N/A

	both executive and nonexecutive directors, including the chair.	
Section C, 2.3 (NHS foundation trusts only)	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	N/A
Section C, 2.4 (NHS foundation trusts only)	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	N/A
Section C, 2.5 (NHS foundation trusts only)	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.	N/A
Section C, 2.6 (NHS foundation trusts only)	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of nonexecutive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	N/A

Section C, 2.7 (NHS foundation trusts only)	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	N/A
Section C, 3.1 (NHS trusts only)	NHS England is responsible for appointing chairs and other nonexecutive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, nonexecutive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Requirement noted – appointments conducted in accordance with this.

Section C, 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	All new Board members are required to sign a self-attestation form. DBS checks are completed for all new Board members. All Board members are compliant with the revised requirements in the FPPT Framework following the Kark review. This is reported to Board annually in March.
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.	Comply - The Trust Chair has served four years to date, with a further six years as a NED prior to that. The term ends in 2025 and it is understood that a process to recruit a new Chair is then required. Discussions have commenced with NHS England regarding this. At present, two of the NEDs have exceeded six years in post. However, in both cases their terms have been agreed with NHS England and no further terms will be issued upon expiry of their current terms.

Section C, 4.4 (NHS foundation trusts only)	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	N/A
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	Each member of the Board is subject to an annual appraisal. Each Committee of the Board produces an annual report, reporting delivery against annual work plan and objectives. The Audit Committee reviews the annual reports from Committees.
Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director	All Board members have an appraisal with agreed personal development plan.

	should engage with the process and take appropriate action where development needs are identified.	
Section C, 4.8 (NHS foundation trusts only)	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	N/A

Section C, 4.10 (NHS foundation trusts only)	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	N/A
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Requirement noted. The Nominations and Remuneration Committee undertakes succession planning for Director roles.

Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply – would adhere to this if ever required.
Section C, 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Induction programme and training offered to Board members.
Section C, 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	Comply – addressed within appraisal and mid year review processes.

Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply – available to all.
Section C, 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Induction programme and training offered to Board members.
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply – addressed within appraisal and mid year review processes.
Section C, 5.6 (NHS foundation trusts only)	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	N/A

Section C, 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	The Chair of the Trust ensures that directors receive information in a format they require and within a timescale that will allow sufficient time to prepare for the meetings. The Chair also allows sufficient time and opportunity for clarification questions to be asked in the meeting. Directors are also encouraged to seek clarification outside of the meeting in order to assist discussion at the Board meetings. There are opportunities to input to how the reports will be presented and the information they contain.
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	Comply – as above.

Section C, 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Appropriate papers and reports are presented to the Board of Directors. The Board has an annual business cycle which sets out the standard papers that will be presented to them, and the Board can also agree to receive a report on any matter if it requires. The Board of Directors will from time-to-time ask for information it requires to allow it to carry out its role and to be assured of performance. Any member of the Board of Directors can request any item to be reported to Board meetings and may also ask for this to be looked at in more detail in the Board sub-committee structure.
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The Board of Directors seeks assurance directly and through its committees via assurance and escalation reports. On occasions the Board and its committees invite senior staff to provide presentations to the Board. Non-Executive Directors can request external assurance as appropriate.

Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of nonexecutive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	All directors have access to professional independent advice at the Trust's expense (including legal advice and access to auditors).
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Committees are supported by the relevant executive director, senior manager/s and Trust staff.
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	This would be explored in appraisal and mid year review and be raised as a separate issue if this was not taking place. The non-executive directors will challenge the executive directors if papers are not sufficiently detailed or clear. The non-executive directors will use their skills and experience to challenge the decisions of the executive in an appropriate and professional manner having due regard to necessary standards of care required in such a role.

Section C, 5.16 (NHS foundation trusts only)	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.	N/A
Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	Comply – cover is renewed each year and overseen by the Company Secretary
Section D, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a	The Trust's Audit Committee comprises three independent non-executives and is chaired by a non-executive director with recent and relevant financial experience. The Trust Chair is not a member of the Audit Committee.

	whole should have competence relevant to the sector in which the trust operates.	
Section D, 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee	Comply – evidenced in the Audit Cttee annual report to June Public Board each year.

	composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.	
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should retender its external audit at least every 10 years and in most cases more frequently than this.	The Trust's external auditors were appointed in 2020. There are no concerns about the performance of the current auditors and there is a high level of experience of the systems in place at the Trust.

Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	**Explain** Although the Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports, work needs to be undertaken to develop this specific policy. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust. This provision has therefore been marked as non-compliant but the intent to comply confirmed and a policy will be developed during 2024/25.
Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients.	The Trust complies with the national guidance on VSM remuneration with respect to bonuses, and has paid these to some VSMs in some years – any decisions about this are made by the Nominations & Remuneration Committee.

	• Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	

Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Remuneration for the Chair and NEDs set in accordance with this guidance.
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	Has not arisen - requirement noted.
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Comply – should this ever be required.
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	The Nominations and Remuneration Committee has delegated responsibility for setting all executive director remuneration, and for other senior managers not covered by the Agenda for Change terms and conditions of service. This is evidenced in the Committee's terms of reference and the Standing orders and Standing Financial Instructions.

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

Provision	Requirement	Comply
Section C, 4.9 (NHS foundation trusts only)	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.	N/A
Section C, 5.7 (NHS foundation trusts only)	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	N/A

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.

Provision	Requirement	Comply
Section C, 2.9 (NHS foundation trusts only)	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	N/A

The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request.

Provision	Requirement	Comply
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	This is outlined in the Standing orders, standing financial instructions and scheme of reservation and delegation of powers which is available on the Trust's external website.

Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Statement on Board of Directors page on Trust's external website.
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	The terms of reference of the Nominations and Remuneration Committee are published on Board and Committee Governance page on Trust's external website.

Trust Board meeting held in public: 28 March 2024

Agenda item number: 2023-24 (134c)

Title: Declarations of interest and compliance with fit and proper person requirements made by directors for 2023/24

Category of paper: for information
History: Not applicable

Responsible director: Chief Executive
Report author: Company Secretary

Executive summary (Purpose and main points)

Board members: declarations of interest

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

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

In February 2024, all directors were asked to review and update their declarations of interest and a schedule of disclosures for 2023/24 is Appendix 1 to this report.

Board members: fit and proper person requirements

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

Following the 2019 Kark Review of the original Fit and Person Test, a Fit and Proper Person Test (FPPT) Framework was introduced in Summer 2023 with the aim of strengthening and reinforcing individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. The new framework introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The regulations require directors to:

- be of good character
- have the necessary qualifications, competence, skills and experience
- be able by reason of their health (subject to reasonable adjustments) to properly perform tasks intrinsic to the position
- not have been responsible for, contributed to or facilitated any serious misconduct or mismanagement while carrying out a regulated activity
- not to be unfit to hold office on a range of grounds (eg undischarged bankruptcy, criminal convictions, inclusion on barred lists, serious misconduct in the course of carrying out a regulated activity etc).

During February 2024, all directors have provided a self-attestation to confirm that they are in adherence with the FPPT requirements. In addition, annual checks have been conducted to confirm former satisfactory background checks are still current, these include

Google and social media searches, health and social care regulators' checks, disqualified directors, insolvency and bankruptcy registers. The checks have also been applied to the interim directors who have joined the Board since the framework went live in September 2023, and Board Member References have been supplied for departing directors since that date.

Independence of Non-Executive Directors

All NEDs are regarded as independent, evidenced through the Board's Register of Interests, Board & Committee minutes, and their individual annual appraisals.

Recommendations

- Note the declarations of interest made by directors for 2023/24.
- Note that the Trust is fully compliant with the Fit and Proper Person Test and Framework as at the date of this report.
- Note the statement regarding the independence of Non-Executive Directors.

Leeds Community Healthcare NHS Trust
Director's declarations of interests for disclosure 2023/24
TRUST BOARD

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Brodie Clark CBE (Trust Chair)	None	None	None	None	None	None	None	None
Thea Stein (CEO until 31 August 2023)	None	None	None	Trustee of Nuffield Trust CQC Executive reviewer	None	None	None	None
Sam Prince (Interim CEO from 1 September 2023)	None	None	None	None	None	None	Justice of the Peace – England and Wales (North and West Yorkshire)	None
Helen Thomson Deputy Lieutenant for West Yorkshire	Helen Thomson Ltd	Director Helen Thomson Ltd	None	Trustee: Sue Ryder	Trustee: Sue Ryder	None	None	None
Alison Lowe OBE	Blue Light Commercial from 1 May 2022	None	None	Trustee, Together Women	Trustee Citizens Advice Leeds	None	Deputy Mayor for Policing and Crime in West	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
				Trustee Citizens Advice Leeds	Trustee, Together Women		Yorkshire from 9 August 2021	
Richard Gladman	Director of Verbena Digital Ltd	Verbena Digital Ltd - Owner	Verbena Digital Ltd	Non-Executive Director Humber and North Yorkshire Integrated Care Board	None	None	None	None
Professor Ian Lewis	None	None	None	Trustee: Rossett School, Harrogate (until March 2024)	None	None	None	None
Khalil Rehman	NED @ Salix Homes Ltd Director, TSI Caritas Ltd NED @ University of Central Lancashire (UCLAN)	None	None	Director @Medisina Foundation Ltd Non-Executive Director East Lancashire Hospitals NHS Trust	Consultancy/ Advisory work for Touchstone Support Ltd	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Rachel Booth (Associate Member)*	None	None	None	None	Full time employee of BUPA which holds some NHS contracts in its care homes, dental and hospital businesses in the UK.	None	None	None
Andrea Osborne (Interim Executive Director of Finance and Resources from 5 February 2024)	None	None	None	None	None	None	None	None
Dr Ruth Burnett	None	None	None	Medical Director Leeds GP Confederation Performs GP work at Crossley Street Surgery, Wetherby on an unpaid basis as	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
				part of Continuing Professional Development and maintaining registration. Facilitator Windsor Leadership Trust				
Steph Lawrence MBE	None	None	None	Executive Director of Nursing and AHP's for Leeds GP Confederation. Fellow of Queen's Nursing Institute. Working two days per month for Queen's Nursing Institute on a voluntary basis from 1 March 2024.	None	None	None	Formal dinner provided by a local university £50 12 October 2023

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

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Andrea North (Interim Director of Operations from September 2023)	None	None	None	None	None	None	None	None
Bryan Machin (Executive Director of Finance and Resources until 31 July 2023 then Interim Executive Director of Finance and Resources from 1 November 2023 to 2 February 2024)	None	None	None	Trustee and Vice-chair of St Anne's Community Services. (Registered Charity, Housing Association and Company Limited by Guarantee) Non-Executive Director Bradford Teaching Hospitals NHS Foundation Trust – From December 2023	Zero hours contract with Community Ventures Management Ltd (any financial arrangements with Community Ventures or any affiliated company will be undertaken by Cherrine Hawkins, Deputy Director of Finance)	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Yasmin Ahmed (Interim Executive Director of Finance and Resources from 26 June to 25 December 2023)	None	None	None	None	None	None	None	None

***** Non-voting Board member

Trust Board Meeting Held in Public: 28 March 2024

Agenda item number: 2023-24 (134d)

Title: Risk Appetite Statement Annual Review

Category of paper: for approval
History: TLT 13 March 2024

Responsible director: Chief Executive
Report author: Risk Manager

Executive summary (Purpose and main points)

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

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

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

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

TLT was asked to review the current statement (attached, with changes highlighted in yellow) and indicate any changes, paying particular attention to:

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

TLT discussed the risk levels set out in the risk appetite statement. TLT agreed the following changes after taking into consideration the new strategic goal relating to equity and the Quality and Value programme:

1. Expansion of the risk appetites in relation to delivery of care and meeting financial duties to within a range of minimal to cautious for taking controlled risks. This recognises that uncontrolled risks will not be taken, and patient care will not be put at risk but provides greater scope for opportunities to be taken without compromising care.

   Definitions of minimal and cautious risk appetite are provided below:

   a. Minimal – (As little as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential
   b. Cautious - Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.

2. Inclusion of a risk appetite for the fifth strategic goal (equity). The statement reflects the existing appetites for taking controlled risk in relation to innovation (open) and delivering outcomes (cautious) through an equity lens.

Recommendations

The Board is recommended to:

- Review and approve the risk appetite statement

Trust Risk Appetite Statement

1. Introduction

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

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

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

2. Use of the Trust risk appetite

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

A risk score higher than the preferred risk appetite may be agreed by the Trust Leadership Team in certain circumstances, for example where external circumstances prevent a risk being reduced in the short term. The rationale and approval will be formally documented and regularly reviewed.

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

3. Risk appetite statement

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

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

RISK APPETITE STATEMENT

Strategic Goal: Work with communities to deliver personalised care

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

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

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

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

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

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

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

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

Strategic Goal: To use our resources wisely and efficiently

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

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

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

Strategic Goal: To embed equity in all that we do

The Trust is committed to promoting equity in access, experience, and outcomes. The Trust has an ***open*** **(high)** risk appetite for collaboration with people and communities to ensure their experience influences equitable approaches to change, such as for the Quality and Value Programme.

Priority will be given to changes that protect equity and the Trust has a ***cautious*** **(moderate)** risk appetite for risk that may compromise the delivery of outcomes but are inclusive of an equity focus.

Reputation

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

4. Risk Appetite Target Scores

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

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

Leeds Community Healthcare NHS Trust

Trust Board meeting held in public: 28 March 2024

Agenda item number: 2023-24 (135)

Title: Register of sealings December 2023 to March 2024

Category of paper: for information
History: N/A

Responsible director: Chief Executive
Report author: Company Secretary

Executive summary (Purpose and main points)

In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal.

The corporate seal had been used twice in February 2024 and a copy of a section of the register is presented to the Board**.**

Outcome: the Board:

- noted the use of the corporate seal.

Register of affixing of corporate seal and signatories to legal documents

OCCASION	PARTIES INVOLVED	DOCUMENT APPROVED & SEAL ATTESTED BY	DATE
Lease (renewal): Heather Ward, Wharfedale Hospital	Leeds Community Healthcare Leeds Teaching Hospitals Trust	Interim Chief Executive and Interim Executive Director of Operations	02.02.2024
Lease (renewal): Bilberry Ward, Wharfedale Hospital	Leeds Community Healthcare Leeds Teaching Hospitals Trust	Interim Chief Executive and Interim Executive Director of Operations	02.02.2024

Trust Board Meeting Held in Public: 28 March 2024

Agenda item number: 2023-24 (138i)

Title: Learning and Development Strategy 2024-2029

Category of paper: For approval
History: TLT 6 March 2024 Quality Committee 25 March 2024

Responsible director: Executive Director of Nursing and Allied Health Professionals

Report author: Head of Clinical and Professional Development

Executive summary (Purpose and main points)

This paper provides an overview of the proposed Learning and Development Strategy 2024-2029 for consideration and approval.

The Strategy has been developed in consultation with staff and revised following feedback from senior leaders. Four key action areas emerged, along with 6 themes that run as golden threads throughout each of the action areas.

The Strategy, named by staff as 'Love to Learn' reflects the necessity to strengthen our current learning and development offer by gaining a better understanding of the breadth of activity that takes place across the organisation and ensuring a robust infrastructure is in place to provide both support and appropriate governance. This initial focus will allow us to establish the solid foundations on which to continue to build.

Love to Learn reflects the financial climate in which we operate and seeks to maximise the impact of every pound we spend on learning and development through establishing clear systems and processes for capturing, evaluating and sharing learning to maximise our return on investment.

Recommendations

- **Review and agree the content of the Learning and Development Strategy 'Love to Learn', and the associated operational plan**

1. Introduction

The Learning and Development Strategy 2024-2029 has been developed following extensive engagement and consultation with staff from across the organisation and therefore reflects what is important to them.

This consultation made it clear that staff valued learning and development, though there were areas that we needed to work on as they weren't meeting needs. This was important to establish a solid foundation on which to build and realise our ambitions.

Engagement with staff also showed they unanimously felt the Strategy should include all staff groups and not be just for clinical staff, and that it needed to feel relevant for staff within services and they therefore suggested it should be called 'Love to Learn'.

2. Love to Learn

Following engagement 4 key action areas emerged:

1. Lifelong Learning
2. Learner support
3. New roles including apprenticeships
4. Statutory and mandatory training

These are crucial for developing the workforce we need now and in the future, and for maximising opportunities for learning by building a culture of continuous learning.

3. Golden threads

A number of themes also emerged and it was identified that these were common themes across all of the action areas. These have therefore been included as 'Golden Threads':

a) Equality and diversity
b) Leadership development
c) Partnership working
d) Increasing use of technology and digital solutions
e) Supporting recruitment and retention
f) Quality and value

To simplify the language of Love to Learn these golden threads have not been mentioned explicitly in each of the actions, and therefore all actions must be considered with the golden threads in mind to understand the breadth and ambition of the action as these are implicit throughout. For example the actions do not repeatedly state we will work in collaboration with system partners as that is implicit from the golden thread; similarly it does not repeatedly state we will seek digital solutions as that is a golden thread etc.

4. Recommendations

Quality Committee is recommended to:

- Review and agree the content of the Learning and Development Strategy 'Love to Learn' and the associated operational plan prior to it being submitted to the Trust Board

Leeds Community Healthcare NHS Trust

"Love to Learn"

Our Learning and Development Strategy 2024 – 2029

Purpose

Leeds Community Healthcare NHS Trust vision is:

"We provide the best possible care in every community."

A key component to achieving this is through valuing our workforce and promoting a culture of continuous learning. This not only supports our staff but also puts development and improvement at the heart of everything we do.

LCH describes a Culture of Continuous Learning as an ongoing process, encouraging all staff to increase their knowledge, and to develop new skills to respond to changing needs.

It's a culture where every opportunity for learning is utilised through using both traditional and non-traditional learning approaches, for example learning from feedback, safety investigations, reflective practice, mentoring and supervision (see appendix 1 and 2).

Learning is embedded across the Trust at individual, team, service and organisational levels.

Love to Learn has been developed following extensive engagement with staff and services to ensure it addresses the needs of staff while supporting the Trust in its strategic ambitions. This strategy is for all staff, those providing direct clinical care and those supporting them to provide the best possible care in every community today and tomorrow. It is acknowledged that different professional groups do have different needs, and these will be reflected in the overall approach.

Love to Learn aims to be aspirational, and to achieve some of the ambitions it is necessary to first ensure we have the right foundations on which to build. As such, this strategy sets a clear direction of travel for the Trust for the coming years describing the priorities which will determine the actions, and resources required to deliver our goal. It builds on the achievements of the previous Learning and Development Strategy and takes account of the changes in the national and regional priorities.

The NHS Long Term Workforce Plan (2023) highlights several priorities for learning and development to support staff from early career through to retirement. Similarly, the importance of learning and development in recruiting and retaining staff is emphasised in several national initiatives designed to fill workforce vacancies, particularly in nursing and non-registered roles. A focus on practice learning, preceptorship, apprenticeships, and career development is evident in the national context and this is reflected within this strategy.

Love to Learn should be seen alongside several key Trust strategies and policies all contributing to developing and delivering our stated learning culture. Some of these are:

- Workforce Strategy 2021 – 2025
- Personal and Professional Development Policy (under review)
- PL369 Preceptorship Policy (including Primary Care) 2021- 2024
- Research and Development Strategy 2020-2025
- Quality Strategy 2021- 2024

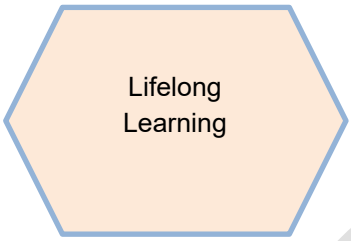
Our Goal

"To ensure our workforce community is able to deliver the best possible care in all the communities we work with".

Love to Learn aims to be aspirational and each action area is underpinned with the Trusts vision, values and behaviours. The goal and priorities identified will help shape conversations as we continue to develop our culture of learning.

To help us achieve our goal we have identified four areas of action to inform priorities and allocation of resources to meet the needs of the populations we serve.

Alongside the strategy will be the associated operational plan, which provides a clear indication of how we will work towards our goal over the next 5 years.



Four areas of action

1. **Lifelong Learning:** Lifelong learning is about ensuring our staff are equipped with the appropriate skills and knowledge to work safely and are supported to grow, develop, and realise their potential throughout their career.

2. **Learner Support:** The provision of excellent, quality assured learner experiences for all learners within the

Trust. Learners include apprentices, students attending university and similar

programmes, T Levels, work experience etc.

3. **Development of New Roles including Apprenticeships:** Development of new roles in line with Trust and local and national business plans which includes maximising opportunities to 'grow our own' through the use of both clinical and non-clinical apprenticeships wherever possible.

4. **Statutory and Mandatory Training:** The provision of required statutory training and training essential for staff to perform their role safely.

Our Approach

Underpinning our 4 areas of action are our "golden threads" which run through the strategy and operational plan. Staff engagement in developing this strategy identified that staff wanted to engage with the strategy and it therefore needed to be as accessible as possible, including the use of plain English.

Therefore, these golden threads, while they may not be explicitly stated within each activity are recognised as essential to achieving our goal and are implicit within each action.

Golden Treads

- **Equality and diversity**: We will ensure there is equity in access to learning and development, regardless of their abilities, background or lifestyle and appreciate our differences, respecting values, beliefs, cultures, and lifestyles when delivering our strategy.
- **Leadership development**: We will ensure that the strategy supports the Trust Development Plan.
- **Partnership working:** We will maximise opportunities to work with our partners across the health and social care system, sharing learning and making best use of finite resources.
  Our partners include:
  - Leeds Health and Social Care Academy and their constituent groups,
  - Leeds Local Authority,
  - West Yorkshire Health and Care Partnership,
  - Educational providers
  - Other local and national specialist organisations for example Queens Nursing Institute.
- **Increasing use of technology and reducing digital exclusion:** We will develop new ways of delivering learning and development, building on current and new technologies.
- **Supporting recruitment**: Our learning and development will support how we recruit and retain staff
- **Quality and value**: We recognise the financial constraints in which we operate and will make the best use of the resources we have in order to maximise opportunities while maintaining quality.

Reporting and Governance

To achieve the goal set out in ***Love to Learn*** an associated operational plan has been developed which outlines the specific actions required to delive the agreed priorities.

The operational plan includes specific measures/deliverables or key performance indicators (KPIs). The Operational Plan will be reviewed annually and reported via the Trust's Quality Committee. It will be updated as action progresses, or new issues identified requiring action.

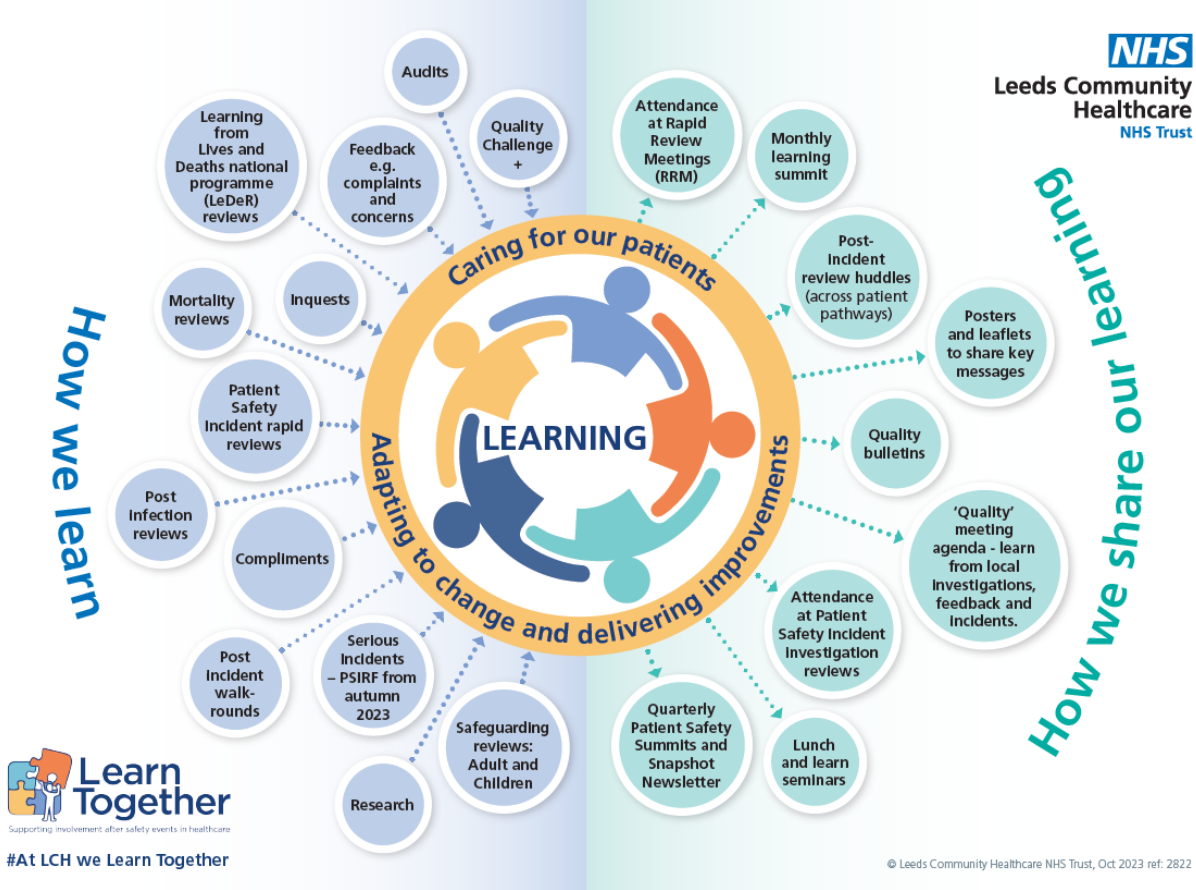
The Learning and Development Steering Group, led by Head of Clinical and Professional Development, will be responsible for monitoring delivery of the operational plan. The group will escalate issues that may affect the plans delivery through reporting to the Trust's Quality Assurance and Improvement Group (QAIG) and Quality Committee.

Appendix: 1

How we learn: a wide variety of approaches is needed to suite different learning styles and needs

Appendix: 2

How we learn: Demonstration how clinical governance supports learning and sharing to help ensure the provision of the best possible care



Appendix 3

Achievements of Learning and Development Strategy 2020 – 2023

Implementation of the 2020-2023 Learning and Development Strategy was impacted the Covid-19 pandemic and subsequent workload pressures as the focus and priorities of clinical staff was on delivery of frontline services. Nevertheless, significant progress was made on aspects of the strategy albeit at a slower pace than planned.

1. Student and Learner Support

PRIORITY AIM: The provision of excellent, quality assured educational experiences for the students and learners within the organisation

WHAT DID WE PLAN TO ACHIEVE	ACHIEVEMENTS
a) Increased numbers of student mentors, practice supervisors and practice assessors in the organisation to provide high quality placements for students and learners b) Enhanced engagement with final year nursing students to attract them into community roles c) Students and learners within the organisation have high quality learning experiences in the organisation	• Successful system wide bid to support expansion of placement capacity including • Appointment of Practice Learning Facilitator (PLF) to work across LCH and Primary care – opportunity to introduce shared placement models • Additional PLF post agreed Q3 2022. This increased capacity will support expansion of placement capacity, support learners and mentors and quality assure placement areas • Throughout 202/221 focus on reopening placements closed due to Covid19 and new ways of working. • Alternative models of placement support are being used to some effect e.g. virtual placements and blended approaches are being tested with some success. • Work undertaken to ensure consistency in approach and support between Nursing and AHP students leading to an increase in AHP placements. • A support package developed for final year nursing students who chose to undertake an extended placement with the Trust. Majority of these students secure roles in LCH on qualifying • PLF has developed readily accessible electronic resources to support both staff and learners and promote quality placements. Includes learning materials that cover professional body standards, development of a Placement Charter and processes for supporting AHP students • Introduction of student forum to bring together learners from across the Trust and learn what's working well and where changes are needed. • Formal learner feedback is overwhelmingly positive. Isolated cases where experiences could have better have been acted on immediately • The types of learners supported within LCH have increased and include larger numbers and types of apprentices, T level students and internationally educated learners.
d) Expansion of the preceptorship programme	• Preceptorship Programme evaluated and a number of changes made to ensure relevant for all, with scope to tailor

to provide a multidisciplinary programme available to all clinicians joining the organisation e) Continual evaluation of the preceptorship programme in line with national HEE guidance	it to individual needs. • Preceptorship Policy re-written to reflect changes • The revised programme was launched Q4 2021/2 • Continued engagement and feedback from services led to a further revision of the programme in Q3 22/23. This programme is evaluating very well and a wider mix of staff and services are represented. • Self assessment undertaken against the National Preceptorship Framework for Nursing and meeting the majority of the standards

2. Statutory and Mandatory Training

PRIORITY AIM: Staff will have access to training that is essential for their role being delivered in an efficient and effective way

WHAT DID WE PLAN TO ACHIEVE	ACHIEVEMENTS
The organisation will effectively and efficiently deliver the core statutory and mandatory training	• The Mandatory and Statutory Compliance Project (MaST) to map training content to the national Core Skills Training Framework and to specify staff groups it applies to is now complete across all subjects and has been signed off by the Audit Committee. • Training being mapped to specific staff groups means that numbers requiring training are more accurate, allowing better planning of sessions • A number of training topics were changed from face to face to e-learning, virtual or blended approaches during the pandemic. Where these have worked well the alternative form of delivery has been kept or options introduced. This has resulted in training that is more accessible and timely while also reducing travel time and expenses. • Where appropriate trainers are delivering sessions locally e.g. Police Custody Suites

3. Learning Needs Analysis (LNA)

PRIORITY AIM: A clear and continuing understanding of the evolving learning needs of the organisation to deliver safe and effective services

WHAT DID WE PLAN TO ACHIEVE	ACHIEVEMENTS
a) We will have a clear understanding of the learning needs of staff within the Organisation b) Business Units and corporate teams will regularly analyse their operational plans to inform our learning needs of our clinical staff and corporate support staff c) High quality Appraisal discussions with inform the LNA process linked closely with our resourcing needs. Priority will be given to training in our hard to fill roles	• The approach to undertaking an LNA has evolved over the period of this Strategy and is becoming more robust with each iteration. • A regional approach to LNA has now been developed, and while the primary aim of this is to inform commissioning of University led programmes it also has the benefit of identifying common needs and potential benefits of working with local organisations to release economies of scale. • The regional approach is supplemented by review of learning and development activity that has been funded by LCH • The Leeds Health and Care Academy completed work looking at common training needs across providers to agree which will be commissioned centrally and explore alternative ways these needs may be met. • Significant work has now been completed to establish the learning and development needs of Neighbourhood Clinical Assistants (NCA's) in line with their developing role, along with the introduction of a new Senior NCA role. A comprehensive programme of education and skills development has been established for both roles. • Updated appraisal toolkit developed with checklist that includes development needs

4. Continuing Professional Development

PRIORITY AIM: Support for staff to continually develop in their role through formal courses or experiential learning opportunities, underpinned by appraisal discussions and a talent management approach

WHAT DID WE PLAN TO ACHIEVE	ACHIEVEMENTS
a) Budgets for learning and development will be centralised so organisational and business priorities are supported. This will include the new CPD monies b) We will have access to courses required to develop our staff to support the local and national strategic aims and objectives c) Leaders will be skilled in having talent management conversations underpinning appraisal discussions	• Several different budgets for staff development/training across the organisation centralised in April 2021 • One point of access and simplified funding request form implemented. • This single process means it's easier for staff and facilitates analysis of spend across services and professions, and informs the Trusts LNA • To date no application for funding has been turned down • Staff intranet page developed as single place to access anything related to learning and development. This 'Love to Learn' page provides information and links to resources and more information – previously had to search through different teams/ services pages. Feedback to date has been positive and we will continue to develop the site and its content. • Work commenced to establish clear career pathways and progression routes for staff working in clinical roles. This will help to ensure parity in level of responsibility and educational requirements across all roles and services, while also supporting recruitment and retention. • Appraisal toolkit launched with resources to support staff and managers in undertaking appraisals.

5. Apprenticeships and Development of New Roles

PRIORITY AIM: Support for staff to continually develop in their role through formal courses or experiential learning opportunities, underpinned by appraisal discussions and a talent management approach

WHAT DID WE PLAN TO ACHIEVE	ACHIEVEMENTS
a) Clinical apprenticeships are informed by our workforce plans and linked with appraisal discussions b) Non-clinical apprenticeships are accessible for staff in the organisation	• Apprentice Lead appointed to support establishing the systems, processes and infrastructure to expand our apprenticeship provision and make best use of the levy • The Trust has consistently underspent on the apprenticeship levy since it was introduced in 2015. In 2022 for the first time all of our apprenticeship levy funding was allocated, and it is projected that this will continue. • An increasing number and range of clinical apprenticeships supported – from entry level through to senior roles (details on request) • Worked with operational colleagues to agree consistent and equitable process for supporting apprentices. Workforce needs identified and forecast of numbers and types of apprenticeships agreed • 5 apprentices have completed the Registered Nurse Degree Apprenticeship and are now working as staff nurses in our services. A further 7 are due to qualify by and of Q4 2022/3 • Entry level apprentice role introduced in Neighbourhood Teams to support recruitment of local people. This is being expanded to include admin roles

Trust Board Meeting Held in Public: 28 March 2024

Agenda item number: 2023-24 (139i)

Title: Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

Category of paper: For assurance
History: last reviewed by Quality Committee 25 March 2024

Responsible director: Executive Director of Nursing and AHP, DIPC

Report author: Deputy DIPC and Head of IPC

Executive summary

The Infection Prevention and Control BAF provides assurance that Leeds Community Healthcare (LCH) is compliant or partially compliant with the criterion as outlined in the newly revised Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022). The purpose of the document is to ensure that patients who use Leeds Community Healthcare NHS Trust services receive safe and effective care. It is paramount that effective prevention of infection must be part of everyday practice within LCH and be applied consistently by everyone.

Recommendations

The Board is recommended to note the contents of this board assurance framework and the paramount importance of infection prevention.

Infection Prevention and Control Board Assurance Framework (BAF)

1 Introduction

'Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care.' This updated version of the infection prevention control board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The purpose of the framework is to provide assurance to the board on the compliance with the updated version of the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022).

2 Background

During Covid a BAF was presented to Quality Committee and the board providing assurance on compliance with specific control measures for the pandemic. This version of the BAF is fully updated to reflect the ten criterion of the code of practice which was revised in 2022.

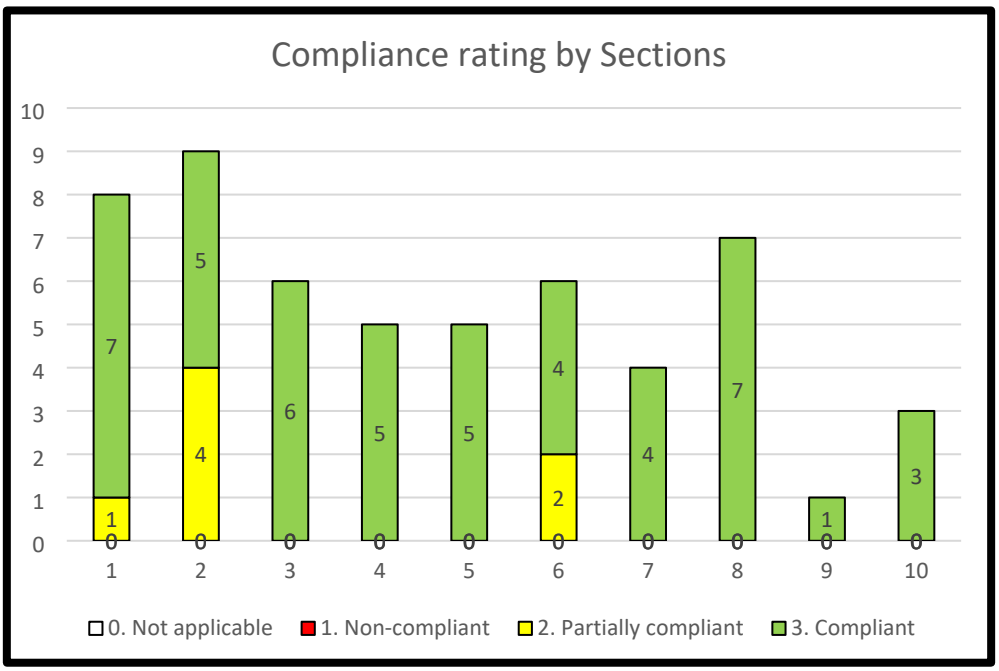
3 Current position/main body of the report

The document provides information on the identified Key Lines of Enquiry (KLOE) and provides assurance of the specific measures that LCH have in place to control the spread of infection.

4 Impact:

4.1 Quality

The majority of elements are fully compliant. There are some areas highlighted as 'partial compliance' however there are mitigating plans in place.



4.2 Resources

Non identified.

4.3 Risk and assurance

Identified elements of partial compliance are highlighted in the document and are as follows;

- They implement, monitor, and report adherence to the National Infection Prevention and Control Manual (NIPCM) – process in place to update all relevant policies that link to the NIPCM as and when policies and guidelines are due for review – this is over a rolling programme for the policies it is applicable to.
- There is evidence of compliance with National cleanliness standards – assurance required from external providers e.g. Leeds City Council, Ministry of Justice etc. This continues to be an area of non-compliance and a short life working group is in place led by LCH estates and facilities to seek further assurance from external providers in relation to cleaning. Previously escalated to the Health and Safety Group (HSG) (Feb 2024).
- That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept – provision in place to continue fit testing relevant clinical staff inline with A-Z of pathogens, locally held excel document in IPC however more robust mechanism being sought e.g. PIP for greater assurance and data metrics.
- If clinical staff undertake procedures that require additional clinical skills there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records – this requires further collaborative work with the Clinical Education Team / Clinical Leads. An example of this would be assurance around aseptic technique or catheterisation.

See appendix 1 for all identified gaps in non-compliance and identified risks as well as a further detailed outline in the excel document.

5 Next steps

Review the IPC BAF on a quarterly basis and for the contents of the document to be highlighted at the IPCG. Escalations to be raised at QAIG and for Quality Committee to receive this document on a six monthly basis.

6 Recommendations

The Board is recommended to note the contents of this document for assurance.

Appendix 1:

Key line of enquiry (partial compliance)	Risk of partial compliance	Mitigation
1.4 They implement, monitor, and report adherence to the NIPCM. (National Infection Prevention and Control Manual.	Minimal risk due to current policies being in place that cover the entirety of the NIPCM.	To be implemented as part of Annual Plan for 2023-24 / 24-25 with gradual rolling plan of adding reference to policies.
2.1 There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	The being that we do not have full assurance from external partners on cleaning activity for example: Leeds City Council for St Georges and Ministry of Justice at Wetherby Young Offenders.	Continuation of short life working group to be in place with Estates to discuss assurance from external partners and areas of concern that are escalated from IPC Environmental and Cleaning Audits.
2.4 There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	This is with specific reference to the water coolers within LCH premises.	This is in reference to the internal mechanics of the device that require flushing through via external contract. Health and Safety Group aware and this is being led on by Estates and Facilities. Mitigation is that the outer of the machine is cleaned and that there is water testing in place.
2.5 There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	The risk being that we are unaware of some of the planned maintenance with external partners, which may impact compliance with HTM in the Built Environment as well as provision of services.	This is now in place for LCH premises and is listed on the agenda for the IPCG. Audits are shared by IPC to Estates and Facilities – non-compliant areas reaudited 3 monthly.
2.7 The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	The Waste Policy is in place and LCH are in the process of moving to a new tender for the Waste Contract. We are compliant with the majority of this KLOE apart from the correct waste streams being in place. We have a legal responsibility to ensure compliance with this standard.	There is a planned timescale on adopting the new waste streams with a Waste Manager in post within LCH.

6.5 That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	A rolling training programme is made available for staff who require fit testing for FFP3. Inaccuracy in the detail of the fit testing record due to it being stored on an excel document, for example if staff leave or are on long term sick. We would meet compliance with HSE, however NHS England recommended during the Covid-19 pandemic for this to be stored on a programme such as ESR.	A locally held excel document is stored within IPC, however it does not provide individuals or teams the ownership.
6.6 If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	There is a risk about the assumption that staff are not having regular updates or checks to ensure practice is inline with current evident base. There is also a concern that due to limited assurance there is a concern that we are not able to prevent avoidable HCAI's e.g. accurate aseptic technique, insertion and maintenance of catheters.	Staff self-declare competencies and work in an autonomous manner under their relevant codes of practice. Bespoke training can be provided by specific teams such as CUCS, CVAS and IPC.

National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff and others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

N.B. Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

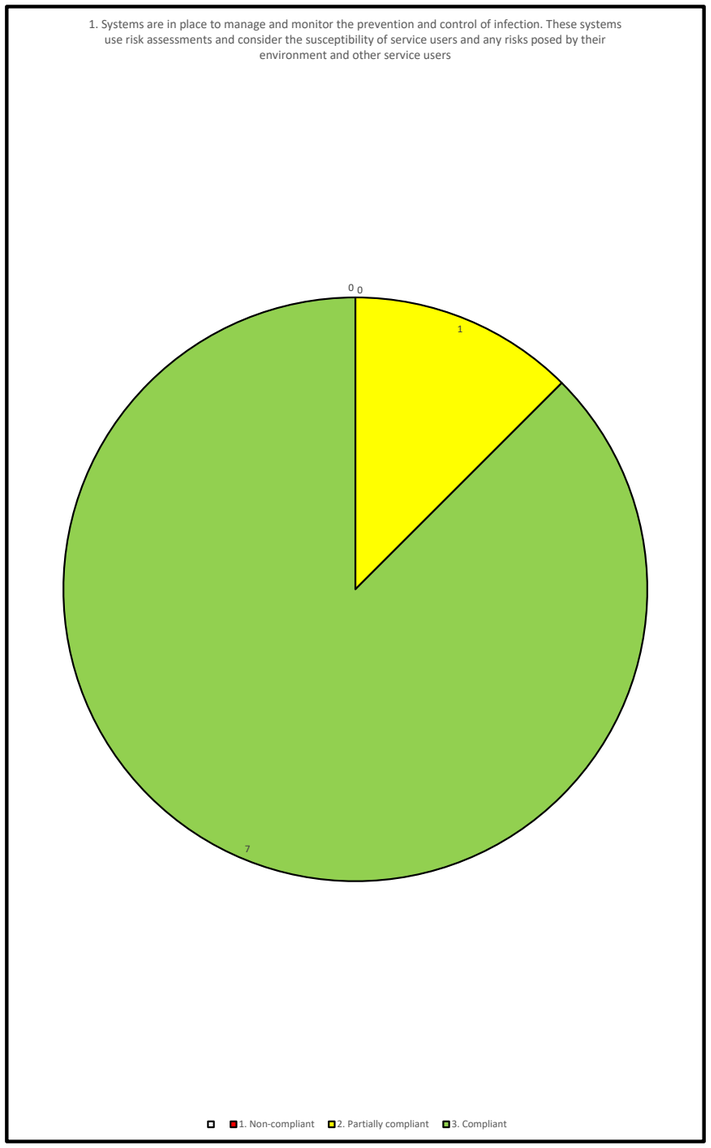
Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by

Links

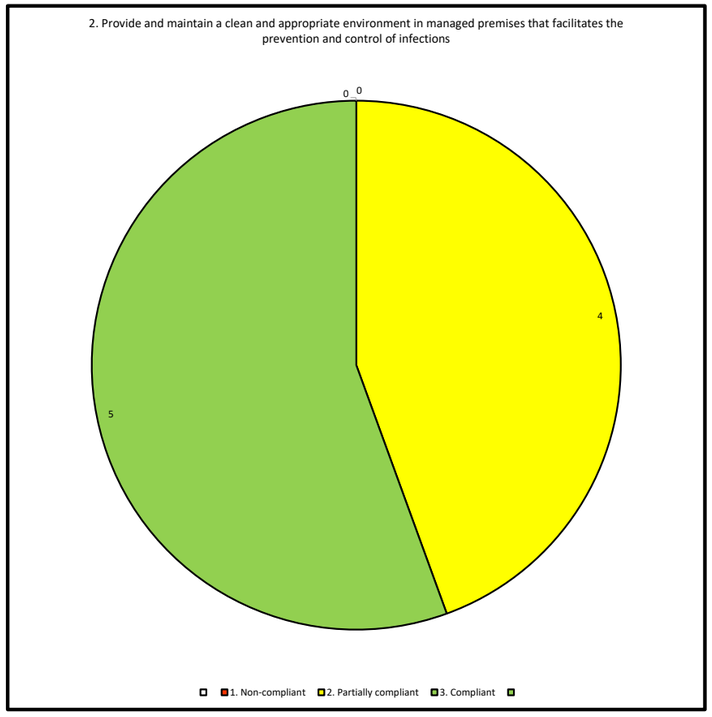
Section 1	
1.4	NIPCM
1.6	NICPM
	Primary care, community care and outpatient settings,
1.8	Acute inpatient areas
	Primary and community care dental settings
Section 2	
2.1	National cleanliness standards
2.2	Patient-Led Assessments of the Care Environment (PLACE)
2.4.1	HTM:03-01.
2.4.2	HTM:04-01
2.5	HBN:00-09
2.6	HTM:01-04
	NIPCM
2.7	HTM:07:01
	HTM:01-01
2.8	HTM:01-05
	HTM:01-06
Section 3	
3.2	UK AMR National Action Plan
3.3	UK AMR National Action Plan.
	NICE Guideline NG15
3.4	TARGET
	Start Smart, Then Focus
Section 5	
5	NIPCM
Section 6	
6.2	Roles and responsibilities
Section 7	
7	NIPCM
Section 9	
	UKHSA
9	A to Z Pathogen
	NIPCM

Infection Prevention and Control board assurance framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	There is a robust governance structure where a quarterly IPCG is held, escalations from this meeting feed into QAIG, upwards to Quality committee and then the board. The DIPC is the Executive Director of Nursing and AHPS and the Deputy DIPC is the Head of IPC. Terms of Reference are in place and this is reviewed annually. The Infection Prevention and Control (IPC) programme for 2023/24 to be disseminated in Quarter (Q) 1 discussed and updated quarterly at the IPC group (IPCG) outlining collective responsibility for keeping to a minimum the risks of infection and general means by which it will prevent and control such risks Programmed actions to involve all staff members and services within the Trust not solely members of the IPC team. There is an Overarching Policy in place detailing the roles and responsibilities of the organisation inline with the Health and Social Care Act code of practice (2022) and has been updated in February 2024.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	PPM+ provides monitoring intelligence for community IPC. Relevant policies in place for the Management of Outbreaks in the Community Setting. 7 day provision of IPC to provide SME advice. Engagment with UKHSA for specific infection outbreaks. Escalation process outlined in the IPC Overarching Policy. Communicable				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Use of Datix is embedded across the organisation, with specific entry points to capture IPC incidents such as sharps incidents and environmental issues. IPC have a process in place to monitor datix on a daily basis and a flow chart that coincides with the policy around sharps management. IPC education events and champion sessions promotes use of Datix and there is an organisational culture of promoting reporting of incidents. Plans in place across the organisation to implement PSIRF, there is an identified patient safety specialist for IPC. Deputy DIPC chairing improvement group for sepsis and deterioration.				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Current policy pack in place that incorporate the detail of the NIPCM and references the content across LCH IPC Policy suite. The current policy manual outlines all relevant criteria as detailed in the Health and Social care Act. Overarchin Policy references NIPCM (2022) and H&SC Act (2022).	Embedding of Transmission based precautions throughout education and training.	Staff undertake Level 1 and Level 2 ESR Training. We are looking to develop some seasonal communications to appropriately risk assess for TBP's.	To be implemented as part of Annual Plan for 2023-24 / 24-25.	2. Partially compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	PPM+ provides surveillance of MRSA, CDI, GNBSI data, a process is in place for IPC to complete appropriate Post Infection Reviews of specific HCAI's. All outbreaks in inpatient areas such as Wharfdale would be escalated to the DIPC and the Managagement of Outbreakspolicy would be followed, including reporting to UKHSA. Further detail outlined in the Overarching Policy. Escalation and reporting via the IPCG and quarterly to QAIG.			PPM+ platform under review as to how effective this infratructure is. LTHT have moved to a new platform: ICNet and this will be reviewed internally as to whether it can be considered as an effective surveillance system for the community.	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Hand hygiene, environmental, mattress and cleaning audits are completed throughout LCH. MEG is the electronic auditing platform that captures the relevant information and provides assurance of compliance. This is recorded as part of the quarterly IPCG and escalations are made to QAIG where there are notable concerns. Goverance process detailed in the Overarching Policy.			New Hand hygiene Audit tool rolled out in October 2023. Results from teams across LCH consistently record at 100% which does question the validity of assurance. Further consideration to be given to an AI method of measuring compliance.	3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Staff receive training as part of induction programme which covers the core fundamental basics of IPC. All staff then undertake statutory and mandatory training as part of E-Learning for Health and the attendance figures for locations are monitored and recorded as part of IPCG and HSG. any concerns escalated to Clinical leads Via Clinical Leads Meeting and QAIG.				3. Compliant

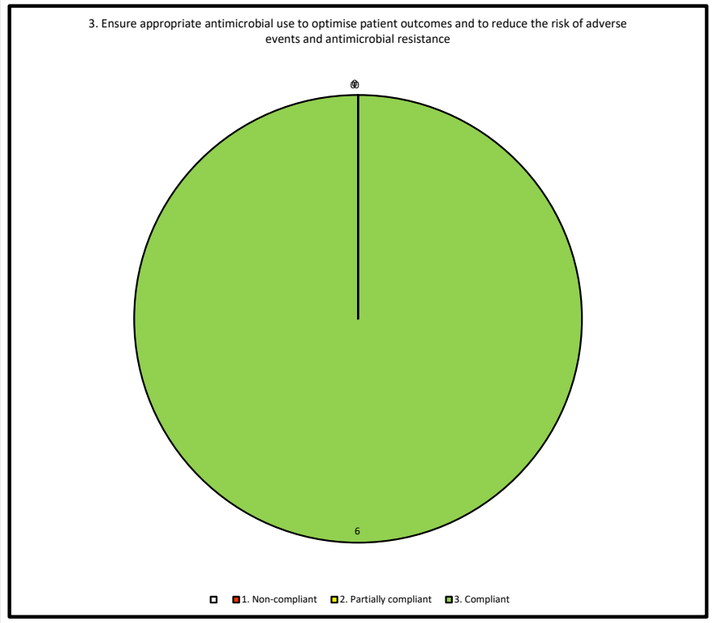


1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	IPC support teams with risk assessments where required for example for specific infections e.g. CPE in an inpatient setting. Specific risks discussed via IPCG where an action log is in place.	This KLOE is compliant however to note the following to improve assurance: Formal logging of risk assessments needs to be captured with a more robust system in place.		IPC team have supported with localised training at Wharfdale on localised issues.	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	The National Cleaning Standards were implemented in November 2022. Monitoring of standards is in place and this is led by the Domestic Services manager. 'Scores on the door' in place and escalation of concerns is identified through IPCG and HSG, with an action log in place. Reports to come via IPCG from Domestic Services Manager. Environmental audits capture areas of non compliance. Working group in place for implementation of standards.	Assurance required from external partners such as WYOI, LCC, Adel Beck, Custody Suits etc. Cleaning Policy to be ratified - currently being completed by LCH Estates and Facilities Team.	Continuation of short life working group to be in place with Estates to discuss assurance from external partners and areas of concern that are escalated from IPC Environmental and Cleaning Audits.		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE inspections are undertaken every September. Inspection team in place and external inspectors have been recruited. Action plans and report shared Q1 of fiscal year and shared with DIPC. Escalations taken to QAIG and the Board. Anecdotal feedback to be provided to QAIG prior to national report being recieved.			Currently fully led by IPC, however more of a Facilities and Estates ownership is required. Further discussion required with LTHT / national PLACE team re completion of Wharfdale Inspections	3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	S shape cleaning in place and labelling of patient equipment. Policy in place for reusable materials and a contract is in lace for external decontamination of reusable pieces for dental and podiatry. The IPC Policy manual outlines clearly roles and responsibilities across the trust. A bespoke video has been made by IPC with a voiceover to support the methods of cleaning as outlined in cleaning policy.		National Cleaning Standards in place across the organisation and each area has been accessed and provided with a risk category.	Cleaning Policy has been to the CCPG in March 2024 and is near completion for ratification. It is acknowledged that some elements of the policy will not be in place for example assurance from external landlords e.g. Leeds City Council	3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Water Safety Group in place with external provision provided by a qualified water expert. Regular legionella sampling from mains taps, as well as dental waterline testing is in place and assurance audit completion for HTM 01-05 from dental.	Water coolers maintenance checks - estates team seeking further assurance on maintenance checks and the contracts in place.	No mitigating risk in place as it is the internal mechanics of the device that require flushing through via external contract.	HSG aware - to mitigate risk consideration of putting device put of use until assurance mechanisms in place.	2. Partially compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Non compliant enivironmental concerns identified through annual IPC audit completed. The audits are shared with the estates team and non compliance is re audited within three months	To capture as part of separate piece of work to identify quarterly maintenace required and for this to be discussed with HSG. Some additional premises that are used by LCH to be audited annually e.g. Daniel Bever premise at LTHT (SJUH site).	Audits are shared by IPC to Estates and Facilities - non compliant areas reaudited 3 monthly.	To discuss with Diane Allison how non compliant elements are captured by Estates and Facilities.	2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	All linen within inpatient areas such as Wharfdale is managed by LTHT. Linen policy in place and NIPCM followed. For areas such as Hannah House a process is in place and there is a Management of Linen Policy in place that details the safe processing of laundry.	Assurance required from LTHT of provision and care of linen.		Policy updated March 2024.	3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Procedure recently fully reviewed and updated. Awaiting ratification of management of Waste Policy. A 'Waste Manager' is in place that is part of the Estates and Facilities Team, with SME provided from IPC. Waste captured as part of the environmental audit. Concerns or escalations of non compliance via the IPCG and QAIG	We have existing waste streams in place that separate clinical and non clinical waste, with appropriate signage to direct staff. The streams however do not meet the new standards as outlined in the Waste management Policy.	Tender to new waste provider from April 24, when new streams will be in place.	New Waste Policy implemented, recognise that a number of elements in the policy are currently not being followed. New tender process in place for waste disposal company, additional colour coding and a waste manual / guide to be implemented. Shared work with IPC / Waste	2. Partially compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	External decontamination process in place for dental and podiatry. Annual assurance and monitoring visit made to Tameside by IPC, dental and podiatry. All other equipment is single use and disposed of. Datix in place for instruments returned to Tameside with sharps still attached.			Tender process to be reviewed - discussed with Andrew Davies and Jo-ann Watson - awaiting update. Annual assurance visits made to the provider in Tameside, with dental and podiatry - due to be performed in April 2024.	3. Compliant

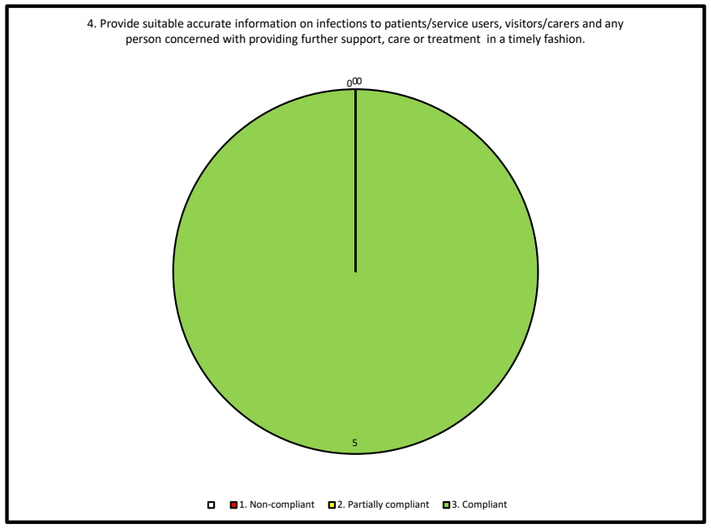


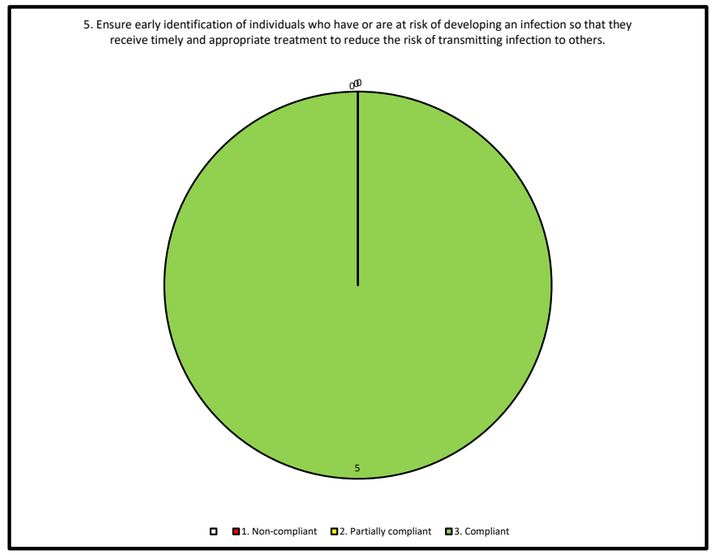
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food safety compliance in place for Wharfdale in patient area and Hannah House. Training monitorted via ESR. Compulsary training for relevant staff members. Assurance detailed through PLACE inspections and Environemtnal Audits.				3. Compliant

3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	Guidelines for antimicrobial use are developed in line with Leeds health Pathways processes, with microbiology input & peer review prior to approval via the LTHT antimicrobial governance route. AMS identified lead Head of IPC and head of Medicines Management				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	The IPC Annual Report dtails activitiy on AMS and AMR is captured in the IPC Annual Plan as well as the IPC Overarching Policy.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	The Executive Director of Nursing and AHP's as DIPC has overal responsibility for AMR throughout LCH.				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • To optimise patient outcomes. • To minimise inappropriate prescribing. • To ensure the principles of Start Smart, Then Focus are followed.	LCH IPC is part of the WY ICB AMR Collaborative Working Group, as well as the place based AMR group established by LCC. Resouces and tool are shared across the system and used as part of our approach throughout LCH. It is recognised that there is a small amount of prescribing throughout the trust. A flash report will be produced from Oct 23 jointly by Medicines Management and IPC on the systems in place as well as the audit processes to ensure that prescribing is inline with trust guidance. IPC week every November captures AMR as a health promotion day, information and links are available on the Oak and IPC are part of the NHS Futures platform for sharing resources, good working practice and bench marking.			Discussions with MEG about an electronic AMR audit that can be put in place. Considerations given around joint working with LTHT for the paediatric CVAS service.	3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • Total antimicrobial prescribing. • Broad-spectrum prescribing. • Intravenous route prescribing. • Treatment course length.	IPC support teams with risk assessments where required for example for specific infections e.g. CPE in an inpatient setting. Specific risks discussed via IPCG where an action log is in place.				3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	There are resources available on the Oak highlighting AMR and AMS. LCH IPC are engaged with system work in relation to QI for AMR, due to relatively low prescribing rates internally there are plans in place to undertake deep dive audits/QI approach into services such as podiatry for px, LSH and WYOI.			To engage with ODI re QI for AMR.	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	There are leaflets and information made available for specific infections. LCH IPC collaborate with PH at LCC to ensure that the information available meets the needs of the population group of Leeds and that alternative materials in multiple languages is available via UKHSA.			To add to relevant policies the different language options for information sharing.	3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	All policies and leaflets are revised every three years. Information is available on the internal and external internet as well as the Leeds Healthcare Pathways.			Consider QR codes on patient letters, texts to share information about specific infections. Start to share NHS Choices link to specific infections e.g. MRSA, CDI which are reviewed on a national level and available online.	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	All leaflets include the general principles of IPC, including importance of hand hygiene. Other control measures might include cleaning, washing of personal items, cough etiquette etc. as well as the principles of AMR - this would be dependant on the infection.				3. Compliant

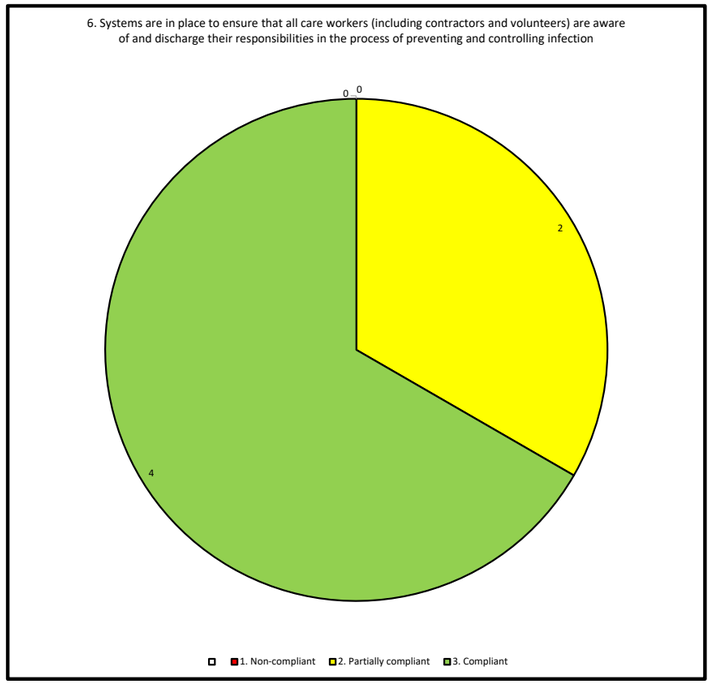


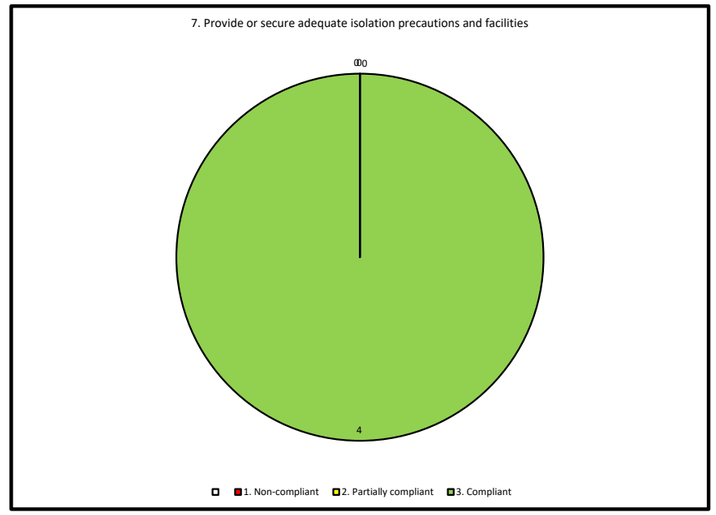
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	In patient areas have an infection control board that highlights the important key control measures. As part of national campaigns information shared with colleagues and individuals visiting our inpatient areas and health centres. Stall provide information and we hold external events to promote IPC at venues such as Kirkgate Market, use the display screen at Milllenium Sqaure etc. We use social media means by sharing information on 'X@ and the LCH Facebook page. Campaign material for winter vaccination campaigns is ordered from central DH and is shared to proote oublic health messaging.				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Patient passports are in place for catheters, a localised passport is used through the acute and community setting. We have a lead within the IPC Team for Devices related products and they sit on the IPS DRIPP Events.			Previous discussions have been had with CUCS around the auditing and usuage of Catheter Passports. Do CVAS use passports for DRIPP?	3. Compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Patients admitted to inpatient areas are not routinely tested for MRSA unless there is clinical rationale to do so. If patients do have clinical symptoms, swabs/smples are taken and transferred to the laboratry as per SOP. Results are then shared with inpatient area and via PPM+. Policy Manual available on the Oak outlining requirements. Stools assessment and chart in place to ensure prompt samplingfor potential CDI cases.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patients in inpatient areas have infection status regularly reviewed. Medical provision in place and escalations via GP or 111/999 should this be required. Patients have NEWS2assessment as per clinical need / policy and concerns around deterioration should be promptly escalated. IPC support with risk assessments for in patient areas.			**Education and bitesize training in place for sepsis and deteriotion.**	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Patient transfer form in place as per policy, for when patients are discharged from inpatient areas to care home or back to acute provison, detailing specific pathogens e.g. MRSA, CDI, CPE etc.			To audit transfer forms from Wharfdale to ensure completion and accuracy of detail. This is a 6 monthly audit on a sample of 20 patients.	3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage displayed on external ward area should an outbreak be in place, as well as specfic restrictions for bays if patients are being cohorted to reduce onwards tranmission.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreaks of two or more for either staff or patient sreas are reported to UKHSA. Outbreak toolkit in place and monitoring / surveillance completed. IPC is a 7 day service and daily checkin of outbreak location are completed where SME is provided.			Point of care testing has been made available to the recovery hubs and wharfdale for potential respiratory infections, which can help detect and provide confirmation of an infection.	3. Compliant



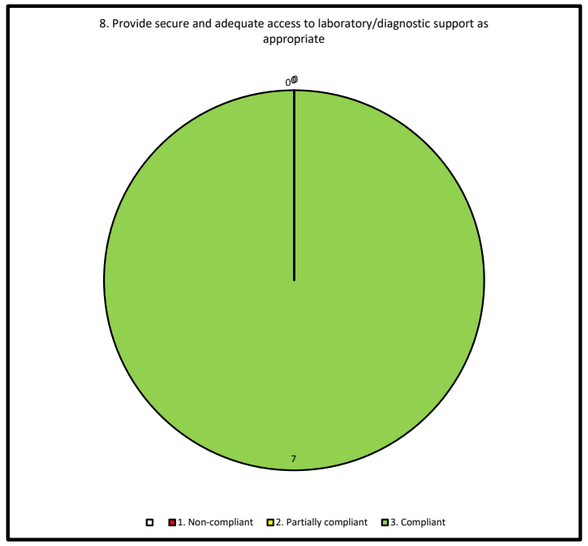


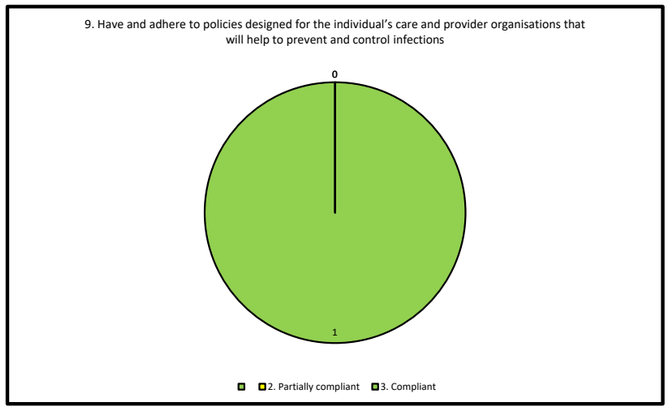
6.	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Face to face induction training is provided to new starters. This is a 15 minute presentation that captures the basic requires for IPC. All staff are then required to complete either level 1 or level 2 E-Learning for Health Training via ESR.	Induction is not mandated for all staff, as it is only for 15 minutes it does not cover the entirity f IPC that the staff members must be made aware of.	The staff member must complete their ELFH IPC training within a two period of starting.	On average we are >90% compliant with IPC training, however we identify quarterly poor uptake cares and these are escalated to QAIG.	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Roles and responsibilities are outlined in the IPC Overarching Policy as well as other IPC Policies e.g. Standard Precautions. They are discussed as part of the Induction Training.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Training compliance figures captured at IPCG and HSG. Escalations of non compliance captured at QAIG via flash report. Average >90% compliance for level 1 and 2 training.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Staff receive training via E-Learning for Health. Information and videos on donning and doffing is available on the Oak. Staff undertake a PPE and Hand Hygiene Audit. Audit of system one notes for PPE/HH in place.			NIPCM referenced in IPC related policies.	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff are re fit tested every two years as outlind by the HSE. Staff that are fit tested are recorded on a locally held (IPC) excel document.	A more robust mechanism e.g. ESR / PIP to record competency is required.	A locally held excel document is stored within IPC, however it does not provide individuals or teams the ownership.	Consideration around co procured PPE within the system for future pandemic prepardness, as well as sustainability approach.	2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Registered staff should not be carrying out a task if they believe they are not competent. The ABU provides training to clinical and non clinical staff. Non qualified are currently undertaking new competency frameworks delivered by the Neighbourhood Team Clinical Skills and Competency Educators. All of the training provided in ABU has been peer reviewed and assessed by the relevant specialists and there are regular (3-6 monthly) meetings with those specialist services to review training materials and update training as and when there are changes to policies or practice. There are lesson plans and guides in place for all of our training sessions so that if anyone else had to cover a session there is a guide to follow.	To explore further around what is exactly in place for all clinical staff that undertake a procedure. For some clinical competencies staff self declare compliance, however there are gaps around refreshers and where this information is appropriately stored.	Staff self declare competencies and work in an autonomous manner under their relevant codes of practuce. Bespoke training can be provided by specific teams such as CUCS, CVAS and IPC.	Understand gaps for business units and how this could be accurartly recorded on staff profiles on ESR.	2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Risk assessments are undertaken for inpatient areas for specific infections such as CPE. These are supprted by the IPC Team and coincide with the relevant policy and the NIPCM.	A formal logging system to be in place for risk assessments ? Added to patient notes.		Further education has been provided via the IPC team on completion of risk assessments.	3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	In patient areas have specific isolation (side room) facilities. Hannah House is all single side rooms. Wharfdale has a number of side rooms that can be used if a patient has a specific infection e.g. CPE or CDI. Risk assessments are completed in collaboration with the IPC team, to ensure the correct positioning of the patient, including standard precaution principles and tranmission based precautions. If in the event a side room could not be a sourced a Datix would be completed and a hierachy of control measures to reduce onwards transmission would be in place. Isolation Policy available on the Oak and Level 2 IPC training covers isolation principles.				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	NIPCM added to policy suite and standard precautions policy reflects TBP's. Staff education and comms in place.			Education system in place to update staff on TBP's. The new HH audit tool captures this.	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Policies in place to reflect this, patients withhin our inpatient areas would have a risk assessment in place if they were to be transferred. If this were to occur it would be as a result of deterioration.			Transfer form in place at Wharfdale - discussed with Kirsty Jones.	3. Compliant



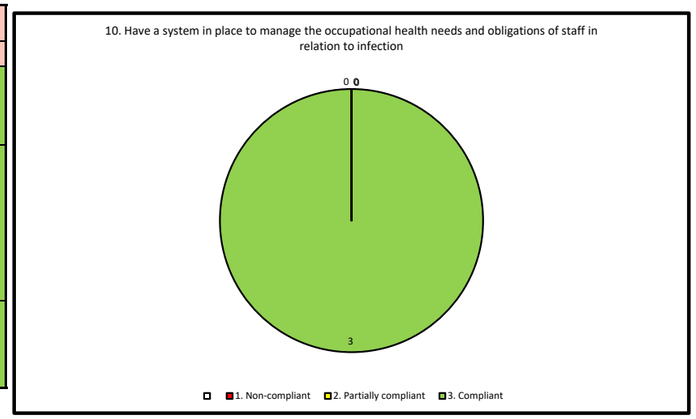


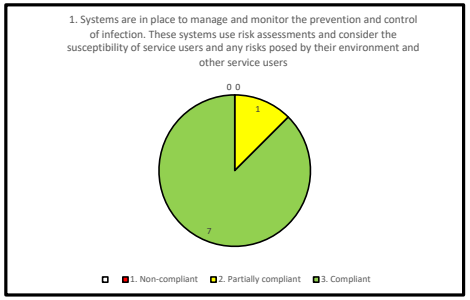
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Contractual arrangements / SOP in place for the processing of laboratry samples with LTHT.				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	The IPC team is a 7 day service, details are shared across the trust on how to reach out should additonal support / SME advice be required for specific pathogens / risk assessments. On call manager overnight / weekend / BH should escaltion be required. UKHSA have on call manager details should an ncident management meeting be required for a specific outbreak. Contact details for the IPC team available on the Oak. Champions are dispersed across the organisation to support teams, regular champion days are held to educate and they are a point of contact within their services.				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	SOP is in place for the testing of samples via LTHT laboratry. Microbiology provision provided via a SOP through LTHT. PPM+ platform shares results to the IPC team and a SOP is in place for the details of specific pathogens e.g. MRSA, CDI, E.Coli to be added onto the front page of Ssys1 notes. This is to add an additional layer of assurance as laboratry notes should be shared directly with the teams. Advice is provided on Sys 1 around decolonisation, standard precautions, tranmission based precautions etc.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Patients on discharge from LTHT should be provided with a transfer form highlighting any specific HCAI's e.g. MRSA, CDI, CPE. If these patients are admitted into one of our inpatient areas e.g. Wharfdale then a risk assessment with IPC will be undertaken. If patients are transferred from one of our inpatient areas to the acute setting or a care home a transfer form will detail any specific pathogens.			Audit of transfer forms to be undertaken. Liasised with Wharfdale re transfer form back into LTHT should patient have a specific pathogen.	3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Policies are in place for testing of patients should there be a clinical concern of infection. IPC training level 2 provides education on this. Staff undertake NEWS2 clinical assessment and should the patient require a specific swab or sputum sample.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	SOP is in place with LTHT for laboratory services. This incorporates agreements with other external providers e.g. Collindale (UKHSA) and other providers for specific testing of pathogens e.g. MPX.				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	SOP is in place with LTHT for laboratory services. This incorporates agreements with other external providers e.g. Collindale (UKHSA) and other providers for specific testing of pathogens e.g. MPX.				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Specific infection policy is in place that details and references the A-Z of Pathogens. All policies available on the Oak and Leeds Healthcare Pathways. Outbreaks are monitored by the IPC team - which provides as 7 day provision as part of the cooperation agreement with LCC. Tams can contact IPC for support and SOP is in place on how to monitor an outbreak. As per policy all outbreaks are reported UKHSA and an ILOG number is provided to detail on samples. IPC attend any specific IMT's with UKHSA. Bitesize training provided to staff virtually on specific infections, accessed via the Oak. Staff attend online virtual ELFH IPC training Level 1 and Level 2 - attendance rates monitored via IPCG/HSG from BI reports. Onaverage compliance 90-92%			Gap analysis against current policies to identify potential gaps and further fit testing to be completed by IPC.	3. Compliant





10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Pregnancy risk assessment completed by line manager. IPC contacted if in the event of a concern that is escalated.	IPC do not have assurance of risk assessment s that are being undertaken for individual staff members as this is service specific.	Locally held by line managers.		3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Process in place and contract with SWYFT occupational health service. Flow chart for staff to follow in the event of a sharps incident. Lanyard card provided to staff members, posters are displayed, screen savers in place and policy outlines procedure. IPC support staff member by contacting them within 24 hours of datix to support the individual and ensure process followed.				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Contract in place with SWYFT for Occupational Health Provision and staff upon employment complete medical questionnaire via Recruitment and HR.	We do not receive any data from SWYFT outlining OH provision for IPC related activity, for example immunisation, occupational irritant dermatitus, needle stick injury response.		Escalated to Ann Hobson to discuss KPI's in place with SWYFT.	3. Compliant




1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
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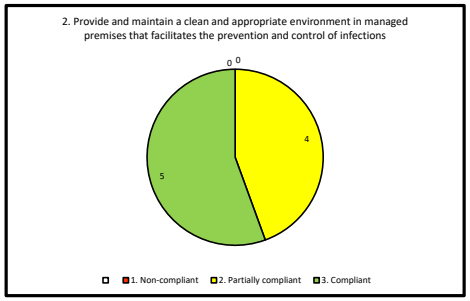
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
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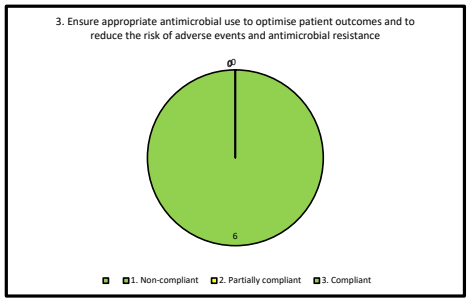
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
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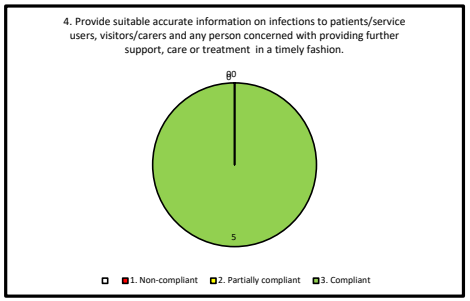
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.
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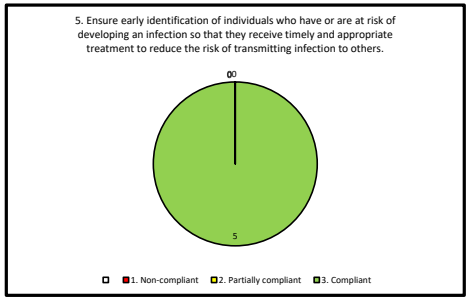
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
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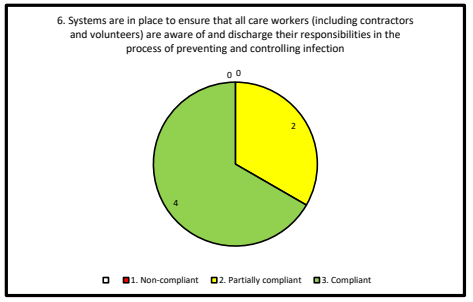
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
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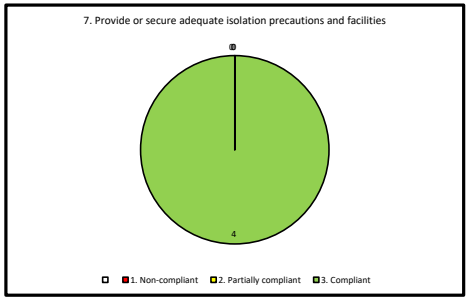
7. Provide or secure adequate isolation precautions and facilities
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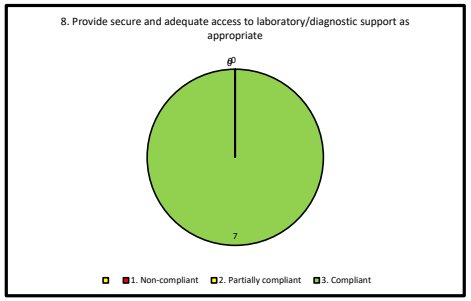
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate
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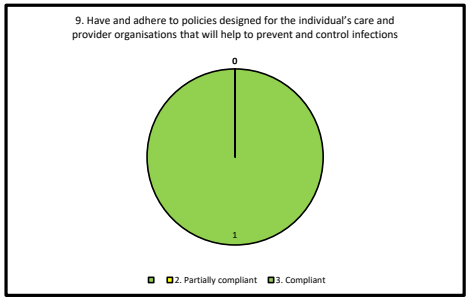
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
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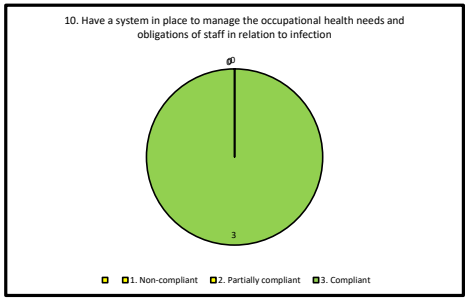
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
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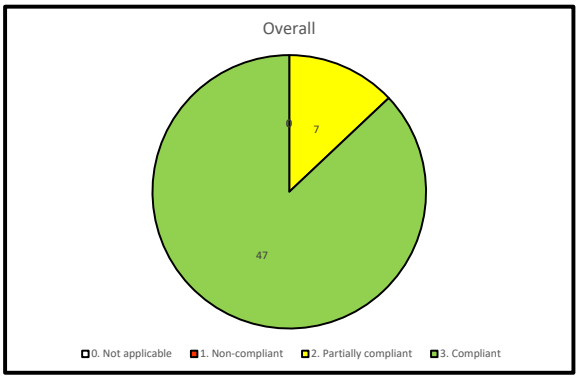
Overall
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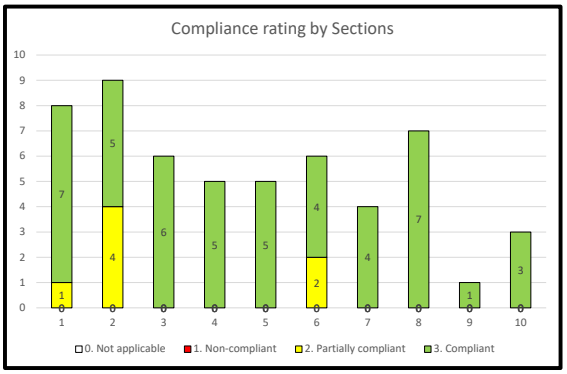
2. Partially compliant
3. Compliant


Compliance rating by Sections
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0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held in Public: 28 March 2024

Agenda item number: 2023-24 (140)

Title: Update on Children, Young People and Families Strategy 2022-25

Category of paper: For information

History: The Strategy was approved by the Trust Board in 2022.

Quality Committee 25 March 2024

Responsible Director: Interim Executive Director of Operations

Report author: Head of Service for Operations and the Children, Young People and Families Strategy – Children's Business Unit

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Executive Summary

The paper provides an update for the LCH Quality Committee on the progress made against the objectives as outlined in the Children, Young People and Families Strategy 2022-25.

This covers the progress made on the Strategy in the period September 2023 to February 2024.

The overarching aim of the strategy is to deliver high quality healthcare in the most appropriate setting for children, young people, and their families. We achieve this by working in partnership with children, young people, and families, integrating with other organisations and by developing our services and colleagues across the Children's Business Unit.

The Children's Young People and Families Strategy 2022-25 is organised into our 8 objectives:

This paper provides a progress update on each of the objectives and some of the achievements within the Childrens Business Unit. The annual Business Plan 23-24 is regularly reviewed by the Children's Management Team and provides evidence of a governance process in maintaining development and accountability of the Strategy.

Please note that the objectives have a lifespan in the context of the strategy's timeframe.

Progress update Q3 and Q4

Objective 1: Agree and Develop fully Integrated Offers for Children and Young people in Leeds.

We have continued to progress with our communication offer following on from the launch events in Autumn 2022 which were system wide events for all services who work with children specifically regarding communication. Whole system events took place in Autumn 2023 to implement change across the universal plus/focussed support level of the offer. Good practice was spotlighted in relation to Family Support, Environment, Workforce, Early Identification, and Intervention.

A 2-3 year implementation plan has been developed for the Communication Offer for further engagement, roll out and evaluation. We continue to work with Local Authority partners and 3rd sector organisations in the development of the Offer.

The Children's Speech and Language Therapy teams are establishing working with Children's Centres to facilitate Early Communication Groups. Children's Centres are located in the poorest areas in the city. The groups are having multiple benefits including linking families up with their local centre and the range of activities/support that they can access there, building skills in the Children's Centre staff regarding supporting good communication and making appropriate referrals.

The Emotional Health and Well-Being Offer has been mapped out across the health and social care system, and will be reviewed in line with CAMHS Quality and Value Programme starting in Q1 24/25.

The progress on the initial 6 Offers has been delayed due to staff's capacity to lead and engage on the Offers. The Children's Business Unit Clinical Lead maintains oversight on the progress of the Offers to date.

Objective 2: Demonstrate the Effectiveness of Service through Outcomes and Sharing Best Practice.

Outcomes

We continue to progress our Goal Based Outcome measures across the business unit.

We have a new process for recording Goal Based Outcomes on SystmOne which will allow us to report on the aggregate numeric scores so we can measure our effectiveness. The new process has been rolled out in Q4 and we aim to go live with the updated reporting at the end

of Q1 24/25. Our outcomes work has been shared as best practice at the North of England Special Educational Needs and Disabilities Designated Clinical Officer forum. We have received very positive feedback from other Trusts who are very keen to learn from our experience. We are currently looking at whether we could provide training on the use and benefits of Goal Based Outcomes to other Trusts.

0-19 PHINS have introduced a validated outcome tool the Revised Children's Anxiety and Depression Scale (RCADS). This allows young people to rate various symptoms of anxiety and low mood and is already widely used in CAMHS. An audit completed following the introduction showed it improved the recording of the young person's voice and gave a clearer understanding of concerns.

CAMHS have a CQUIN target for outcome measures in 23/24. It will not be achieved due to the migration to SystmOne from Carenotes and the need for setting up and consistently recording the outcomes. An action plan has been developed in Q4 to improve performance and this is now being reported on monthly at the Quality and Performance panels in the Children's Business Unit.

Research and Good Practice

We have several studies currently running in services. CBU has clear ambitions for improving a culture of research and innovation and has linked with the Clinical Lead for Research to progress. This closely matches with the Trust wide vision.

ICAN are a recruitment site for an outcome measure validation study, and we are in the process of becoming a study site for two randomised controlled trials (RCT) looking at physio interventions for children with Cerebral Palsy. We are also in the early stages of setting up as a study site for a large RCT investigating the effectiveness of self-care interventions for children with neuro-developmental conditions. The team are also continuing to work with Kings College London on Children's Palliative Care Outcome Scale validation study; a study to validate a new quality of life outcome measure for children with life limiting conditions. The recruitment deadline has been extended to June 2024.

CAMHS are part of the study on Wellbeing while waiting evaluating social prescribing in CAMHS: study protocol for a hybrid type II implementation-effectiveness study | BMC Psychiatry | Full Text (biomedcentral.com) and the first young people have been recruited into the project. There has also been a cohort of young people involved in the joint project on social prescribing with Leeds United Football Club. A psychiatrist is completing a PhD, and their study area is around gender differences and self-harm.

0-19 PHINS have supported two research projects during this reporting period. The first is focused on experiences of domestic abuse and involved conversations with women and health visitors. The Stepping Stones Study is evaluating the different care models and pathways for pregnant women who use drugs, from early pregnancy to one year after the birth of their baby. The Stepping Stones Study - King's College London (kcl.ac.uk)

As these research projects conclude or initial findings are considered it will be important to share the learning and recommendations with services and the wider system to consider and make changes to clinical practice.

Education Mental Health Practitioners in the MindMate Support Team presented on "Whole Setting Approach in Leeds" at the 1st National Education Mental Health Practitioners conference. The importance of the whole setting approach is that everybody within the

education setting has an important role in emotional and mental health, much like the emphasis of safeguarding being everybody's business.

Objective 3: Children, Young People and Families will have a Positive Experience of our Services.

All initial contact letters for all services now include information in the top ten languages that are recorded on the communication annexe on SystmOne and a service specific telephone number. This was to improve access to services and help reduce Was Not Brought/Did Not Attend.

In October 2023 our Youth Board were involved in the PLACE (Patient Led Assessment of Care Environment) inspection at Hannah House, an action plan was formulated from the inspection and the service with support from facilities are implementing these recommendations. Areas of improvement the Youth Board wished to see included creating a child friendly appeal on approach and when entering the building.

We have had continued success in developing links with 3rd Sector organisations and many of the organisations take part in service development consultations. For example, the review of the Childrens Community Eyes Service, Communication Offer, and the Initial Contact Letter.

Infant mental health has produced a video to help reduce families' anxieties when referred into the service. The film will be launched during infant mental health awareness week 12-18 June. It features four families the service has worked with who describe their initial anxieties and their positive experiences following working with the service. The service is also producing two short social media edits which will be shared widely.

Youth Board

The Youth Board currently has a membership of 32 young people, our priority for 2024 is to widen our membership and involve more young people who have accessed our services. We are marketing our Youth Board by advertising on the Be Collective and Doing Good Leeds volunteering websites ensuring that young people from across Leeds can apply to join the group. In addition to this the Youth Board is promoted via social media, within Children's Business Unit and via our third sector links. We also work closely with groups such as Leeds GATE (Gypsy and Traveller Exchange) and attend their youth group on a regular basis.

We have revamped our Parent and Carer group to be an Involvement Group this was to ensure that anybody can be involved and not just restricted to parents and carers. The group is for people over the age of 19 and we have the Youth Board for those aged under 19.

A new Involvement Newsletter for the Children`s Business Unit has been developed the newsletter is to celebrate and promote our engagement with children, young people and adults. This will also help provide evidence of the breadth of engagement with our services.

Objective 4: Services will be Delivered through a Fairdays Work, within Budget, be Cost Effective and Value for Money.

All services in the CBU are working on a "A Fair Day's Work -Phase 2", which will support services as we undertake the Quality & Value Programme. This integral piece of work has been crucial to understanding the baseline level of all services from budgets and financial

monitoring to benchmarking & productivity, understanding demand, pathways and offers across the services.

Objective 5: Retain and Expand services by being Tender Ready and Open to Business Development Opportunities.

We have continued to develop and introduce new services:

The Paediatric Community IV Antibiotic Service was launched in February 24 which will ensure children up to the age of 16 will be offered daily antibiotics at home instead of having to travel to the acute hospital – this is a massive celebration for both LCH and Leeds Teaching Hospitals NHS Trust and a nod to supporting the left shift movement of care closer to home.

The School Aged Immunisation and Flu programme commenced from September 23, in collaboration with other local providers across West Yorkshire, another great example of collaboration and partnership working.

MindMate Support Teams are now covering 53% of Leeds school/further education settings continuing the improvement in coverage of the city. Team 4 has recently recruited eight trainees who will primarily work with schools in South Leeds.

Objective 6: Services will have a Workforce that is Skilled and Competent to meet the Changing Health and Wellbeing Needs of Children and Young People.

We have supported and encouraged several colleagues from our Black and Minority Ethnic (BME) workforce to participate on the BME mentoring programme.

We are continuing to support a number of colleagues across the Business Unit with apprenticeships, covering a variety of roles including speech and language therapists, social workers and nurses. We continue to work closely with the organisation on how we utilise apprenticeships and development posts for staff at the start of their career.
In Q3 we had several of our Children Nurse apprentices attend the celebration event organised by the organisation.

We have recruited to two trainee Advanced Clinical Practitioners (ACP's), one has started in post and the second starts in role in September 24. We are also in the process of recruiting to a qualified ACP to support with the pre-school autism pathway. These roles will support opportunities for nursing and allied health professionals to develop their skills to work in an extended role. This will encompass clinical practice, leadership and management, education, and research.

Objective 7: Maximise the Potential of Technology

The Children's Business Unit Digital Steering group continues to meet to share good practice and discuss digital innovations to maximise the use of technology. We are supporting a colleague to participate in the Aspiring Digital Leaders Course.

As part of 'A Fair Day's Work Phase 2' conversations we are engaging with staff on challenges and ideas for making the most of technology and making the working life balance and productive. The CBU digital steering group is escalating the need for a Patient Information Hub and are ready to support services to utilise this new technology to improve access to resources for children, young people and families and other supporting adults.

Baby Bubble has been possible through collaboration with Leeds Teaching Hospitals, 100% Digital and The Do Good Foundation. They have run four groups across the city, two in restorative early support areas, one city wide for women with gestational diabetes and the other in a non- restorative early support area of the city.

Teams across the Business Unit are using text messaging to support young people and families through the Systmone communication annex which allows information sharing and signposting. We are exploring how technology can improve communication with children, young people, and their families. We are keen to ensure that we explore current social media platforms and apps, and this can be evidenced as with the partial development of an app for Hannah House. We have created the role of social media ambassador, and a member of our Involvement Group is helping to create posts which are published on our 0-19 PHINS social media platforms. The Youth Board have requested an X (formally Twitter) account, this will help promote involvement with those who access our services and, we are hopeful the 3rd sector groups would follow us.

Objective 8: Make Children and Young people's Services a Wonderful Place to Work and First Choice Employer by Investing in the Health and Wellbeing of our Workforce.

We are committed to supporting the health and wellbeing of all colleagues across the Children's Business Unit. We have representation at the Trust Health and Wellbeing Engagement group and Health and Wellbeing Champions in each service. The champions have formed a group to look at what is available, share ideas and resources. The first meeting was in January 24 with a plan to meet quarterly. We have continued to work with colleagues on an individual basis in promoting the Trust Health and Wellbeing initiatives and the significant programme of support they can access.

With the recent publication of the staff survey results the leadership team have had the opportunity to discuss the results and themes across the Business Unit. All teams are now discussing their results, celebrating any areas of improvement, and considering action that teams feel need to be undertaken. The Business Unit will develop an action plan ensuring we hear the concerns of the workforce and implement any actions that need to be in place.

As part of our long-established resource group, we have developed a Children's Business Unit preceptorship document. Information from exit interviews and appraisal conversations highlighted the requirement and need to standardise the offer across the business unit which sits alongside the Trust's preceptorship package.

CAMHS have listened to practitioner's requests for support and organised six monthly continued professional development events in service, which have been well received, helping to support development and networking across the service.
Several topics were discussed at these events ranging from Trauma Informed Approach, Self-Harm**,** Record keeping training, The National Perspective on Intellectual Disability, SEND – our statutory duties within health, Intersection of Neurodivergence and Gender Identity/ Diversity, Neuro Affirming Language and the Neurodiversity Information Hub.

Conclusion

The Trust and the Business Unit is facing a significant financial challenge over the next few years. It is incredibly important for the Children's Business Unit to ensure that robust

governance arrangements continue to remain in place which will support regular monitoring of this strategy, and most importantly, the Quality and Value Programme will provide that assurance.

The strategy's implementation and the aims and objectives are mostly on track and steady progress has been made against all objectives as outlined above with clear evidence of achievement throughout the year.

As with any enterprise, there is risk that the current pressures and the volume of work have the potential to impact on the timely delivery of the objectives.

Areas requiring focused attention over the coming months will be maintaining momentum on our annual Business Plan, which is integral to the Strategy objectives, ensuring the business unit maintains primary focus on the Quality and Value Programme which will in turn evidence clear outcomes for families, retain and develop our staff and services and ensure our Offers and pathways are clear and accessible.

Recommendation

The Board supports the continued progress on the 8 objectives and acknowledges the progress over the last six months.

Quarterly Management Report – Estates

1st October – 31st December 2023

1.0 Introduction

In accordance with the Strategic Partnering Agreement dated 29 September 2004 relating to the Primary Health and Social Care estate in the Leeds area, Leeds Community Healthcare Trust (LCHT) have entered into a Partnering Services Agreement (PSA) with Community Ventures (Leeds) Ltd (CVL) for the provision of an estate management service.

The current PSA between LCHT and CVL commenced on the 1st January 2023, terminating 31st December 2025 with an option of two 12 month extension periods.

As part of this agreement CVL provide a fully resourced Estates Department which currently comprises of;
Associate Director of Estates
Head of Estates
Estate Officer (Operational)
Estate and Property Assistant (vacancy)
Property Manager

Other support will be provided as required using the CVL supply chain.

An Estates Maintenance contract is in place to provide all aspects of the estate statutory and reactive maintenance requirements across the owned properties, and some of the leased properties. The contract terminates on the 31st March 2028.

There are other properties that LCHT occupies space within where the maintenance responsibility lies with the Landlord.

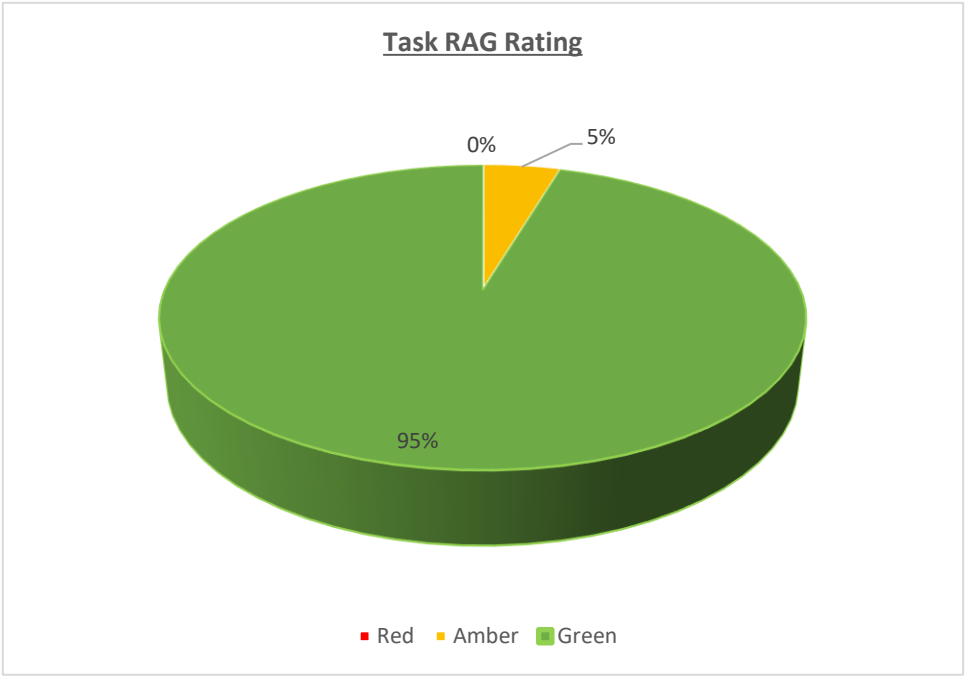
LCHT occupies space within ten of the LIFT buildings in Leeds and as a tenant of Community Health Partnerships. The overall Landlord, Community Ventures (Leeds) Ltd, has overall maintenance responsibility for these buildings. LCHT liaise with Community Health Partnerships as part of the management the LIFT buildings, rather than directly with operations team at Community Ventures (Leeds) Ltd.

This formal report includes key performance metrics, linked to the Partnering Service Agreement, and provides greater transparency for the Trust about the performance of the service that it receives from CVL.

2.0 Summary

The reporting period for this report is 1st October and 31st December 2023. This report aligns with the quarter periods within LCHT's financial year.

There are 63 elements included within the report which have all been RAG rated. In the reporting period 60 tasks returned as green rating, 3 returned Amber and 0 Red.



Other items to note:

Section 3.0 C - Estate Management and Maintenance

Overall performance of the estate maintenance contractor continues to be good.

461 PPM tasks were planned and completed across the estate in the reporting period, including leased/occupied properties. That includes 219 PPM tasks relating to statutory compliance.

3.0 Key Performance Indicators

A Policy, Governance & Information

Metric	Current Position	RAG Rating	Next steps
Regular and appropriate review of estate policy and procedures			
All Policies, Procedures and Estates Management Plans are reviewed in a timely manner	All Policies, Procedures and Estates Management Plans are currently in date. PL 353, Medical Gas Operational Policy has been reviewed by Estates, and reviewed by the CCPG who advised that significant amendments are required before the Policy can be re-presented to the CCPG. PL258, Control of Water Quality (legionella and Pseudomonas) Operational Policy and Procedures in under review. PL311 has been reviewed and sent for comment before sending to CCP Group.		Review Policies and Plans as and when review dates dictate . Amendments made, needs representing to CCPG Currently being completed. Pest control policy being completed.

Undertake the annual Premises Assurance Model (PAM) assessment and provide and implement action plan			
PAM assessment has been undertaken in last 12 months (including audit of information)	It is now mandatory to complete a PAM every 12 months. This has formed a contractual requirement for the Trust since April 2020, and key elements of the PAM assessment will be considered by the Care Quality Commission in their inspections. Estates completed the PAM in 2022, it has been completed by Facilities and Estates in 2023		
PAM actions are being monitored and none are overdue	On completion a report and action plan will be produced and provided to the Business Committee based upon the information received from services.		
Action and implement DH/NHS guidance and policy directives relating to Estate and asset management i.e. HTMs, HBNs, HGNs			
DHSC and NHS guidance and policy directives relating to Estates and Asset Management are actioned where required	All actions required are up to date.		
Manage and provide statutory/mandatory estate information /activity returns			
All mandatory and statutorily required estates information/returns are provided as accurately as possible and on time	ERIC return for the period 2022/23 has been submitted. Reporting on the Surplus Land Return is now quarterly has been completed and lodged within the required timescales. Currently there are no sites identified as surplus.		

Ensure adherence with Trust SFIs/SOs	All property transactions and procurements adhere with Trust SFIs/SOs		
The Trust Intranet Estates and Facilities page is regularly reviewed and updated to reflect current arrangements	Page managed by the Senior Estate Manager who has received training on the Trusts new intranet, MyLCH.		The page will be regularly reviewed and updated.

B Health and Safety

Metric	Current position	RAG Rating	Action Required
All Estates related H&S issues reported on Datix have been managed to conclusion	Any reported have been managed to conclusion and closed satisfactorily on Datix.		
All NHS Estates and Facilities Alerts and communications have been managed to conclusion	Any reported have been managed to conclusion and closed satisfactorily on Datix		
Any H&S issues that require reporting to NHS Estates and Facilities have been reported.	None		
Any H&S issues reported through the estates and grounds maintenance	None in reporting period		

contract have been managed to conclusion			
Any Estates related issues on the Trust Risk Register have been updated.	None.		

C Operations –Estate Management & Maintenance

Performance Management of the day-to-day estate management and maintenance activities through the appointed contractor through quality checks, monthly review meetings and evaluation of monthly reports			
Contract Review meetings with Estates maintenance contractor are held quarterly and performance is managed	Contract Review meetings are held monthly, ensuring contractual standards are maintained. Overall performance of the estate maintenance contractor continues to be good. Sharepoint and Maximo CAFM system are being updated with all relevant statutory documents.		

	Quotations are supplied within expected SLA period, and then reviewed by the Estates team and either queried or approved. The contract terminates on the 31st March 2028.		
Estate maintenance contractor's reporting is timely and accurate	Monthly reports are submitted on time, relatively accurate, and require only minimal amendments.		
All reactive works are carried out within specified timescales	Minimal SLA failures were recorded in the reporting period. KPI's have been developed in line with the contract.		
The cost of all reactive work is reviewed and monitored to ensure that they are accurate and represent value for money	Monthly Reports analysed financially.		
Planned Preventative Maintenance (PPM) tasks are completed on time and to the required standard demonstrating good asset management and statutory compliance.	461 PPM tasks were planned and completed across the estate in the reporting period, including leased/occupied properties. That includes 219 PPM tasks relating to statutory compliance. A Building Technical Audit analysing service records relating to PPM statutory and some non-statutory tasks has been implemented using Assure and the Estate Manager and has been completed for all retained sites in the reporting period.		
PPM Plans are reviewed to ensure that they are appropriate and support a cost-effective maintenance regime.	Plans are reviewed annually and amended to reflect any changes in the estate; omissions and additions. PPM schedule has been created and agreed for White Rose Office Park.		

The quality of the work undertaken on Trust occupied properties is monitored to ensure that it meets relevant standards and quality.	Calls for Reactive works are “triaged” by the Estates team for necessity and correct Priority with regular monitoring of completed works for quality and value for money.		
Any persistent faults are investigated and an appropriate course of action is recommended	Calls for Reactive works are “triaged” by the Estates team for persistent faults.		
Close working relationships are managed with the Facilities Department to ensure a seamless Soft/Hard FM interface	Estates continue to work closely with Facilities, Health and Safety and Infection Prevention and Control in management of the estate.		

Undertake planned audit, surveys and safety tests to ensure compliance and appropriate governance for water, fire, asbestos, water, electrical etc.			
Leased Properties			
Compliance within the leased estate is well documented and understood	Work is continuing to be undertaken to Landlords statutory compliance responsibilities and to write to Landlords requesting necessary assurances.		This is on the H&S Committee Action Plan to monitor progress.
Owned Properties			
Gas boilers are serviced annually by the estates maintenance contractor and are compliant.	Gas boiler checks are undertaken annually under the Gas Safety & Use Regulations 1998. All LIFT buildings are compliant as demonstrated in the Technical Audits		

All Water Risk Assessments (WRA) are Current (in accordance with ACOPS L8)	Six new WRA were completed in 2023 with a further 6 WRA being planned to be completed in 2024. A new WRA for White Rose Office Park instructed has been completed October. WRA's are currently renewed in LIFT buildings every two years as demonstrated in the Technical Audits provided by the Landlord.		Continue to review WRA's regularly or when there is a change in circumstance such as building occupation of changes.
All buildings have current Five-Year Installation Testing for electricity	Five yearly compliance checks of owned properties completed in 2018 with remedial works completed and where necessary Minor Works Certificates received. Retesting of the LCH retained properties was completed in September / October 2023.All related remedial works are in the process of being completed. All LIFT buildings are compliant as demonstrated in the Technical Audits provided by CVL.		
All identified Portable Appliances have been tested	Portable Appliance Testing (PAT) was last undertaken at the beginning of 2024 with 14210 appliances with further appliances being tested to be tested at drop in sessions. All staff were advised of the dates of testing on MyLCH and Midday Briefings and testing at all sites completed. Progress has been made with IT to allow testing of IT appliances within IT server rooms.		
All LOLER inspections are current	All equipment across LCH estate including equipment located within buildings leased or managed by third party is subject to regular		

	inspection under the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998. Inspection programme undertaken by the estates maintenance contractor. All inspections previously undertaken by Allianz are now being carried out by the estate maintenance contractor.		
All fire alarms and fire safety equipment is tested	Fire alarm maintenance of the owned properties is carried out under the main Estates maintenance contract. PPM service reports and recommendations for remedial works resulting from PPM tasks are managed under the Estates maintenance contract and monitored by Estates team. Fire extinguisher maintenance in the owned properties is undertaken by the Estates maintenance contractor and any remedial works required managed as required. Responsibility of fire safety equipment and fire-fighting equipment within the LIFT buildings lies with the Landlords.		
Information relating to Estates Statutory Compliance is provided to the Fire Safety Advisor to allow completion of Fire Risk Assessments	When requested Estates provide the Fire Safety Advisor with information relating to Estate Statutory Compliance in line with the agreed process developed after the 2018 TIAA Estates audit to allow completion of Fire Risk Assessments. Fire strategies and plans for all sixteen owned properties are in place. The Fire Strategies primarily address life safety and have not been developed to address property protection. However, the features that are included within the strategies for life safety, as required by the		

	Building Regulations 2010, will contribute in some extent to business and property protection. The Strategies include the protection from Hazard Rooms as defined in the LCHT Fire Risk Assessments. Management of Fire Logbooks and FRA's in LIFT buildings, is the responsibility of the Trusts immediate Landlord, CHP. LCHT provide FRA for their own demise within LIFT buildings. All internal doors including fire-doors are being replaced as part of the on-going 23/24 Capital works programme, At Kirkstall the internal doors including fire doors are being replaced as part of the 23/24 Capital works programme.		
All other statutory inspections are undertaken as required	Other statutory inspections such as air conditioning, lightning protection and emergency lighting tests are carried out as required to the frequencies required and are included in the pre-planned maintenance schedules in place for each site and completed by the estates maintenance contractor.		

D Energy Management

Metric	Current Position	RAG Rating	Action Required
All energy and utility information is collected and recorded	Monthly consumption data is collected and provided to the Sustainability and Environment Manager to support their important work for the Trust.		

	The Estates team are working with utility providers to have smart meters installed, which will make accounting easier and alleviate the need to have metes read regularly.		
Reports are compiled on energy expenditure	Ongoing		
Initiatives are considered and recommended to the Trust where this will reduce energy consumption and costs	Low energy LED lighting continues to be installed as part of any refurbishment and improvement works, Burmantofts LED lighting is being completed as part of the 23/24 Capital programme. LED lighting requirements are being collated as part of the building inspections that are being rolled out in March. The information gathered will be shared with the sustainability team, in the event of any further funding becoming available.		
All Energy Performance Certificates (EPCs) and Display Energy Certificates (DECs) are current	9 EPC's, all within renewal dates 8 DEC's with annual renewal all within renewal dates 10 DEC's with ten year renewal all within renewal dates		
Energy contract renewals are monitored and managed, with the Trust being provided with appropriate advice	Energy is procured through Crown Commercial Services and renewed annually. The tariffs through CCS have rolled over for 24/25 with a new CCS NHS basket being planned for 25/26.		
Annual sustainability reporting is provided in line with Trust and NHS requirements	Estates work closely with the Trusts Sustainability and Environment Manager including providing the necessary data for annual reporting.		

	The Estate Officer (Operational) will be the key contact for Estates, supported by the Senior Estate Manager.		

E Property Management

Metric	Current Position	RAG Rating	Action Required
All Lease events (e.g. lease renewals, rent reviews) and notices are managed	We are currently working closely with the ICB on GP leases within LCHT retained estate. A draft Heads of Terms is currently in place with St Georges which is being worked through and a lease is aimed to be in place by the end of this financial year. LTHT have now left the building and LCHT and local care direct will have separate leases.		Continuing to be monitored.
Additional income received from new lease/occupation agreements in the reporting period	Work on all outstanding GP leases to commence in the next quarter. Work is continuing to formalise leases and licences across the estate. Provider to provider agreements continue to be monitored.		Continuing to be monitored.

Arrangements for handing back space to Landlords at lease termination (including dilapidations) is managed appropriately	None in the reporting period.		
Value for money advice is provided with reference to independent specialists where appropriate	We have been liaising with the DV and independent valuers relating GP practices and St Georges centre.		In progress
The retained Trust estate is managed in accordance with Health Building Note 00-08	Ongoing – no exceptions to report		
Any new Trust occupations (where Landlord or Tenant) are documented appropriately	None		
Existing informal occupations are documented where possible/appropriate	The Property Manager is starting to review the Licence Agreements for the 24/25 financial year. Ongoing issues with LYPFT using space at Kippax. A significant amount of time is still being spent on discussions with LYPFT on operational matters and revised operational procedures are about to be issued. LYPFT will continue with their SLA arrangement until circumstances dictate otherwise. Licences to Occupy and SLAs have been agreed with LTHT for space occupied by LCH – to be signed. These will be coming up for renewal in 2024. Estates continue to meet with third party occupiers regularly with notes of meetings kept on file.		In progress

Space which is void/vacant and available for occupation is identified and managed	All sites have been re-opened for clinical services with the exception of Otley and Horsforth. The Accommodation Group has been established and attended by the Property Manager.		In progress
(In partnership with Finance) all charging processes are audited and reviewed regularly to ensure these reflect contractual arrangements	The Integrated Sexual Health Service occupies two areas in the Merrion Centre under leases with Town Centre Securities. The service has won the tender and estates are working with the service to facilitate vacating Merrion Centre and Wade House and relocating into Beeston Hill (and spoke sites)		In progress
Ensure the MICAD system is up to date reflecting changes in services and accommodation occupation ensuring appropriate charging process in place which reflect contractual agreements	A significant exercise is still required to update MICAD information to verify appropriate charges to third parties and to support Finance with reference costs and service line reporting. Estates have had meetings with MICAD and work is being carried out to look at what we use currently, and how the MICAD system could be updated and utilised.		In progress
Provide expertise and support to the Estate Strategy Implementation Board (ESIB), the Business Committee and the Trust Board	The Associate Director of Estates has taken an active role in reviewing the function of the ESIB and its various subgroups and ensuring alignment to the Estates Strategy Plan (April 2023), and attends on a monthly basis.		

F Minor Works/ Backlog Maintenance Programming

Metric	Current Position	RAG Rating	Action Required
6 Facet surveys are in place and current	Six Facet surveys of all owned properties were completed at the beginning of 2021 and these are due to be updated in 2024.		
Trust priorities for investment are reviewed from existing information and a 3 year plan is maintained	Six facet surveys should be carried out every six years but there will be benefit in carrying them out sooner to demonstrate the benefit of the large amount of Capital Works undertaken in 21/22, 22/23 along with the refurbishment of Seacroft Clinic.		
An in year project plan for Capital Works is prepared / implemented	A capital programme for 2023/24 has been developed noting the significant drop in Capital funds available to Estates due to the spend on WROP. Work is being undertaken at Burmantofts, Chapeltown, Meanwood and Kirkstall.		

G Strategic Estate Management Support

Metric	Current Position	RAG Rating	Action Required
Advise on and support initial thinking on strategic estate policy and direction	The Estates Strategic Plan (April 2023) was developed signed off by Business Committee. This includes a 3 year delivery plan, which now forms the basis of discussions at the Estates Strategy Implementation Board and its various subgroups.		
Represent the Trust on City wide Estate issues	The Trust Associate Director of Estates attends the Leeds Strategic Estates Board and is now providing additional support to the Chair of this Group (LCH Executive Director of Finance and Resources) due to departures from the LCC team who previously supported this group.		

H Non - Recurrent Services/Activities

Metric	Current Position	RAG Rating	Action Required
All Non-Recurrent Services are delivered within the timescales and project expectations of LCHT	Live Non-Recurrent Services are; 5020-115 (078) Capital works management. Value of £26118.54 +VAT In Progress		

	Preparation of Floor Plans for Matrix Booking System Value: £9,162.50 + VAT Complete		

I Finance

Metric	Current position	RAG Rating	Action Required
(period 1 January to 31 December)			
Financial spend on the Partnering Services Agreement for the period 1 January 23 to 31 December 23 is in line with budget	Spend to date: £286,436.00 Annual Fee: £286,436.00		
(period 1 April to 31 March)			
Financial Spend on Reactive Works undertaken by the estate maintenance contractor within budget (first 100 jobs)	Spend to Date: £122,715.18 (9 months) Annual Fee: £163,620.25		
Financial Spend on other reactive and ad hoc works are managed in line with the contract with the estates maintenance contract	Additional Reactive Works (above 120 jobs): £1500.00 Additional Reactive Works (Quoted): £32,263.25 Ad Hoc works: £45,666.10		
Financial Spend on Planned Preventative Maintenance undertaken by the estate maintenance contractor within budget	Spend to Date: £182,673.55 (9 months) Annual Fee: £243,564.75		
Financial spend on planned grounds maintenance	Spend to Date: Included in above figure. Annual Fee: Included in above figure		

Financial Spend on gritting and snow clearing	Spend to Date: 10,627		Winter services provided between November and March annually
Metric	**Current position**	**RAG Rating**	**Action Required**

J Training

Metric	**Current position**	**RAG Rating**	**Action Required**
Estates team have completed the Trusts mandatory in house training modules	Water quality training has been completed by the Estates team in the last reporting period.		
Estates team have completed any training deemed necessary by CVL to fulfil the requirements of the PSA	The Estates team continue to attend webinars and mandatory training throughout the reporting period.		
Estates team continue to undertake Continuous Professional Development training	The team has attended a number of virtual training and informative webinars over the last 12 months. Training providers included the Institute of Healthcare Engineering and Estate Management.		

NHS
Leeds Community Healthcare
NHS Trust

Report author: Angela Brogden

Tel: 0113 378 8661

Supporting Healthy Weight and Active Lifestyles.

Date: 12th March 2024

Report of: Head of Democratic Services

Report to: Scrutiny Board (Adults, Health and Active Lifestyles)

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

Brief summary

- It is reported that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015 and that the UK-wide NHS costs are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year (Public Health England 2017).
- Given the wide-ranging implications of living with obesity on health and beyond, the Adults, Health and Active Lifestyles Scrutiny Board agreed to utilise its March 2024 meeting to have a themed focus on supporting healthy weight and active lifestyles for the population of Leeds.
- Information has therefore been provided to the Scrutiny Board by Public Health, the Leeds Health and Care Partnership, the Leeds GP Confederation and Active Leeds, which is appended to this report. Senior representatives from these organisations and service areas will also be attending the Scrutiny Board's meeting to help address Members' questions and contribute to the Board's discussion.

Recommendations

Members are requested to consider and provide any comment on the information appended to this report as well as determining what, if any, further scrutiny work it may wish to undertake on this matter.

What is this report about?

1 The Adults, Health and Active Lifestyles Scrutiny Board agreed to utilise its March 2024 meeting to have a themed focus on supporting healthy weight and active lifestyles for the population of Leeds.

2 The following information has therefore been provided to the Scrutiny Board by Public Health, the Leeds Health and Care Partnership, the Leeds GP Confederation and Active Leeds:

- ***A report from Public Health setting out the local approach and plans in place to deliver an environment that leads to a healthier weight*** – this report (set out in Appendix 1) presents the issues behind the high levels of excess weight in Leeds and outlines the evidence and recommendations for interventions that local authorities can deliver to create an environment that leads to a healthier weight.

- ***A report from the Leeds Health and Care Partnership on the Leeds Tier 3 Specialist Weight Management Service Recovery and Redesign Plans*** – this report (set out in Appendix 2) sets out the progress that has been made since the Scrutiny Board's earlier consideration of the Tier 3 Specialist Weight Management Service provision in July 2023.

- ***A report from the Leeds GP Confederation*** – this report (set out in Appendix 3) presents the perspective of primary care and General Practitioners, via the Leeds GP Confederation.

- ***A joint report from the Director of City Development and Director of Public Health on the Physical Activity Ambition*** - this report (set out in Appendix 4) provides an update on the Physical Activity Ambition for Leeds, which is being led by Active Leeds and Public Health. It includes details of work programmes and achievements delivered by Active Leeds and Public Health against the priority workstreams.

What impact will this proposal have?

3 The Scrutiny Board is keen to explore the Leeds offer around supporting health weight and active lifestyles given the wide-ranging implications of living with obesity on health and beyond.

How does this proposal impact the three pillars of the Best City Ambition?

☒ Health and Wellbeing ☒ Inclusive Growth ☒ Zero Carbon

4 Services aimed at achieving a fit and healthy population aligns with the vision of the Leeds Health and Wellbeing Being Strategy that '*Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'*.

5 Embedding physical activity into everyday life also provides a unique opportunity to contribute to the other city strategic pillars of Inclusive Growth and Zero Carbon, as well as aligning with key strategies such as the Leeds Mental Health Strategy, Transport Strategy and developing the Local Plan.

What consultation and engagement has taken place?

Wards affected:		
Have ward members been consulted?	☐ Yes	☐ No

6 Senior representatives from Public Health, the Leeds Health and Care Partnership, the Leeds GP Confederation and Active Leeds will be attending the Scrutiny Board's meeting to present the appended reports and contribute to the Board's discussion.

7 The appended reports also provide further information in terms of any relevant consultation and engagement processes that have informed the content of the information provided.

What are the resource implications?

8 Details of any related resource implications will be captured within the appended reports.

What are the key risks and how are they being managed?

9 Details of any related risk management implications will be captured within the appended reports.

What are the legal implications?

10 This report has no specific legal implications.

Appendices

- Appendix 1 – Report from Public Health setting out the local approach and plans in place to deliver an environment that leads to a healthier weight.
- Appendix 2 - Report from the Leeds Health and Care Partnership on the Leeds Tier 3 Specialist Weight Management Service Recovery and Redesign Plans.
- Appendix 3 - Report from the Leeds GP Confederation.
- Appendix 4 - Joint report from the Director of City Development and Director of Public Health on the Physical Activity Ambition.

Background papers

- None.

Appendix 1

Healthy Weight in Leeds: Our Approach and Plans

Purpose of Report

This report is presented as one of four and focuses on the role of Leeds City Council in developing and delivering prevention focused population interventions to increase the proportion of people with a healthy weight. The three additional reports focus on the role of the NHS in delivering behavioural and pharmacological interventions to support weight loss; the perspective of primary care and General Practitioners, via the Leeds GP Confederation; and an update on the Physical Activity Ambition for the city.

The purpose of this report is to present the issues behind the high levels of excess weight in Leeds. It outlines the evidence and recommendations for interventions that local authorities can deliver to create an environment that leads to a healthier weight. Child and Adult healthy weight plans are described and attached in appendix A and B, the Local Government Healthy Weight Declaration (Appendix C) and Leeds Food Strategy (hyperlinks to web version included) are also included in the main body of the report. Our approach utilises a combination of population and life course interventions demonstrated through the strategy and plans presented. Child and adult health are inextricably linked and interdependent on one another due to the profound impact of the early years on adult health and wellbeing and vice versa. Because of this child and adult interventions are both included in this report and the intention is to develop a single Healthy Weight Plan for the city that covers adults and children.

The key points of the report are:

- The proportion of adults and children who are overweight or living with obesity remain high in Leeds and nationally. This affects approximately two in three adults, one in five 4–5-year-olds and over one in three 10–11 year old children in Leeds. The highest percentages of obesity are in the 10% most deprived parts of Leeds affecting one in three adults.
- The causes of excess weight are complex. However, two of the main factors are an increasingly unhealthy environment and the extensive marketing and availability of cheap, nutrient poor food which is high in fat, sugar, and salt.
- Addressing environmental and commercial factors that affect food intake are likely to have the greatest impact on increasing the percentage of adults with a healthy weight from a current estimated level of 33%. In terms of children when considering maintenance of a healthy or healthier weight from early childhood and throughout the full life course, food intake and physical activity have a more equal role.
- National and local approaches have overly focused upon individual lifestyle interventions for example, education, food labelling and information campaigns that have limited effectiveness and can increase inequalities. Successful approaches need to be built around a system wide approach with priority placed upon addressing unhealthy environments.
- Local Authorities can play a vital role in positively influencing many aspects of the unhealthy environment as part of this system wide approach.

Scrutiny is asked to note the contents of this report and consider the Leeds approach and plans being presented.

1.0 Background

The distribution of population weight has changed dramatically in the past 30 years coinciding with an increasingly unhealthy environment and the practices of the commercial food industry.

Food systems have become saturated with ultra-processed, energy dense foods that are high in fat, sugar, and salt. Marketing, sponsorship, and promotions are everywhere, tapping into emotions, exploiting vulnerabilities, and shaping social norms. Price promotions are more widespread in the UK than anywhere else in Europe. Nutritious foods are less accessible and unaffordable to lower income groups and fast-food takeaways are more common in urban areas with high deprivation. Unhealthy foods are intensely promoted with price reductions on multiple purchases. Advances in modern technology shape work and leisure time, and transport and urbanisation has reduced the need to move as much.

Children, young people and vulnerable population groups including people diagnosed with a severe mental illness or learning disability are more susceptible to unhealthy environments that prompt behaviours. In these population groups, habitual active behaviours need to be structurally embedded into a daily routine and supported through the built environment[1] (walkable neighbourhoods, structured activity in schools/ community settings, active play etc).

There are two key controllable variables attributed to maintaining weight; food intake and physical activity (both routine daily activity and additional exercise). While being physically active is of course important to health, particularly in maintaining lean muscle mass, experts agree that inactivity amongst adults is a much less prominent cause of excess weight than unhealthy eating, and once people have gained weight, studies show that exercise alone is a much less effective way of losing it than improving diet. Physical activity does have a role in improving mental health which, in addition to contributing to our overall wellbeing, may help in part to support weight loss and can help to maintain a healthy weight once people have lost weight. In terms of children when considering maintenance of a healthy or healthier weight from early childhood food intake and physical activity have a more equal role. The city is responding to increasing physical activity in all ages with the 'Physical Activity Ambition', progress against which is being presented in a parallel report. This paper will therefore focus on the food, policy, and environmental elements that are being delivered within the broader strategy that addresses all determinants of a healthy weight.

[1] WHO. European Regional Obesity Report 2022. Available from: https://iris.who.int/bitstream/handle/10665/353747/9789289057738-eng.pdf?sequence=1

2.0 Economic Impact

Obesity exacts a societal cost in terms of reduced well-being and mortality. For example, financial costs result from the care and treatment of obesity-related diseases and workplace costs by decreasing worker productivity and increasing the need for support services. Obesity is estimated to cost the NHS £6bn a year and the UK economy £27bn a year through lost productivity.

3.0 The Relationship between Weight, Health, and Wellbeing

Excess weight can lead to serious health consequences such as cardiovascular disease (mainly heart disease and stroke), type 2 diabetes, musculoskeletal disorders like osteoarthritis, some cancers (endometrial, breast and colon) and sleep apnea. These conditions can cause substantial disability and premature death[2]. Obesity can reduce life expectancy by an average of 3 to 10 years.

In addition to this physical impact, mental wellbeing is also affected with both adults and children being more likely to experience poorer mental health including depression and anxiety. Weight bias, discrimination and stigma are often experienced by children and adults living with obesity causing harm to mental health[3]. It can cause barriers to accessing health care, anxiety about going to public places and self-harming behaviours such as alcohol misuse and disordered eating patterns.

Chronic stress, depression and anxiety may also lead to excess weight due to the additional challenges this poses to moderating consumption in an unhealthy environment[4]. Children and adolescents are more likely to experience low self-esteem and bullying which can impact on other aspects of their life, including educational attainment and the development of friendships. Adults are more likely to experience discrimination and to earn lower wages.

A healthier weight and better mental health can help prevent these problems, stop them from getting worse, or even reverse them.

[2] Institute for Government. Tackling Obesity: Improving Policy Making on Food and Health. April 2023. Available from: https://www.instituteforgovernment.org.uk/sites/default/files/2023-04/tackling-obesity.pdf

[3] Rubino F et al. Joint International Consensus Statement for Ending Stigma of Obesity. Nature Medicine. 2020; 26; 485-497. Available from: https://www.nature.com/articles/s41591-020-0803-x

[4] Obesity Health Alliance. A 10-year Healthy Weight Strategy. 2021. Available from: https://obesityhealthalliance.org.uk/wp-content/uploads/2021/09/Turning-the-Tide-A-10-year-Healthy-Weight-Strategy.pdf

4.0 Levels of Healthy Weight, Overweight and Obesity in Leeds

Table 1 – Levels of Overweight and Obesity in Children and Adults

Age Group	Overweight & Obesity combined		Living with Obesity	
	Leeds	National	Leeds	National
Reception Child	21.3%	21.3%	9.4%	9.2%
Year 6 Child	37.4%	36.6%	23.3%	22.7%
Adult (18+)	65.0%	63.8%	24.2%	Not available

4.1 Children

2022-23 figures show that Leeds child obesity rates have decreased since the higher levels during COVID-19. In reception age (children aged 4-5 years old) obesity has decreased from 9.9% to 9.4% which are similar to 2017/18 and much lower than the COVID-19 years. Year 6 (children aged 10-11 years old), child obesity levels are at 23.3% which are lower than during COVID-19, however, remain slightly higher that pre-COVID levels which were at 20.8% in 2019/20. These trends for both school age groups are similar to the national child obesity rates.

Children's excess weight figures, which combine overweight and obesity figures, shows that for this year (2022-23) excess weight in reception age children has decreased slightly from 22.4% to 21.3% and for Year 6 it has also decreased slightly from 39.4% to 36.6% nationally.

National and local data shows there is a strong relationship between children living with obesity and deprivation, with obesity rates double for children living in the most deprived wards when compared to the least deprived. Aggregated data over the last five years shows the proportion of children living in the most deprived fifth of Leeds who are living with obesity rose slightly, moving to 12.3% from 11.9% for Reception children and from 27% to 28% for Year 6, which is in line with the general trend seen in the rates in England and Yorkshire and Humber Region.

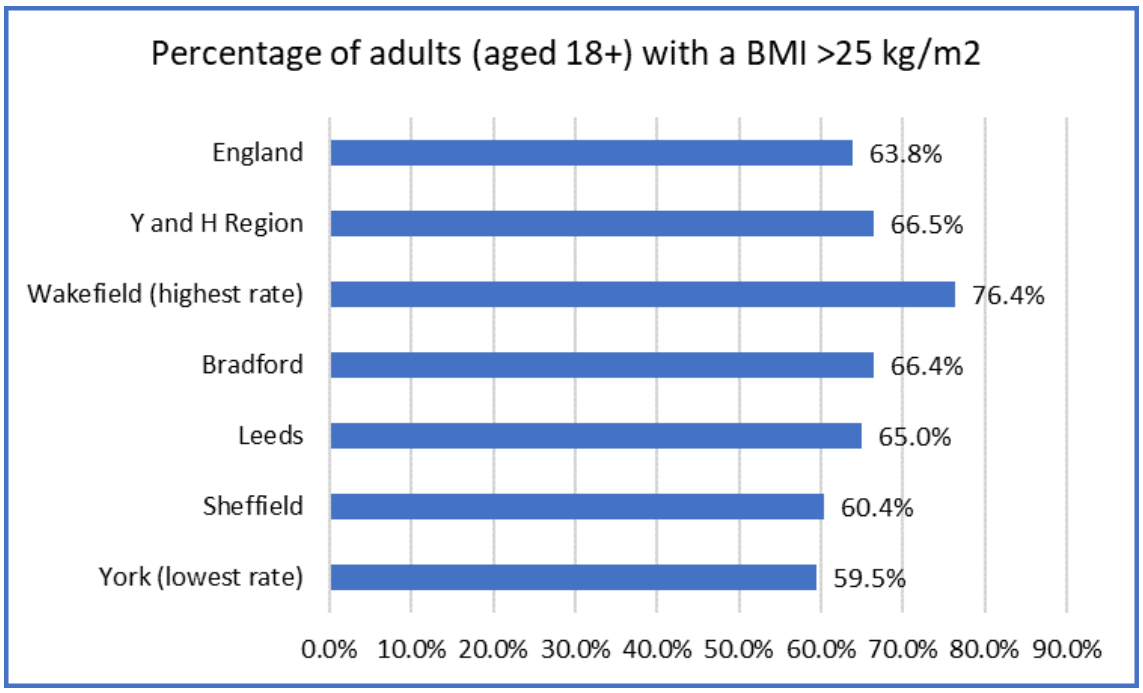
4.2 Adults

According to the World Health Organisation's definition, adults with a body mass index (BMI) from 25 to 30 kg/m2 are classed as overweight and those with a BMI of 30 kg/m2 are living with obesity.

From data collected through Sport England's Active Lives Adult Survey (self-reported height and weight), it is estimated that 65% of the Leeds adult population have a BMI over 25.

In comparison with all other towns and cities in the Yorkshire and Humber Region, Leeds has the 4th lowest rates in the region and has slightly higher rates than England.

Figure 1. Comparison of Leeds with other cities in the Yorkshire and Humber Region and England (Active Lives Adults Survey 2021/22)



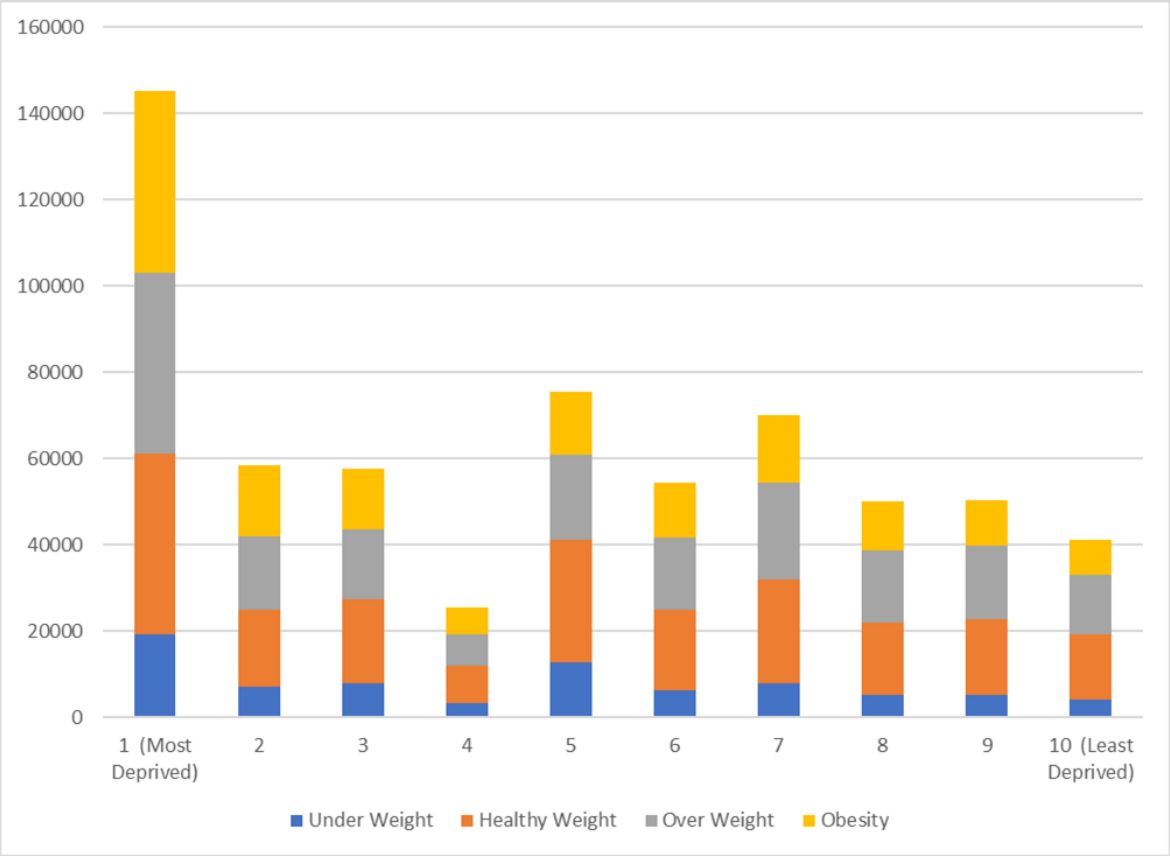
More in depth data is drawn from GP practices in Leeds, most recently in 2023, exploring the ***numbers and percentages*** of all patients, with a recorded BMI, by BMI category.

This data (illustrated in Figure 2) shows that people living with obesity are most likely to live in the most deprived 10% decile than any other decile. 27.8% (number = 42,224/ 151,918) of the total number of people living with obesity are living in decile 1. All other deciles are less than 11%, with the lowest levels in decile 4 (4.1%) and 10 (5.3%).

Overall, there are estimated to be 145,211 adults registered with a GP in Leeds who live in decile 1. Of these, 29% (number = 42,224/ 145,211) have a BMI recorded of 30 or above compared to 20% (number = 8,094/ 41,094) in decile 10 (least deprived). Of the whole adult Leeds population with both a recorded BMI and IMD decile, 6.7% are living with obesity in decile 1 compared to only 1.3% in decile 10.

Obesity is disproportionately affecting more people who live in decile 1. This supports the need to address root causes of obesity that are associated with lower socio-economic status such as a higher density of hot food takeaways, support into employment, fair wages, access to affordable healthy food etc. However, it is also a condition that is widespread across the city and affecting 151,918 adults in total (24% of the adult population), with an additional 189,545 in the overweight category. This demonstrates the importance of utilising whole population strategies that improve health for all, with emphasis on interventions that have a greater effect on the more deprived areas.

Figure 2. Comparison of GP registered patients with a recorded BMI (March 2023) and IMD decile (2019) to show differences in the number of adults for each BMI category by decile.



The inequality widens further when specific population groups, life stages and risk factors are also considered alongside socio-economic factors. A few key groups to be aware of are:

- Women with a diagnosis of depression (31.7% of all women with depression are living with obesity)
- Men or women with a diagnosed learning disability, autism or severe mental illness (37.0% of people with a severe mental illness are living with obesity).

5.0 National Context

In 2007, the Government Office for Science Foresight published a review titled 'Tackling Obesities: Future Choices'[5] highlighted that weight is mostly driven by circumstance and the environment we live in.

'Society, has radically altered in the past five decades with major changes in working patterns, transport, food production and food sales'

It concluded that the most 'socially responsible and prevention focused' scenario would be most effective in the long term. The report recommended that population-level interventions that impact everyone and rely on non-conscious processes are most likely to be both effective and equitable in tackling major risk factors for overweight and obesity.

Since the report's publication, national efforts to address obesity in line with this recommendation have been hampered by a combination of issues but mostly due to concern about the perception of 'nanny-statism' and lobbying from commercial industry. As a result, recent government policies implemented in England have focused on campaigns and behaviour change programmes that emphasise an individual's personal responsibility to self-manage their health. There is a role for this, however these interventions have limited success if wider systemic and social issues are not addressed adequately. Furthermore, corporate messaging about public health, consistently focusing and shifting emphasis upon the benefits of physical activity and distracting from the importance of a healthy nutritious food intake, are tactics to maximise sales and profits.

There has also been a tendency to focus on policies that rely on the voluntary adoption of healthier practices by the commercial industry, despite evidence showing that large corporations are unlikely to do this without regulatory action. Measures that have had some effect include the sugar levy on beverages introduced by UK government in 2018. This is an equitable whole population approach that has been shown to have greater impact on children and lower income groups, while simultaneously reducing sugar consumption across the whole population. Legislation on food and drink product placement in the retail sector has recently been implemented, but is unlikely to have a significant impact without additional measures. Restrictions on food advertising and promotions have however been delayed with a continued emphasis on 'working with' the food industry to voluntarily adjust the nutritional content of foods produced and advertised.

The food industry is highly influential in shaping the environment, social norms and increasing accessibility, availability and affordability of high fat, sugar, and salt foods. Policy that regulates food industry activity, to promote a healthy and nutritious diet as the norm and to make healthy food more accessible with regards to availability and price needs to happen at a national level.

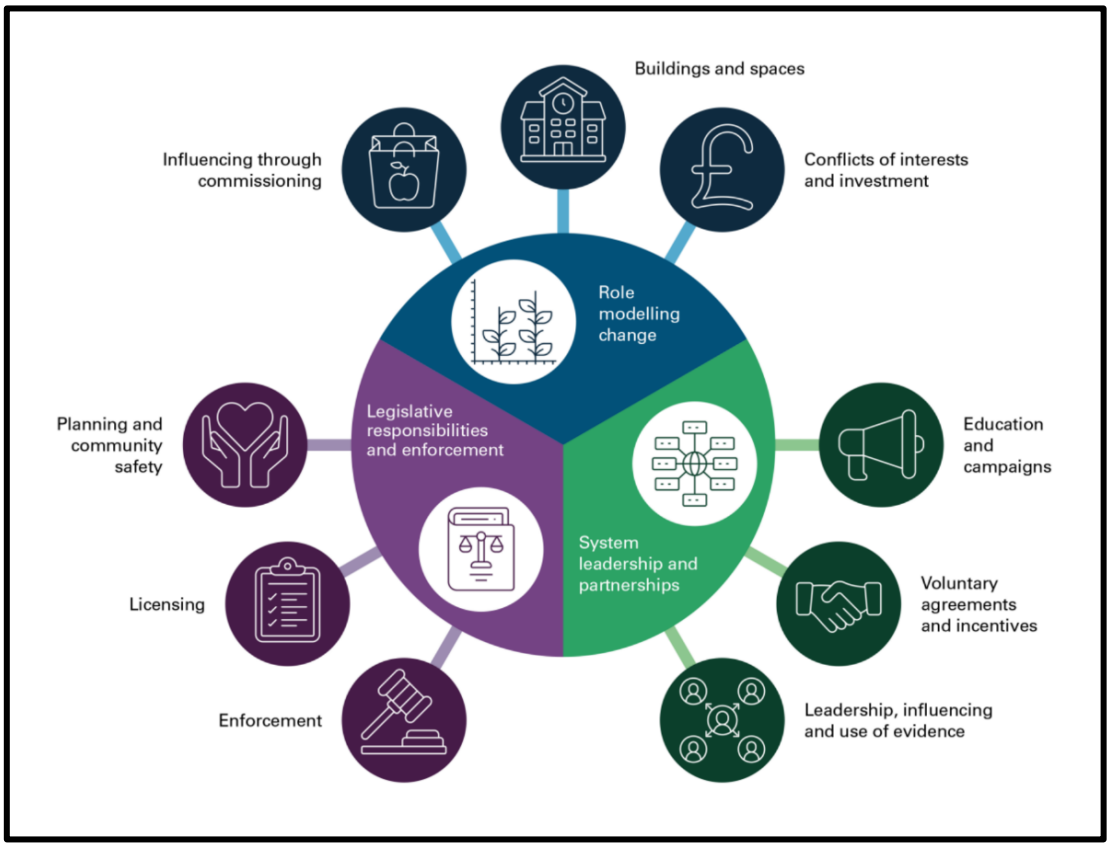
[5] Foresight - Tackling Obesity: Future Choices Project Report. Government office for science. 2007. Available at: Tackling obesities: future choices - project report (2nd edition) (publishing.service.gov.uk)

6.0 Our Approach and the Role of Local Authorities

Although there is a reliance on Central Government to design and implement legislation and regulation, there are a range of actions that can be implemented locally to increase the numbers of people in Leeds who are a healthy weight.

The Health Foundation have developed a framework to support Local Government action (Figure 3) to address the leading risk factors for ill health including poor diet. This includes action to improve the quality and nutrition of foods offered out of the home, addressing the high density of hot food takeaways, implementing procurement and advertising policies, increasing access to physical activity and greenspace and using local public health intelligence to inform licencing and planning.

Figure 3. Framework for Local Government Action: Addressing the Leading Risk Factors for Ill Health[6]



To inform the interventions to deliver the framework, the National Institute for Health Research (NIHR) conducted a review of the evidence to tackle obesity relevant to local authorities[7]. (How can local authorities reduce obesity? - NIHR Evidence).

[6] The Health Foundation. Briefing: Addressing the Leading Risk Factors for Ill Health – a framework for Local Government Action. October 2023. Available from: https://www.health.org.uk/sites/default/files/upload/publications/2023/LG%20risk%20factors%20briefing_RGB_final.pdf

[7] National Institute for Health and Care Research. How can local authorities reduce obesity? Insights from NIHR research. Available from: https://evidence.nihr.ac.uk/how-local-authorities-can-reduce-obesity/

The review reiterated the need for system wide approaches both within local authorities and with local partners, which will primarily benefit the health of the population but also realise additional benefits including addressing health inequalities, contributing towards net zero and increasing economic productivity.

The review does recognise the competing pressures that local authorities are facing such as rising social care costs, but also highlighted that rising prevalence of obesity has a negative impact on tackling many of these pressures. The review also recognised that tacking obesity at a population level goes hand in hand with the 'levelling up' agenda.

Population interventions across the life course are being co-ordinated in Leeds through four key strategies and plans which support healthy weight in the city:

1. The **Leeds Food Strategy (2023)** has been developed with "FoodWise" (the city's local food partnership). The overarching vision is to have a vibrant food economy where everyone can access local, healthy, and affordable food produced in ways that protects our natural environment. Improving Leeds healthy food availability and affordability and reducing the impact that unhealthy food environments have on Leeds citizens health and wellbeing is central to the strategy.
2. The **Adult Healthier Weight Plan (AHWP)** aligns with the Best City Ambition and Marmot City commitment with its emphasis on the role of social and environmental determinants of health. It also seeks to increase awareness of the complexity of obesity and the protective factors for reducing the risks associated with weight gain.
3. The **Child Healthy Weight Plan** sets out a whole system preventative programme from pregnancy to 19 years old and the contribution that Leeds City Council and key partners will deliver to promote child healthy weight and address obesity over the coming 5 years with the vision every child in Leeds will be a healthy weight.
4. Leeds City Council adopted the **Local Government Healthy Weight Declaration** (HWD) in 2018 (Appendix C) to establish an environment, infrastructure and cultural shift that make a healthier weight accessible. This is an internal policy using the Council's influence and powers involving cross-departmental working.

   There is a proposal to work towards the creation of a single Healthy Weight Plan for the city that covers adults and children rather than separate plans and also consider appropriate governance arrangements to steer and oversee healthy weight work programmes across the life course.

7.0 Achievements and Progress

7.1 The **Leeds Food Strategy** has three core missions, which all have a key role in healthy weight. These are:

- Health and wellbeing
- Food security and economy
- Sustainability and resilience

Examples of current work:

- Establish an LCC healthy catering award for implementation across all our leisure centres and cafe's. A survey is being developed across LCC venues asking customers and staff for their views on the current offer.
- The Food Procurement Guidelines were formally adopted through the Leeds Food Strategy in 2023 to ensure LCC is purchasing and offering sustainable and healthier food and drink items that have a lower content of fat, sugar, and salt. Because of these guidelines 13 food contracts to date have considered the Governments Buying Standards for Food. Civic Flavour provide a healthy options menu at the lowest price point for buffet services in Council buildings. Next steps will be to ensure these are adopted effectively and monitor effectiveness through the strategies internal food group.
- The Eat Well Forum has been re-established by Leeds City Council for coordination of city-wide action to improve health and wellbeing through food. Food Projects work together and network through the Eatwell Forum to support the delivery of the Leeds Food Strategy mission 1 – Health and Well-being. Community Food Projects help people to take control of where food comes from, learn how to cook, understand healthy eating messages and connect. Some examples include the Public Health commissioned Better Together providers delivering projects like the "Recipe station" to provide people with low cost ingredients and recipes to help prepare healthier food and "Food Budgeting sessions" which involve healthy eating information and cooking sessions.
- The Leeds Food Strategy aims to support children and adults in Leeds to be able to access affordable healthy food. An example is the development of a Healthy Start action plan and focused campaign to increase uptake of healthy start vouchers. This addresses some of the socio-economic barriers for healthy weight affecting adults with young children on low incomes.

The issue of the impact of advertising of unhealthy food across Leeds was highlighted during the development of the Food Strategy. Public Health has explored the feasibility and impact of advertising and sponsorship policies that restrict the promotion of unhealthy commodities that cause harm, which usually includes food and drinks high in fat, sugar or salt (as well as alcohol and gambling) for possible adoption by Leeds City Council. Various local authorities who have implemented this policy include Barnsley, Haringey, Greenwich, Knowsley, Bristol, Merton, Southwark and Luton along with Transport for London. There has been no impact or concerns raised regarding a

decrease in revenue following the implementation of these council advertising policies[8]. In the case of Transport for London, an increase in revenue was reported in their evaluation.

7.2 The new draft **Adult Healthier Weight Plan (AHWP)** attached in Appendix A has an emphasis on the role of social and environmental determinants of health. It also seeks to increase awareness of the complexity of obesity and the protective factors for reducing the risks associated with weight gain. The AHWP contains the following priority themes:

1. Build a food system that increases accessibility and availability of nutritious and affordable food that supports health and wellbeing. For example, reviewing the density of hot food takeaways in Leeds to establish a baseline and improve systems for monitoring effectiveness of the current Supplementary Planning Document.
2. Create an environment that enables equitable opportunities for walking, wheeling, and cycling (active travel) and access to nature for wellbeing. For example increasing opportunities for walking and cycling and maximising learning through the Department for Transport pilot programme in Burmantofts, Harehills and Richmond Hill linking social prescribing with active travel (part of the Physical Activity Ambition).
3. Actively promote resilience and wellbeing through compassionate approaches for all adults. For example, through developing training, raising awareness of person centred language and sharing resources. We have co-produced a resource that explains weight stigma: Stamping out weight stigma: a checklist for the workforce
4. Provide targeted support that increases equitable access for key adult life stages, diverse communities and people living with disability, and long-term conditions. For example, the co-production of a healthy weight framework for Primary Care Network (PCN) health and wellbeing coaches to support patients. Also ensuring that the NHS Diabetes Prevention Programme is accessible to those eligible and tailored to individual needs of diverse communities
5. Increase awareness and understanding of the complexity of obesity and its wider determinants (social, and commercial) that amplify inequalities. For example raising awareness of the social and commercial determinants that affect a healthy weight.

The next steps are to develop the actions with a set of indicators and measures to monitor the plan which will be included in the proposed single Healthy Weight Plan across the life course.

7.3 The key principles that underpin the Child Healthy Weight Plan (Appendix B) are:

- All children will have access to what they need to be a healthy weight and all care givers will feel confident and be equipped to raise their child to be a healthy weight.
- Families who are most at risk will be identified early and well supported by a highly skilled workforce.
- Leeds will be the best city to raise a family to be a healthy weight.

Working with schools forms a key element of the approach to child healthy weight set out in the plan. Public Health commission the Leeds Healthy Schools Programme to improve young

[8] Policies to restrict unhealthy food and beverage advertising in outdoor spaces and on publicly owned assets: A scoping review of the literature - Chung - 2022 - Obesity Reviews - Wiley Online Library

people's health and wellbeing at a population level. This is available to all schools across the city. The programme focuses on supporting schools to help their children and young people grow healthy, safely and with responsibility and resilience, while raising attainment and achievement by improving the health and wellbeing of pupils. The School Health Check is an online self-assessment tool, which is integral to the programme. The tool supports schools to measure themselves against best practice in order to develop and embed the fundamental elements to achieve a holistic whole school approach to health and wellbeing across four core themes: Personal Social Health Economic (PSHE) Education, Healthy Eating, Physical Activity and Social, Emotional, Mental Health.

Bespoke support with policy development and policy review on school food is available through the programme and supports the Healthy Eating theme of the School Health Check. The programme provides resources and support for school food planning. This includes:

- Supporting compliance with the statutory food standards and national school food plan.
- Training for leadership and management of school food.
- Developing food policies and toolkits e.g. Packed lunches and free school meals.
- Support from a healthy eating advisor on food nutrition and cooking in schools.
- Support and education for children living with obesity.

The Leeds Child Healthy Weight Partnership is chaired and co-ordinated by Leeds City Council, Public Health Children and Families Team and consists of a range of key partners which oversees the implementation of the Leeds Child Healthy Weight Plan.

Some of the achievements against the plan include:

- The School Food Friendly framework was launched.16 schools have self-validated as School Food Friendly, and 14 schools have been externally validated.
- Under 5's and 5-19 year old Healthy Weight Pathways updated and completed.
- Family Healthy Living Programme delivered over 5,000 activity sessions to 4,500 different children with 45% from ethnically diverse groups.
- 77 HENRY Healthy Families and 16 HENRY Growing Up parent courses delivered.

7.4 The **Local Government Healthy Weight Declaration (HWD)** is a key vehicle for Leeds City Council to use its influence to create a healthier environment that supports a healthy weight. The governance arrangements for the HWD are currently under review. The Healthy Weight Declaration approach also needs to be considered as a possible future vehicle for adoption by anchor organisations in the city particularly NHS partners who are being encouraged to adopt a version tailored for the NHS.

The HWD is embedded within the city's Child and Adult Healthy Weight Plans, Local Plan Update, Physical Activity Ambition – Moving More, Workplace Mental Health and Wellbeing priorities and the Transport Strategy

- Leeds City Council has a Supplementary Planning Guidance policy for controlling Hot Food Takeaways which is currently under review.
- A Healthier Vending Policy was developed through the HWD to ensure food and drink items met specific standards for healthier options. This has led to published research and cases shared nationally.

- Wellbeing sessions continue to be offered to staff. Topics include; stress relief, menopause, sleep well and links to staff networks. The Health and Wellbeing Strategy developed workplace mental health and wellbeing priorities.
- Animation completed to help explain the HWD. Link to animation: An overview of the Healthy Weight Declaration

8.0 Summary and Recommendations

The numbers of adults and children who are overweight and living with obesity remain high in Leeds and nationally. This causes of this are complex however two of the main factors are an increasingly unhealthy environment and changes in the way in which we acquire and eat food. There has been too much emphasis on trying to support individuals to change their behaviours rather than creating healthy places. Successful programmes need to be built around a system wide approach that includes addressing unhealthy environments.

Local Authorities can play a vital role in positively influencing many aspects of the unhealthy environment as part of this system wide approach. In Leeds there are four key strategies and plans that include population and life course interventions to support healthy weight. They are the Healthy Weight Declaration, Leeds Food Strategy, Adult Healthier Weight Plan and Child Healthy Weight Plan. Updates on progress and next steps for each of these strategies and plans have been described. The intention is to work towards a single healthy weight plan covering adults and children and consider appropriate governance arrangements to steer and oversee work across the life course. It is recognised that the Healthy Weight Declaration is a core component of the work programmes and in terms of future direction and governance.

Scrutiny is asked to note the content and consider the Leeds approach and plans being presented.

Appendix A: DRAFT Leeds Adult Healthier Weight Plan 2024 (AHWP)

Vision: Leeds will be a compassionate, and fair city that provides equitable access to opportunities that support a healthier weight.

Priority Themes	Actions	Aligning Policy
1. Build a food system that increases accessibility and availability of nutritious and affordable food that supports health and wellbeing.	1.1 Develop a Leeds Healthy Options Catering Award and toolkit for local businesses/ organisations working with environmental health, LCC catering and trading standards. 1.2 Work with planning to ensure the local plan update will improve access to healthy food and increase food resilience. 1.3 Implement LCC policy that prevents further development of unhealthy food environments such as advertising, licensing, procurement, and planning. 1.4 Influence wider policy and practice of anchor organisations in Leeds that improve access to a range of affordable, appealing, and nutritious foods.	Leeds Food Strategy Local Authority Healthy Weight Declaration
2. Create an environment that enables equitable opportunities for walking, wheeling, and cycling (active travel) and access to nature for wellbeing.	2.1 Work with planning to: 2.1.1 Improve access to walking, wheeling, and cycling (active travel) in areas of increased deprivation and vulnerable groups. 2.1.2 Protect and develop green and blue infrastructure that support health and wellbeing. 2.1.3 Establish a policy that ensures a range of amenities/ facilities/ services are accessible (complete, compact, and connected policy) for improved quality of life and increased walking. 2.2 Increase opportunities for walking and cycling and maximise learning through the DFT targeted pilot programme.	Physical Activity Ambition Age Friendly Strategy 2022-2025 Local Authority Healthy Weight Declaration
3. Actively protect resilience and wellbeing through compassionate approaches for all adults.	3.1 Address weight bias and discrimination in health care, education and workplaces that affects adult health throughout the life-course through policy, campaigns, and training. 3.2 Raise awareness of and encourage the use of person-first language when referring to obesity. 3.3 Ensure people living with overweight or obesity have access to quality mental health support including disordered eating.	Local Authority Healthy Weight Declaration Mental Health Strategy 2020-25 Priority 1 & 5 Leeds Food Strategy

4. Provide targeted support that increases equitable access for key adult life stages, diverse communities and adults living with disability, and long-term conditions.	4.1 Prioritise targeted support, and interventions for key life-stages between age 18-50 years in lower socio-economic groups to prevent increases in BMI and long-term conditions. 4.2 Prioritise adults living with disability, and long-term conditions through targeted programmes specific to their needs. 4.2.1 Ensure that the NHS Diabetes Prevention Programme is accessible to those eligible and tailored to individual needs of diverse communities. 4.2.2 Identify opportunities to support adults with severe mental illness and/ or learning disability. 4.3 Consider diverse communities with multi-cultural needs in the development of policy, campaigns, commissioning, and delivery. 4.4 Provide targeted support for adults at increased risk of obesity and long-term conditions to access the NHS Health Checks. 4.5 Develop and maintain accessible clinical pathways that provide guidance for health care professionals when referring adults to improve their health and wellbeing including healthy weight and mental health pathways for specialist or targeted services.	Child Healthy Weight Plan Breastfeeding Plan Maternal Healthy Weight Plan Best Start Strategy Age Friendly Strategy 2022-2025 Mental Health Strategy 2020-25 Priority 8
5. Increase awareness and understanding of the complexity of obesity and the wider determinants (social and commercial) that amplify inequalities.	5.1 Develop an understanding of the role of food literacy and security in protecting a healthier weight in Leeds. 5.2 Raise awareness of the social and commercial determinants that affect a healthy weight. 5.3 Identify research development opportunities for understanding the impact of the commercial determinants of health and how to address them in Leeds.	Leeds Food Strategy Marmot City Commitment

Appendix B: Child Healthy Weight Action Plan 2022 (detailed version)

Outcome 1: Leeds is an environment/ city which supports families to be a healthy weight	
Priority	**Action**
1. Whole School Approach	• Develop School Food Friendly, linked to the Healthy Schools Framework
	• Support schools with achieving School Food friendly status
	• Monitor the number of schools providing food that is fully compliant with the School Food Standards
	• Increase the number of schools accessing Healthy Eating toolkits (School Food Ambassadors, Free School Meals, Packed Lunches, Food Policy)
	• Launch our local Just One More campaign to promote vegetable consumption in schools.
	• Provide an annual analysis report using relevant questions from the My Health My School Survey
	• Work in partnership with Yorkshire Sport Foundation to promote Creating Active Schools Framework
	• Attend meetings of the Sport Leeds Schools Working group, advocating for whole school approach
	• Increase the number of schools accessing Mini Sports Leader toolkit (developing pupil leadership skills to lead play opportunities)
	• Support schools with playtime provision, working together to increase play opportunities that are inclusive and fun (staff training, pupil training)
	• Programme planning for PE & Sport conference organised by Yorkshire Sport Foundation on 22/11/22, including showcasing Play Sufficiency findings and HENRY physical activity pilot at Castleton school
	• To add an element of Healthy living training onto the Inspiration - Resilience programme / Mental well-being
2. Leisure and Green Spaces	• Love Exploring will remain on offer to families in Leeds in a minimum of 10 parks until at least May 2024
3. Built Environment	• To identify and support key objectives from the Leeds Food Strategy
	• To support the development and implement a high fats, sugar, and salt (HFSS) advertising policy for LCC
	• To review and update the Hot Food Takeaway Supplementary Planning Document (SPD), with a view to adopt into policy
	• To support the adoption and implementation of a Health Impact Assessment Policy for new large-scale developments
	• To implement a new data driven system for Public Health to comment on major planning applications
4. Moves more, play and active travel	• To support and advocate for play through the Play Sufficiency Assessment, and implement recommendations from the Play Sufficiency audit and developing action plan

	• To develop understanding and information sharing of safe and inclusive physical activities by trusted providers for children and families, such as ParkPlay
	• To ensure continued development of sustainable co-produced activities for children and families within the Get Set Leeds Local localities and continued sharing of learning from the GSLL project.
	• To build a “move more” element into the foster carer training
	• To complete active travel and young people project with Leeds University and share the learning from this project
	• To continue to support, expand and improve the Play Streets offer in Leeds
	• To embed the Leeds Commitment to Children's Play, and establish a Play Partnership
	• To offer leadership on the Physical Activity Ambition priorities of children, families and play, and teenagers and mental health (to work with Council Children's Directorate to provide local opportunities and awareness of healthy eating)
	• To make better links with the local leisure centre to deliver families / parent activities.
5. Local Government Healthy Weight Declaration	• To submit an appendices with the Food Strategy executive board paper on reducing advertising of unhealthy foods
	• To launch the HWD animation
	• To raise the profile of weight stigma particularly with healthcare professionals and in schools and the workplace
	• Support the role out of the Pledge for a Healthy and Active Future (PHAF) for Leeds schools
Outcome 2: All children will have the best start for a healthy weight	
Priority	**Action**
1. Maternal Obesity	• Development of a city-wide maternal healthy weight pathway
	• Rollout of the Food and Activity for Healthy Pregnancy Training – both virtually and face to face
	• Explore how we can engage with women and families more in the preconception period to promote the importance of being a healthy weight
2. Breastfeeding	• To support the implementation of the Leeds Breastfeeding Plan - including Baby Friendly Initiative and Breastfeeding Friendly
	• Roll out of Breastfeeding Resource for Schools (Sept 2023 onwards)
	• Promote the links between breastfeeding and child healthy weight at events e.g. Baby Week, World Breastfeeding Week
3. HENRY	• To develop a larger pool of people who will be able to train frontline staff to deliver HENRY locally (both 0-5 and 5-12) which will enable us to continue to scale up the Henry Programme
	•To continue to support roll out Henry Right From the Start Programmes across Leeds in a hybrid model (f2f and online) and in line with contract requirements

	• Number of families engaging in the HENRY 5-12 programme
	• Produce an annual report to evaluate the impact of the HENRY 5-12 programme
	• To disseminate findings from the pilot to introduce physical activity component to HENRY programme at Castleton school, and to explore feasibility of scaling this up.
	• To develop a pilot workshop for HENRY facilitators to have the skills to deliver family movement sessions
	• To create effective links with local leisure centre to provide opportunities for families and parents to access classes and activities.
4. Healthy Child Programme 0-19	• To commission the 0-19 public health integrated nursing service and have quarterly performance monitoring meetings. To share key points and the end of year report with relevant partners such as the mandated contacts where healthy lifestyle is specifically discussed
	• To deliver 88 HENRY Healthy Families programmes a year
	• To review the Healthy Weight/Growth Management 0-19 pathway
Outcome 3: The causes that put particular groups of children at higher risk of an unhealthy weight will be addressed	
Priority	**Action**
1. Family Healthy Living Programme	• To continue to commission the three providers, quarterly monitor their performance and for each provider to produce an end of year report
	• To report on number of activities and children attending these programmes
2. Healthy Holiday Programme	• To discuss the creation of a physical activity toolkit with the Healthy Holidays steering group
	• To work with Zest to produce the Healthy Holidays plus resources (Healthy Eating)
	• To support families with physical and healthy eating in partnership with Zest (with Emma Andrews)
3. Adolescent 'weight management programme'	• To pilot an Inspiration program with a High School in the JESS cluster (secondary age WM)
Outcome 4: All children and families have information and support including from a skilled workforce	
Priority	**Action**
1. Restorative Practice Approach	• To create a Challenging Behaviour training for children and young people (Active Leeds)
2. Better Health, Healthier Families Campaigns	• To encourage and support partners to use the Better Health, Healthier Families resources
	• To encourage schools to use the Better Health, Healthier Families resources
	• To promote the local Just One More campaign with schools, early year settings and other key partners
3. Workforce Development	• To deliver training on food related and behaviour issues for foster carers
	• Number of school staff attended physical activity and food related training courses provided by Active Schools + and Health and Wellbeing Service

4. Weight Stigma	• To deliver a bitesize session for schools around Weight Stigma and embed as part of the School Health Check and review the My Health My School Survey data to see what/ if anything is reported on children and young people being bullied because of their weight, and if weight/ body image is one of their worries
Outcome 5: Children who are an unhealthy weight are identified early and supported	
Priority	**Action**
1. Data collection and pathways	• To continue to measure BMI of 2-2.5 year olds and share the data with partners
	• To finalise the child healthy weight pathways and share with NHS colleagues and partners
	• Number of referrals onto the HENRY 5-12 programme and number of referrals who complete courses
2. National Child Measurement Programme	• To weigh and measure at least 90% of Reception and Year 6 children from each year
	• To produce and distribute findings to key partners
	• The NCMP partnership to meet at least twice a year
	• To trial contacting parents by phone before they receive the NCMP results letter
	• To promote the NCMP data visualisation tool
	• To attend the regional NCMP partnership and share learnings and updates
3. Specialist support	• To support promoting the Complications to Excess Weight (CEW) clinic at Leeds Children's Hospital to relevant local and regional partners
	• To inform paediatric and CEW colleagues of the community programmes available to their children and families
Outcome 6: Key Leeds stakeholders will work with the government and other bodies to shape national policy and practice	
Priority	**Action**
1. Lobbying	• To attend relevant meetings such as OHID, ICB, WY and Leeds, and contribute to discussions and share experiences and examples of good practice
	• To lobby work with regional and national government colleagues on key topics such as reducing advertising of foods high in fat, sugar and salt supporting the TV ban.
	• To contribute to relevant national consultations
2. Consultation and partnership work	• To work with Leeds Youth Board (Bite Back) to collect local insights on the food environment
	• The CHEW partnership, physical activity steering group and Eat Well Forums to meet at least three times a year
	• To attend the Future in Mind prevention group and identify the links between healthy weight and mental health
	• To promote feedback with key groups when required such as families living in deprivation, children living with disabilities, children living in care and BAME groups for completing needs assessments, equality and diversity screening and training

	• The Healthy Design and Placemaking Group to link in and support CHEW agenda

Appendix C: Local Authority Healthy Weight Declaration - Our 16 Commitments

Strategic/ System Leadership

1. Implement the Local Authority HWD as part of a long-term System wide approach to obesity.

2. Advocate plans that promote a preventative approach to encouraging a healthier weight with local partners, identified as part of a 'place based 'System' (e g Integrated Care System).

3. Support action at national level to help local authorities promote healthy weight and reduce health inequalities in our communities (this includes preventing weight stigma and weight bias).

4. Invest in the health literacy of local citizens to make informed healthier choices ensuring clear and comprehensive healthy eating and physical activity messages are consistent with government guidelines.

5. Local authorities who have completed adoption of the HWD are encouraged to review and strengthen the initial action plans they have developed by consulting Public Health England's, Whole Systems Approach to Obesity, including its tools, techniques, and materials.

Commercial Determinants

6. Engage with the local food and drink sector (manufacturers, caterers, out of home settings) where appropriate to consider responsible retailing such as, offering and promoting healthier food and drink options, and reformulating and reducing the portion sizes of high fat, sugar, and salt products).

7. Consider how commercial partnerships with the food and drink industry may impact on the messages communicated around healthy weight to our local communities Such funding may be offered to support research, discretionary services (such as sport and recreation and tourism events) and town centre promotions

8. Protect our children from inappropriate marketing by the food and drink industry such as advertising and marketing near schools and promotions within schools at events on local authority-controlled sites.

Health Promoting Infrastructures/ Environments

9. Consider supplementary guidance for hot food takeaways, specifically in areas around schools, parks and where access to healthier alternatives are limited

10. Review how strategies, plans and infrastructures for regeneration and town planning positively impact on physical activity, active travel, the food environment, and food security. Consider an agreed process for local plan development between public health and planning authorities.

11. Where Climate Emergency Declarations are in place, consider how the HWD can support carbon reduction plans and strategies, address land use policy, transport policy, circular economy waste policies, food procurement, air quality etc.

Organisational Change/ Culture Shift

12. Review contracts and provision at public events, in all public buildings, facilities and ‘providers to make healthier foods and drinks more available, convenient, and affordable and limit access to high calorie, low nutrient foods and drinks (this should be applied to public institutions scrutiny given to any new contracts for food drink provision).

13. Increase public access to fresh drinking water on local authority-controlled sites (keeping single use plastics to a minimum) and encouraging re-useable bottle refills.

14. Develop an organisational approach to enable and promote active travel for staff, patient's visitors, whilst providing staff with opportunities to be physically active where possible (e g promoting stair use, standing desks, cycle to work/school schemes).

15. Promote the health and well-being of local authority staff by creating a culture and ethos that promotes understanding of healthy weight, supporting staff to eat well and move more.

Monitoring and Evaluation

16. Monitor the progress of our action plan against the commitments, report on and publish the results annually.

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Leeds Tier 3 Specialist Weight Management Service Recovery and Redesign Plans

Leeds Scrutiny Board - Adults, Health and Active Lifestyles
Tuesday 12th March 2024

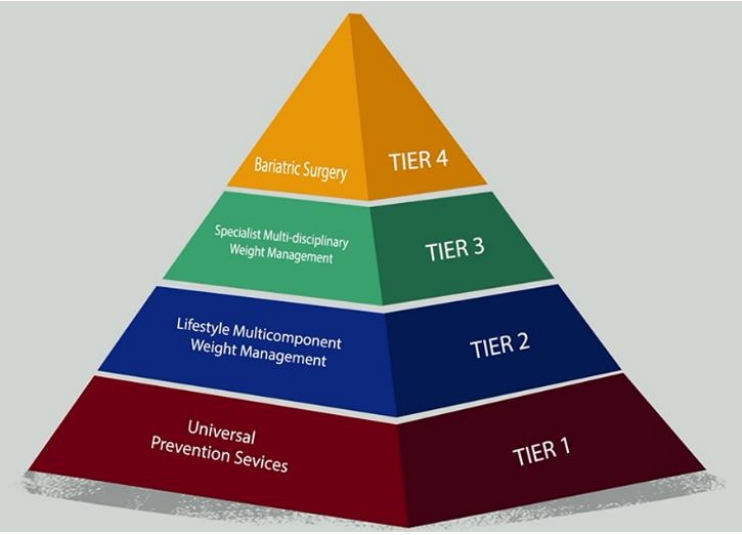
Paper Author(s): Lindsay McFarlane, Head of Pathway Integration, Long Term Conditions, The Leeds Office of the NHS West Yorkshire Integrated Care Board (ICB) - The ICB in Leeds and Ram Krishnamurthy, Clinical Head of Portfolio 2 – Leeds Community Healthcare (LCH)

1.0 Introduction and summary

Weight management services and interventions at both individual and population level are provided in Tiers; Tier 1 and Tier 2 focus on primary and secondary prevention. Local authorities are responsible for commissioning, developing, and ensuring these interventions align with current evidence and best practice guidance.

Tier 3 and Tier 4 represent more specialist, clinically led weight management services, and are commissioned by the NHS. The principle of service provision is to ensure a continuum of person-centred support along a multi-disciplinary weight management pathway that is able to meet individual needs, with higher numbers supported at the lower levels. This is intended to reduce demand for specialist support where the cost and complexity of need is higher. An illustration of this to set the scene is included in **Figure 1** below, in accordance with NICE, Public Health Guideline 53 – 'Weight management: lifestyle services for overweight or obese adults'.

Figure 1: Tiered model of weight management provision



Source: Image from 'Lets Talk About Weight, Public Health England, 2009

This paper is designed to provide the Leeds scrutiny board with an update concerning our Tier 3 Specialist Weight Management service in Leeds. The West Yorkshire ICB in Leeds is the commissioner of this service offer.

The update position summarises that good progress is being made in terms of service recovery and planning for the future redesign of specialist weight management services in Leeds. The highlights include:

- Measures have been taken to mitigate areas of risk / impact on patients and referrers as a result of the current pause to referrals into Tier 3 Specialist Weight Management Services.
- Service recovery is progressing well although it is slow due to the complexity of the patient caseload; we can evidence a reduction in the caseload by 19.7% through appropriate patient management / pathway completion of 260 patients within the tier 3 specialist weight management service between July 2023 and January 2024.
- Opportunities have been identified to further support service recovery; all opportunities will be implemented by the end of June 2024, and will be informed by involvement with patients, carers, staff and referrers.
- Leeds Obesity demographic data has been refreshed and now includes latest BMI data for 23/24; this will help inform referral criteria, prioritisation and future service design.
- July – December 2024, will be utilised to track impact/rate of recovery of opportunities being progressed within the service for redesign.
- Jan-March 2025: Recovery progress will inform timeline / date for when it's feasible to resume to any new referrals (for surgical and medicines pathways). We cannot currently confirm a date.

2.0 Background

The Leeds Tier 3, Specialist Weight Management Service was paused to new referrals from the 15th July 2023, following agreement with Leeds system partners and discussion with the Adults, Health and Active Lifestyles Scrutiny Board during a working group meeting held on 28th June 2023. A summary of the main issues raised during the working group, along with key conclusions and recommendations, was captured in the form of a Statement by the Scrutiny Board, which was formally agreed during the Scrutiny Board's meeting on 11th July 2023 (link to Scrutiny Statement). The Leeds Health and Care Partnership Executive Group (PEG) then provided a formal response to the Scrutiny Board's Statement, which was shared during the Board's formal meeting on 12th September 2023 (link to formal response letter).

Before referrals were paused on the 15th July 2023, we enacted the following measures to ensure that referrers were supported and to mitigate areas of risk as identified via a completed Equality and Quality Impact Assessment (EQIA):

- The decision regarding the referral pause was made in collaboration with all system partners during June/July 2023.
- The referral pause start date was clearly communicated to all referrers via the Leeds GP Bulletin and service website; with two weeks' notice provided concerning the referral pause.
- At the request of the Leeds Scrutiny Committee, we established a monthly multi-disciplinary team (MDT) meeting and have clearly advertised and communicated the offer of MDT discussion to support referrers with people they

may need to support in the absence of a referral route. To date 88 enquiries/patient cases have been discussed with the MDT (12 in August, 9 in September, 9 in October, 24 in November, 22 in December, 12 in January).

- A letter has been sent to everyone on the waiting list, giving a summary of the current situation and providing information and links to helpful websites and local support groups.
- There have been minimal complaints regarding the service pause received from patients and referrers. All complaints have been managed appropriately by either Leeds Community Healthcare (LCH) or the Integrated Care Board (ICB) in Leeds depending on the situation.
- All enquiries from local media / MPs have been managed accordingly
- The Leeds Adult Weight Management Pathway was updated to support all partners with additional supporting information.

It was agreed that with the service paused to new referrals, concentration would be given to recovery of the current waiting list together with a service redesign. This paper provides an update on each of these areas.

3.0 Service Recovery

Following the pause to referrals on the 15th July 2023, the table below (**table 1**) illustrates patient numbers within the service at the point of service close and the current position in terms of recovery.

Table 1: Tier 3, Patient numbers and progress within the paused service

	Change
Number of patients within the service (total service case load)	1323 (15 July 2023) 1063 (31 Jan 2024) Reduction of 19.7% in caseload in 6.5 months
Number of patients awaiting intervention (paused)	577 of the total 1063 case load
Number of patients currently receiving intervention	486 of the total 1063 case load

Please note that the service was commissioned to deliver a 12 month clinical pathway and up to 18 months for liraglutide (Saxenda) pathway, however due to the high number of referrals and high clinical caseload, the patients are remaining with the service for longer periods to complete the MDT pathway.

Following the pause to new referrals which commenced on the 15th July 2023, the following recovery activities have been undertaken:

- All referrals have now been triaged and patients communicated with concerning waiting times.

- Non-recurrent monies totalling £192,500 have been prioritised to the service to support recovery in the short-term. This funding has allowed for the additional recruitment and staffing as outlined below, to facilitate recovery.
    - 0.5 wte additional team manager
    - 0.5 wte non-medical prescriber (specialist nurse)
    - 0.5 wte additional clinical lead dietitian
    - 0.6 wte mental health practitioner support
    - 0.5 wte additional dietitian support
    - 0.3 wte additional physiotherapy support

    This additional workforce was recruited during August and September by the service and will provide additional capacity to help address the backlog until end of March 2024.

- On the 4th September, NICE Technology Appraisal (TA) 875 was published; mandating access to Semaglutide for managing overweight and obesity - Overview | Semaglutide for managing overweight and obesity | Guidance | NICE. Wegovy (Semaglutide) is a long acting, GLP-1, subcutaneous injection manufactured by Novo Nordisk; designed to suppress appetite leading to significant weight loss. The drug alone does not address the root causes of obesity and needs to provided as part of a multidisciplinary weight management service that addresses phycological, dietary and physical activity elements of weight management in order to maximise weight loss and the chances of sustaining weight loss beyond the treatment period. There has been significant media awareness concerning this new drug. The service and ICB in Leeds has therefore spent some time assessing how we might be in a position to offer this drug, and have also commenced discussions with the other places of the West Yorkshire (WY) ICB. An investment proposal of up to £328,000 has been prepared and is due for formal approval at the ICB Leeds Committee in March 2024 that will support 108 patients a year to access treatment with a total pathway cost of £3,034 per patient. The investment proposal will be considered and balanced against all other statutory duties but is strongly recommended, given our obligations to deliver in line with Technology Appraisals.

- The EQIA that we completed for the referral pause has been reviewed at an LCH EQIA review panel meeting on the 16th October; where assurance was obtained that all mitigations have been actioned and that good progress is being made on recovery and service redesign planning.

- Staff morale has been low due to the significant number of referrals and caseload within the service. Additional workforce has begun to help to support staff and better manage the caseload. Staff are continuing to manage patient expectations concerning waiting times, including internal waits. With the service paused to referrals, this risk is currently mitigated.

The ICB and LCH, has had discussions with the Leeds Long Term Conditions Population Board where this recovery and redesign pathway aligns in terms of governance. Based on active and waiting list patients within the service and the recovery activities completed to date (as summarised above), it was acknowledged by the LTC Population Board in December 2023 that based on the current rate of recovery and minimal investment (due to wider system financial challenges); patients at the very end of the waiting list will not start a treatment pathway until November 2026 based on the current rate of recovery, and therefore resuming referrals is not yet feasible. System partners on the LTC Board, which include representation from Primary Care, via the Leeds GP Confederation are aware of this position. The service hopes to bring this date forward by exploring and implementing a number of opportunities as below:

Opportunity 1	**Early identification by working in closer collaboration with LTHT Tier 4 surgical offer to generate some opportunities across both services**
High-level Description	Tier 4 suitable patients (approx. 25% of caseload) identified at month 4 placed on a shared care pathway with LTHT Tier 4 surgical service – potential to reduce tier 3 pathway / reduce waiting time for Tier 4 Efficiencies may be feasible via shared team resources; admin, dietetic and psychological expertise. A small number of patients have been identified as suitable to be reviewed for Tier 4, this should help improve patient experience.

Opportunity 2	**Utilise fully the National Diabetes remission offer and also explore the offer of other GLP1 drugs that may support weight loss within the Diabetes Leeds service – this opportunity will result in the discharging of some patients from the current waiting list**
High-level Description	Mandate that all patients with Type 2 diabetes and applicable BMI have been offered the national Diabetes Remission offer and exhausted this route first. 400 referrals available across WY in 24/25.

Opportunity 3	**Review the psychiatry/mental health support**
High-level Description	Have a clear offer of psychiatry / mental health input within the service to support the patient whilst they are in the tier 3 service.

Opportunity 4	Digital offer
High-level Description	Explore all opportunities for digital delivery, i.e. recording of key education messages/videos (structured education) and group delivery online; Wegovy pathway will support this.

Opportunity 5	More structured education
High-level Description	Provide more offers of structured education for weight management whilst patients are awaiting treatment.

Opportunity 6	Revise referral form and pre-referral work up
High-level Description	In preparation for referrals resuming; a structured process for supporting the service in quality of referrals is needed; for example, all bloods completed prior to referral and pre referral entry requirements evidenced in primary care.

Opportunity 7	Implement new medicine pathway for Wegovy
High-level Description	Implement Wegovy pathway subject to funding approval in March 2024. The pathway will offer a 68-week medicines pathway (in line with NICE guidance) for up to 108 patients in year 1 from go live. The service will have capacity to initiate up to 9 patients a month. Implementation will involve prioritisation of the current specialist weight management waiting list with consideration of patient need including both BMI and comorbidities.

The LTC Board, LCH and the WY ICB in Leeds, cannot yet confirm a date for resuming referrals into the specialist weight management service. The board and partners have agreed the following tentative timeframe for immediate next steps:

- March – June 2024: Work through implementation of all above opportunities which are feasible and assess how these will impact rate of recovery (includes design of referral criteria/referral forms – opportunity 6) with patient/carer, staff and referrer involvement (as outlined in **section 4.0**).
- July – December 2024: Track progress/rate of recovery
- Jan-March 2025: Recovery progress will inform timeline / date for when it's feasible to resume to any new referrals (for surgical and medicines pathways).

4.0 Service Redesign Engagement

We are committed to redesigning our specialist tier 3 service in Leeds, whilst paused to referrals, and are committed to involving stakeholders in this service change in line with our statutory involvement duty. Rather than carrying this out as a one-off piece of engagement, our intention is to involve stakeholders, including staff and patients, in a developing conversation. This will provide flexibility in relation to how the work

progresses and where input on specific areas e.g. focus groups on referral criteria, may be best placed.

To date, we have a service redesign engagement workstream project group which is meeting fortnightly. The following activities have been undertaken to inform our engagement plans for this redesign:

Staff and Referrer survey

As part of the commitment to involve stakeholders in this potential service change, we sought the views of staff in the current service, and of external staff who refer people into the service.

Between October and December 2023, 34 members of staff who work in (10) or refer into (22) the Leeds Tier 3 Specialist Weight Management service completed an online survey, providing their thoughts on what works well and what needs improving about the service - (2) staff did not specify where they were from.

Whilst acknowledging the challenges long waiting times and a lack of capacity bring, staff working within the service told us they value:

- the multi-disciplinary team approach,
- the team's caring approach to patients, and
- the benefits of some virtual / online ways of working.

Staff in the service felt that more work to improve referral processes and information and communications with patients, and wider stakeholders, would benefit staff and patient experiences.

Staff referring into the service reported some challenges with the referral process, with information and communication, and also noted a lack of follow-up about patients who had begun the programme.

Focus Groups (including hearing from patients)

Via the staff and referrer survey, we asked for volunteers to offer their time and expertise to participate in future focus groups. Together with patient representative groups, these focus groups will be asked to consider and discuss possible options for the future model of service delivery which arise from opportunity workstreams outlined in **section 3.0**. We will be keen to hear from patients waiting to use the service, those currently using the service, and people who have completed the service to learn from their experiences. We anticipate this involvement activity will contribute to the work looking at feasible opportunities, including the design of referral criteria / referral forms (opportunity 6) between January and June 2024.

Friends and Family Analysis

During September and October, over 350 Friends and Family survey results from the Tier 3 Specialist weight management service between January 2020 and October 2023 have been analysed.

Main themes include:

- The importance of being, and the desire to be, seen face-to-face – especially following the pandemic.
- People want to speak to someone when they call – not just an answer phone.
- The negative impact of staff turnover, resulting in cancelled or rearranged appointments.
- The need for additional support, especially person-centred and psychological.
- The length of the wait to start with the service.

Other parts of our engagement to date include conversations with West Yorkshire colleagues on work taking place elsewhere. The involvement plan is being updated to take account of the developing conversation approach to involvement activities.

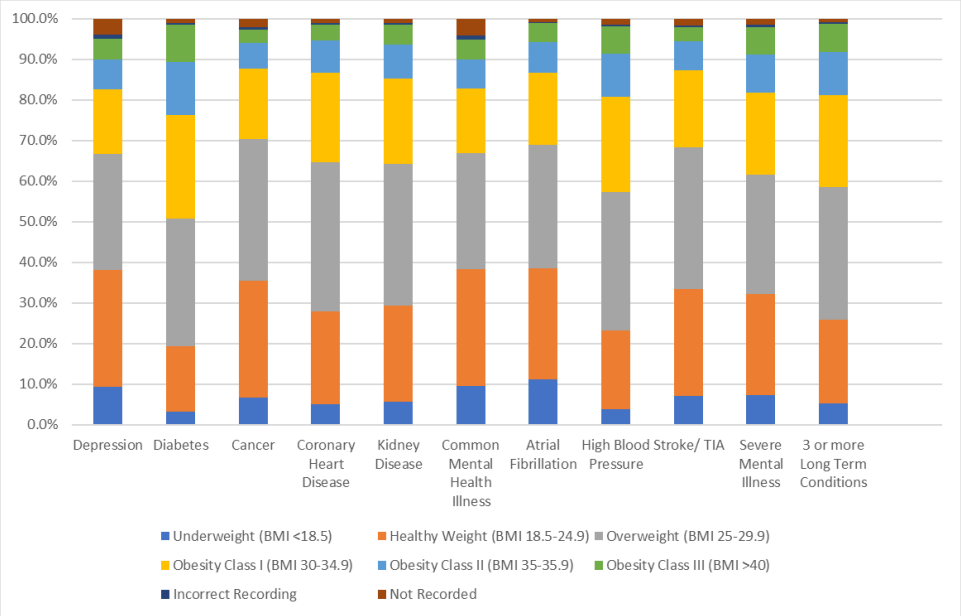
5.0 Latest Leeds Obesity Demographic Data

Alongside service recovery and redesign, we need to consider the refresh of our Leeds obesity demographic data. Some headlines are provided below, with appreciation that related papers provided by Public Health to this scrutiny meeting include further analysis of deprivation and demographics.

Based on 2022/2023, GP practice recordings:

- 29.31% of the Leeds population +18 are a healthy weight (213,760 people out of 729,384 population with a recorded weight in their GP record)
- Almost 40% of the Leeds population; 290,857 are overweight/classed as 'Obesity 1'; a BMI of between 25-35
- 8.3% of the Leeds population has a BMI of 35 and above (60,586) and might be eligible for Tier 3 or 4 specialist weight management services commissioned by the ICB; which this paper relates to.
- As we consider risk stratification of patients as part of the service model (specifically for the Wegovy medicines pathway), we do need to consider the multi-morbidity data that is available from GP records; as summarised in **Figure 2** below for those by BMI. This data will be key for the Leeds Long Term Conditions Population Board.

Figure 2: Percentage of adults 18+ for each BMI category for each long term condition to show prevalence of people with underweight, overweight or obesity classes



Next steps

As detailed within this paper, the next steps are:

- March: Communicate timescales and updates as below more widely following Leeds Scrutiny and ICB Committee meetings in March 2024. Alongside the investment case for Wegovy, discussions have also commenced regarding potentially maintaining the current non-recurrent budget of £192,500 – which would further expedite recovery plans. If supported by the ICB Committee in March, the below timescales may change.
- March – June 2024: Work through implementation of all opportunities and assess how these will impact rate of recovery with patient/carer, staff and referrer involvement.
- July – December 2024: Track progress/rate of recovery
- Jan-March 2025: Recovery progress will inform timeline / date for when it's feasible to resume to any new referrals (for surgical and medicines pathways).

Adults, Health and Active Lifestyles Scrutiny Board

12th March 2024

Briefing

Primary care perspective of supporting healthy weight.

1. Purpose

The focus of the March AHAL Scrutiny Board is on the city's offer to help support healthy weight and active lifestyles.

You have asked for a briefing on a primary care perspective. Recognising that GPs have a key role in the community in terms of helping to identify individuals, potentially through the NHS Health Checks or links with health and wellbeing coaches. Also, when people approach directly, by those in need of advice and support about improving their lifestyle and losing and managing weight safely including signposting to available sources of support or facilitating referrals.

2. Background

General Practice is an active participant in the Long Term Conditions Population Board where many of the decisions relating to Weight Management are agreed. The decisions relating to Tier 3 Weight Management, whilst understanding the rationale including the financial position, have not been wholly supported by General Practice. Pausing Tier 3 weight management services, in order to recover and redesign the service has an impact on patients as well as General Practice. As significant, is the absence of Tier 2 weight management services.

3. Impact

When a patient is identified as having weight issues, the options for General Practice are extremely limited. This is having a significant impact on the ability of GP practices in Leeds to help and support their patients who are overweight or obese and who are at risk of developing related complications.

GPs are asked to check a patients BMI for multiple conditions and are expected to provide primary prevention with NHS health check. But then with no options to offer this can undermine the clinician-patient relationship given no practical therapeutic actions to offer patients after completing an NHS health check or discussing weight management.

Unless patients have diabetes or hypertension, for which a national digital weight management system is an option, there is no Tier 2 weight management service for GPs to refer them to and the decision to pause Tier 3 weight management services accepting any further referrals has already had a huge impact. This being increased demands on General Practice and limited ability to slow down the progression of associated diseases.

Ultimately primary care will be the first service to see the effects of the worse health outcomes which will result from the lack of a tier 2 service, further increasing primary care workload in the medium term.

It is recognised that there are specific healthy weight pathways for 0-5 year olds and, 5-19 year olds. Although some of the services where children are referred to in the pathways can have long waits.

4. The reality

The reality in a GP Practice is;

- For the vast majority of people identified or seeking support, the options are extremely limited.
- Roles in Primary Care Networks (PCNs) tend to be directed towards filling the gaps caused by a reduction in other services. For example, PCN Health Coaches to cover Tier 2 work. This then limits PCN roles on other functions, for example improving access.
- Any options for patients usually come with a cost; leisure centres, weight loss programmes. This then impacts areas of deprivation the most. Potentially increasing health inequalities.
- Weight is often a cause of multiple other clinical conditions. These will be the focus of attention of the clinicians, whilst attempting to motivate someone to lose weight.
    - *A real example: Patient is significantly overweight and requires a knee replacement. Surgery paused until weight is lost. No services to support weight loss. Patient tries their best with limited success. Knee gets worse, becomes immobile. Mental health deteriorates.*
- Education on food choices, combined with cost of living problems, make the GPs impact on encouraging weight loss extremely limited.
- Concern over use of and access to injectable drugs to combat obesity.
- Limited communication to the public of decisions made outside of primary care resulting in unnecessary difficult conversations with patients with the GP being the messenger.
- GPs are expected to deliver the NHS England weight management enhanced service https://www.england.nhs.uk/gp/investment/gp-contract/weight-management-enhanced-service/ but are unable to do so because no tier 2 service exists to refer to, despite this enhanced service stating that local government have been given the funding to deliver this service.

So, what is General Practice doing to mitigate;

- A component of NHS Health Checks is motivational interviewing. This will offer lifestyle advise, signposting and resources in an attempt to make positive behavioural change. This impact of this is limited due to the volume of Health Checks and the time available with patients.
- There maybe local services or interventions that patients can be signposted too, but these will vary. For example, Weightwatchers / Slimming World. Inevitably these have a cost and there is not consistency.
- Social Prescribing colleagues within practice will offer support with healthy living, including smoking and weight. This can be limited and in part, is only as good as the available services within the community and the ability of the social prescriber to offer motivational interviewing type techniques.

- Some PCNs are looking at appointing a dietician. However, the Direct Enhanced Scheme (the NHS England contract for PCNs) has not been confirmed for 24/25, therefore PCNs are unable to make firm commitments regarding staff.

5. Summary

In summary there is a strong sense that the absence of Tier 2 or 3 service for weight management is both unacceptable and counter-productive as it'll lead to increased health-related costs for the city in the future. For individual patients and colleagues in Primary care this position can lead to poor quality care and worsening outcomes.

Leeds has made a commitment as a "Marmot City", central to which is to reduce health inequalities, and yet failing to provide a service to help people reduce their weight will only widen health inequalities further. It will be the poorest who cannot afford to pay for private weight management support who will be impacted the hardest.

There is a recognition of the financial pressures impacting local government. However, obesity currently costs the NHS £6 billion annually, a figure which is expected to rise to over £9.7 billion each year by 2050 if action is not taken. To cut the weight management service in Leeds will not only impact the health of our patients but also increase cost pressures on the NHS in the future.

It is critical that we do all we can now to help patients who need to lose weight and would welcome your support to reinstate this essential service.

Appendix 4

Report authors: Emma Powell, Project Enabler / Gill Keddie, Active Leeds Development Manager / Judith Fox, Public Health Manager / Heather Thomson, Head of Public Health

Tel: 07562 439 310

Physical Activity Ambition Update

Date: 12th March 2024

Report of: Director of City Development and Director of Public Health

Report to: Adults, Health and Active Lifestyles Scrutiny Board

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

Brief summary

This report provides an update on the Physical Activity (PA) Ambition for Leeds which is being led by Active Leeds and Public Health. It includes details of work programmes and achievements delivered by Active Leeds and Public Health against the priorities.

Recommendations

a) Note and comment on the content of the report.
b) To note the progress on the Physical Activity Ambition and priority workstreams.

What is this report about?

1 This report is presented as one of four reports and provides an update on the Physical Activity Ambition work following the last update to AHAL Scrutiny provided in March 2023. The three additional reports focus on the role of Leeds City Council in increasing the numbers of people who are a healthy weight; the role of the NHS in delivering behavioural and pharmacological interventions to support weight loss; and the perspective of primary care and General Practitioners, via the Leeds GP Confederation.

Leeds Physical Activity Context:

2 There is clear evidence that being physically active is essential for good physical and mental health and wellbeing (World Health Organisation, 2023). As well as being physically active, it is important that all adults and children minimise the time spent being sedentary for extended periods according to the Chief Medical Officer (CMO) Guidelines, 2019.

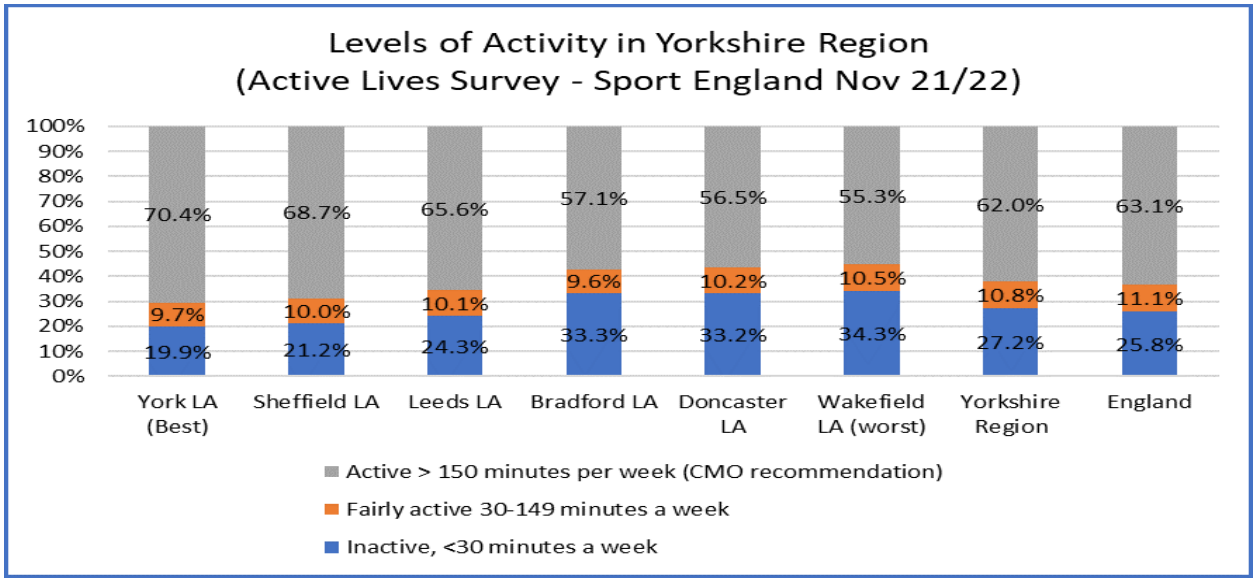
3 Delivering the city's vision for physical activity *'Leeds is a place where everyone moves more every day'* contributes to achieving the Best City Ambition. Creating a city where everyone moves more impacts positively upon health and wellbeing, carbon emissions, and inclusive growth.

4 Physical activity remains a key priority for Leeds City Council and is embedded throughout city policy and strategy. Physical Activity is a priority within the Leeds Health and Wellbeing Strategy 'A city where everybody can be more active, more often' and contributes to reaching our vision to be a healthy and caring city where people who are the poorest improve their health the fastest. It is also highlighted as a key theme within the Big Leeds Chat, as well as contributing to the Leeds Marmot City Commitment to create a fairer, healthier city for everyone.

Levels of Physical Activity in Leeds

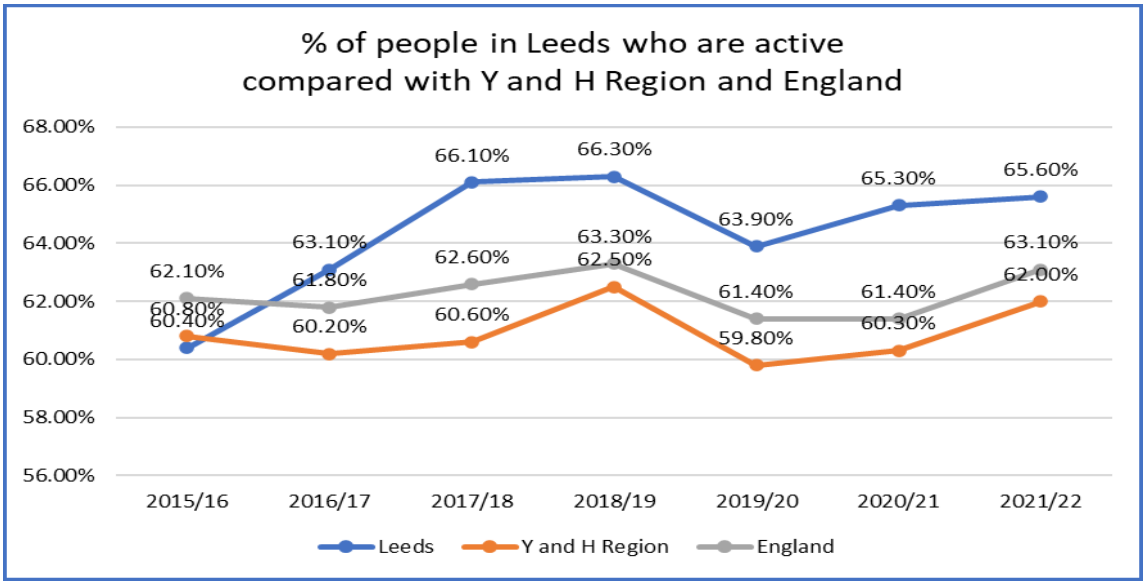
5 Physical Activity data (adults age 16+) is collected by Sport England via the 'Active Lives Survey'. The latest Active Lives data shown in Figures 1 and 2 currently shows that for 2021-2022 Leeds compared well with other towns and cities in the Yorkshire and Humber Region, being the 5th most active area out of 15. The rates of people who meet the CMO guideline of at least 150 minutes of activity per week is 65.6% in Leeds compared with 62% across Yorkshire and the Humber and 63.1% in England. Although this is a positive picture there is much more to be done with the focus being on inactivity levels as this where the most health and economic gains are to be found.

6 **Figure 1:** Sport England Active Live's Adult Data for Leeds, Yorkshire and England Nov 2021/22.



7 When looking at progress over time since 2015, a fluctuating trend is apparent with a notable increase of people meeting the CMO activity guidelines prior to the Covid-19 pandemic, peaking in 2018/19 (66.3%). This trend is also seen in both the regional and national figures although since 2016/17 Leeds has been consistently higher.

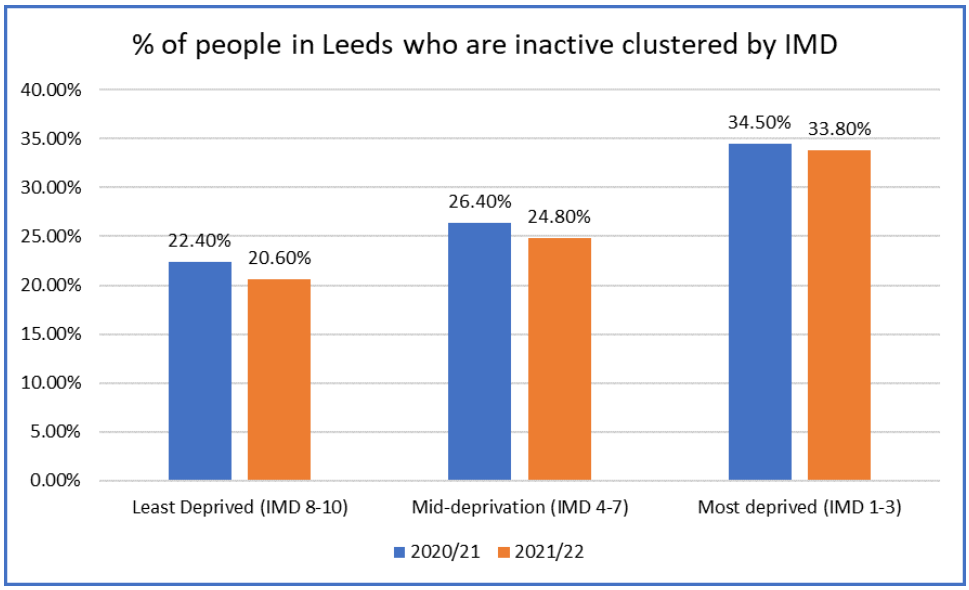
8 **Figure 2**: Sport England's Active Lives Survey comparing Leeds with Yorkshire and Humber Region



Overall, Leeds appears to be recovering in terms of physical activity following the pandemic with activity rates almost back to those in 2017/18.

9 However as shown in Figure 3, on further examination of data by deprivation (collected since 2020/21), it is noted that the levels of inactivity in the city remain highest in the most deprived areas of the city and whilst there is an improvement in people moving from inactive to active or fairly active, this shift has been greater in the least deprived areas (1.8% change) compared with most deprived (0.7% change). This indicates there is a continued need to focus work with these communities to better understand the barriers to physical activity including environmental factors and identify the preferred type of activity.

10 **Figure 3 Active Lives Survey: Inactive clustered by IMD 2020-2022**



What impact will this proposal have?

11 Working together, Active Leeds and Public Health continue to drive forward the vision of the Physical Activity Ambition: *Leeds is a place where everyone moves more every day*. This is supported by a wider network of partners that are involved throughout the governance structures and projects detailed below. Examples of these partners include Leeds Beckett University, Yorkshire Sport Foundation, Health Partnerships Team and the Leeds Place Based Integrated Commissioning Board. All partners recognise that the approach to decreasing inactivity levels is long-term, involving systemic change as well as seeking to harness the strength of individuals and their communities.

12 It is also acknowledged that a greater impact can be achieved in physical activity levels if the change occurs at a societal and environmental level and takes a population approach rather than just focusing upon individual lifestyle interventions. This is the basis of our city-wide approach with all elements of this work under-pinned by a focus on reducing inequalities within the most disadvantaged populations and communities. This can only be achieved by working across the system with a range of partners not only those engaged in physical activity and health but wider to influence system changes.

Physical Activity Governance

13 The Leeds Everyone Moving More Leadership Group supports this work by championing and influencing change in line with the Physical Activity Ambition. There are operational working groups in place to drive progress on the priorities. Physical activity is a complex, city-wide topic that no individual organisation owns. The Council and partners adopt an enabling, place-making role working together with multiple stakeholders.

14 Representation within the Leadership Group is system-wide covering multiple Leeds City Council departments including Operations & Active Leeds, Public Health, Strategy & Policy, Planning and Sustainable Development, and Climate, Energy and Green Spaces as well as the Executive member for Public Health and Active lifestyle. External representation comes from Healthwatch Leeds, Leeds Integrated Care Board, Sport England, Yorkshire Sport Foundation and the Third Sector.

Insight and Evidence Driven Approach

15 As previously reported to this Scrutiny Board in February 2022, the development of the new Physical Activity Ambition began with a city-wide conversation called “Get Set Leeds”. Get Set Leeds was a proactive engagement campaign which was the largest-ever study completed in Leeds around the importance of physical activity on the lives of over 4,500 residents. It encouraged people to share ideas on what getting active meant to them and what might support them to move more. It also focused on identifying assets, barriers, and co-producing solutions. A summary of the findings and key messages can be found here: https://www.youtube.com/watch?v=N_LD9RxEia8

16 In response to the Covid-19 pandemic Leeds Beckett University was commissioned to undertake Rapid Literature Reviews from January 2021 to help to understand the impact that Covid-19 was having on physical activity and wider determinants. The Rapid Literature Reviews have been significant in helping to focus the priorities for the Physical Activity Ambition. Leeds Beckett University has continued to review the literature in order to help shape and guide the work.

Physical Activity Framework and Priority Update

17 Based on guidance from the World Health Organisation Global Action Plan on Physical Activity 2018-2030, the Physical Activity Ambition has applied a framework of four objectives (Figure 4).

18 **Figure 4**: Leeds Physical Activity Ambition Framework

Active society	Active environment	Active people	Active systems
We will create a social norm where it is the easiest choice to be physically active every day.	We will work with people to understand the external drivers affecting their physical activity levels	We will work with identified target groups to create small changes to how capable they feel to be physically active every day and test new ways of working.	We will work in partnership to create a healthier place, a greener city and a stronger local economy.

19 Active Environments and Active People were selected as the initial focus for the Physical Activity Ambition and programmes of work were developed under these. This was agreed by the Physical Activity Ambition Steering Group, Health and Wellbeing Board in 2021 and Adults, Healthy and Active Lifestyles Scrutiny Board in 2022.

20 During 2023 the programmes of work were refreshed and expanded in line with current insight and research and against the strategic direction in the city. This refresh involved engagement with partners and the Leeds Everyone Moving More Leadership Group.

21 There are now seven workstreams, taking a life-course approach, and updates on their progress are described below.

Active People

Children and Young People: Young Minds Get Active (YMGA)

22 This workstream focusing on young people and mental health is being led in partnership across Yorkshire Sport Foundation, Public Health, Children and Families, Active Leeds and third-sector physical activity partners (supported by Street Games and Voluntary Action Leeds), and mental health specialists including MindMate Ambassadors and local schools.

23 The YMGA working group has recently been reviewed and now has a refreshed co-produced purpose statement: *Our group is dedicated to improving the mental wellbeing of children and young people in Leeds. We firmly believe that engaging in Physical Activity plays a crucial role as part of the offer support and as a protective factor. Our primary objective is to expand access to Physical Activity for our children and young people.*

24 In June 2023 a communications campaign was launched called 'Make Your Move' which includes 20 videos co-produced with young people about how movement can help their mental health. Videos featured a wide range of activities including basketball, skating and being out in nature.

25 Content on the MindMate website was updated with campaign assets and supporting materials. The website promotes partner organisations that follow a trauma-informed approach to ensure young people can access support suited to their mental health needs.

26 'Make your Move' has had significant reach. To date, the campaign has:

- Reached 53,368 social media accounts within target group (16-25 year olds in Leeds).
- 1,366 link clicks from Meta (mostly Instagram) to landing page on MindMate site.
- 3,936 video views of 15 secs or more.
- Overall, the 'Click Through Rate' for the campaign was 3x greater than the average for other MindMate campaigns.

27 Following a review of the action plan, the next steps of this workstream will focus on the intended outcome: *The physical activity workforce (including third-sector organisations delivering physical activity opportunities) has a good knowledge of what support is available to support young people to manage their mental health and feels able to navigate referral processes and information systems.*

Children and Young People: Play

28 Play Sufficiency is an ongoing process of research and action to assess, improve and protect children's opportunities for play. Play Sufficiency is a powerful organising principle of community development. By using an evidence-based approach and looking at communities through the lens of a child it has the potential to bridge policy and unite cross-service departments to improve children's lives through developing communities that work for all age groups.

29 Leeds is proud to be the leading the way by being the first city in England to work through a full Play Sufficiency Assessment. The research element has been led by Active Leeds, working with Fall into Place, Public Health and Child Friendly Leeds. Play consultants Ludicology have been commissioned to guide Active Leeds through this journey, funded through the Sport England supported project Get Set Leeds Local (GSLL).

30 Play Sufficiency is about securing sufficient opportunities for children's play and involves far more than simply looking at designated provision. It is about cultivating the time, space and attitudes needed for children's play. The initial assessment provides a thorough account of the ways in which spaces, services, practices and policies currently work across Leeds to support or constrain children's opportunities for play. It also provides an opportunity to identify ways in which adult run organisations can improve their responsibilities towards children and their play. This will in turn inform the development of a strategic action plan aimed at cultivating more favourable conditions for children's play.

31 The Play Sufficiency assessment and subsequent action plan will explore and influence work across a wide range of departments, including those associated with policy development and strategic partnerships, the built and natural environment, and community and children's services.

32 In December 2023 proposals for this workstream were taken to Executive Board where it was agreed:

- For Executive Board to support and endorse the Play Sufficiency priorities, which directly link to Child Friendly Leeds Wish 2, the new play priority in the refreshed Children and Young People's Plan and the Physical Activity Ambition.

- To approve the appointment of the Executive Member for Children's Social Care and Health Partnerships as a Play Champion to raise awareness of Play Sufficiency and to support the work of Play Sufficiency across all directorates of Leeds City Council.

- For the Play Champion to help drive the development of the Play Sufficiency Action plan and provide annual oversight of progress to the Executive Board.

- For the Executive Board to support embedding the Play Sufficiency principles and recommendations within the Priority Neighbourhood Partnership Plans

33 The outputs for 2023/2024 will be:

- A full Play Sufficiency assessment report identifying current levels of satisfaction, strategic priorities, strengths and weaknesses of organisational systems and recommended areas for improvement.

- A strategic and cross-departmental action plan, making best use of the people and financial resources available.

- The continuation of an informed Play Sufficiency Partnership and the development of a governance model for this strategic group.

- The establishment of local Play Sufficiency partnerships at a focused neighbourhood level.

- The development of a Community of Play to celebrate play within the city.

- The capturing and sharing of good practice in Leeds through the partnerships, events and workshops to demonstrate where colleagues, departments and partners have responded to the Play Sufficiency principles.

- The development of a Play webpage, which hosts the Play Sufficiency resources and information (as well as other play-related content for the city) and links directly to the Child Friendly Leeds and Physical Activity Ambition webpages.

Ageing Well

34 The focus on the Ageing Well priority came from a Rapid Health Needs Assessment that identified inactivity levels had risen during the Covid-19 pandemic for those aged 65 years and above. In particular strength & balance activity was reported to have decreased. Modelling also predicts that 110,000 more older people are projected to have at least one fall per year as a result of inactivity (OHID, 2021).

35 A working group consisting of multiple partners including Active Leeds, Public Health and Health Partnerships have co-produced an action plan covering the following areas:

- Communications
- Workforce development
- Age friendly providers and venues
- Connections with secondary care

36 In June 2023 a Leeds strength and balance campaign was launched. This campaign focused on strength and balance for people aged 40 years upwards and/or living with frailty or a long-term condition. This campaign has been influenced by the research reviews conducted by Leeds Beckett University (2021; 2022) which advised that the target audience should be lowered to 40years.

37 Since the launch of this campaign the assets produced have reached a significant number of people and include:

- Impressions (number of times the adverts have been seen): 2,013,853
- Reach (number of people the adverts have been seen by): 182,169
- Link clicks: 2447

38 The strength and balance campaign received additional funding from the Frailty Steering Group and has been extended to March 2024. The campaign directs this targeted audience to supporting materials on the Active Leeds website. This provides more information linked to topics covered in the campaign such as ‘new beginnings and retirement’, ‘menopause’ and ‘building confidence’. There are also details on how to exercise at home and support available in the local community.

39 A review of the Ageing Well priority is currently underway with partners across the city.

LEAP - **Leeds Encouraging Activity in People**

40 ‘Leeds Encouraging Activity in People’ is a pilot targeted exercised referral programme with the primary aim of increasing physical activity levels of inactive people who have a long-term health condition. LEAP targets 4 specific health conditions within the NHS Core20PLUS5 approach:

mental health, diabetes, COPD and hypertension. Physical activity is known to positively affect or help manage these conditions. The pilot project is currently in four Primary Care Network areas which are: West Leeds, Armley, Middleton and Hunslet, and HATCH (Chapeltown, Burmantofts, Harehills and Richmond Hill). This is a new priority workstream within the Physical Activity Ambition.

41 The project works by an individual being referred through a professional such as a GP or community provider or self-referring (meeting the criteria above). The individual is seen and supported by a clinically qualified exercise professional and offered a 52-week bespoke personalised exercise programme. The individual has the choice of local activities which could result in one or more of the following options: discounted leisure centre membership, free / low-cost community activities, home-based programmes, walking/ cycling opportunities. Between April 2023 and January 2024 there have been 865 people through the referral process.

42 LEAP is currently being evaluated by Leeds Beckett University to help establish if the model works for Leeds. There are three key questions in understanding the pilot:

- What impact does LEAP have on physical activity levels?
- What are the associated health and wellbeing impacts of LEAP?
- How do the routines and practices within LEAP influence these?

43 The report is currently in draft with Leeds Beckett University with some of the preliminary key messages:

- LEAP delivers an effective behaviour change approach.
- Most referred clients were inactive before LEAP, 80% of whom became active after joining the programme.
- LEAP is effective in helping individuals who are ready to become physically active to make this a reality.
- LEAP is especially effective in helping people living with multiple morbidities to become more physically active. 73.9% physically inactive clients with multiple morbidities became regularly physically active
- When participants become more active, they report an improvement in their mental health. 76.3% of all clients achieved statistically significant improvements in SWEMWBS (Short Warwick Edinburgh Mental Well-Being Scale) scores.
- Those who join LEAP with a mental health condition experience the highest mental health benefits, moving positively 5.6 points up on their SWEMWBS scores.

44 LEAP is currently funded until March 2024 through multiple partners including Active Leeds, Public Health and the ICB. With support of the evaluation, a programme board and supporting operational groups an options appraisal of how to best proceed into the next financial year is being explored.

Active Environments

Get Set Leeds Local

45 Get Set Leeds Local (GSLL) is a Sport England funded project which combines a place-based approach with community-based co-production. The project began in December 2019 and is funded until November 2025. The total Sport England funding committed to the project to date is £832K. Our place-based approach ensures we work in an asset-based way to bring people

together to develop innovative community projects that meet local need and help create environments to maintain healthy lifestyles.

46 GSLL supports Leeds City Council's locality-based approach focusing work in areas within the top 1% most disadvantages neighbourhoods with a focus on building on existing strengths and capacity in communities. Work is currently focussed in four of our priority localities in Leeds; Seacroft, New Wortley, Beeston and Holbeck. In addition to this over the next two years GSLL Project Team will begin to embed its approach within the Easterly Grove, St Wilfreds priority locality within the Gipton and Harehills ward.

47 GSLL starts with people, building strong connections at a local level using co-production. Our co-production principles guide a process of working with people to design and deliver projects together as communities are more likely to take part in activities if they've been included in their development. We take time listening, talking, and working with people to understand their needs building strong relationships with communities and genuine commitment to overcoming barriers. To support this, Sport England funding can be injected into projects to help overcome barriers in the form of our community chest and co-production funding pots.

48 GSLL's evaluation is delivered through Leeds Beckett University who lead on a developmental process evaluation. This means the story of the project is recorded through-out the project life cycle and fed back regularly to the project team so that they can immediately use the learning to adapt how the project runs. Through the collation of case studies, project stories and journey maps GSLL has started to build a picture of what works well where, when and for whom in each community. This learning is being turned into resources such as the development of an interactive online toolkit that anyone designing community based physical activity initiatives can use.

49 The learning from our evaluation partners so far suggests the project approach has led to the following impact:

- By engaging flexibly and responsively with communities, GSLL has built reciprocal, trusting and sustainable relationships

- Credibility has been established with local partners through the genuine commitment from the outset to co-production.

- GSLL has established trusted relationships by undertaking a subtle, supporting role, not a leading role with community organisations. Consciously avoiding situations where dependency can be built, and local initiative crowded out. The community chest pot has been valuable in generating interest, commitment and trust in communities.

50 A key role for the GSLL project team is to share the learning that is emerging through this work. GSLL is building understanding about how to develop active places in our most deprived communities. It is hoped it is also demonstrating an approach that can be used in community development work across all sectors in Leeds.

51 Over the last 4 years the GSLL team have supported multiple community projects covering a wide range of physical activities to local residents. These projects celebrate moving more in a variety of ways including Football, roller skating, cycling, dance, swimming, running and play as well as litter picking and gardening. Many of these projects have received our community chest pot funding, training and larger co-production funds along with further support and guidance from the Active Leeds team. Key to this has been the teams support in building connections with other assets in their communities. The variety of projects are celebrated in our GSLL newsletter released twice a year, sharing the journeys of these projects. Please find our newsletters here: Get Set Leeds 2023 Newsletter

Active Workplaces

52 This project focuses on working with employers & employees to co-design projects that focuses on their health and wellbeing challenges using physical activity. This is a new priority workstream within the Physical Activity Ambition.

53 The aims of this work are:

- To support organisations with their health and wellbeing challenges using physical activity approaches.
- To support individuals within the workplace to improve their mental and physical health.
- To develop a flexible Active Workplaces model with robust evaluation. Learn how to co-create work-based projects and share learning to scale.
- To create and develop a network of relationships with organisations in the city and increase the connectivity to the physical activity system in Leeds.

54 The Active Workplaces approach has three elements that work together to meet the aims above.

- The Active Workplaces Network: This is a platform for sharing research, insight, and current best practice. Currently 125 organisations have signed up to attend a twice-yearly event in conjunction with Leeds Becketts University and University of Leeds. This conference style event provides these organisations with the latest research and insight and allows a space for the system to connect and network together.
- Wellbeing Leads Thinking Group: A smaller focused thinking group of Wellbeing Leads that are invested in collaboration and joining up to support and learn from each other's challenges and solutions.
- Developing partnerships with organisations: Co–creating approaches with the workplaces to engage workers and managers in physical activity. This includes approaches for prevention and resilience as well as physical and mental health. The offer to workplaces within the model includes but not limited to consultancy, delivery staff, events, training and capacity building, health and wellbeing coaching, confidence and capability building.

55 The Active Workplaces project has been supporting a range of Leeds City Council internal teams & services by working with the internal 'Be Well' approach. A variety of supporting activity includes interactive health and wellbeing events, direct delivery of 1-2-1 health and wellbeing check in's and the co-design of projects that support increased physical activity in the workplace.

56 The innovative Active Workplaces approach has been recognised by key agencies like Public Health Wales and Greater Manchester (GM) Moving, and as such we have been invited to join a UK wide forum to share best practice and contribute to learning / evidence base.

57 Through the Active Workplaces development work we have initiated a range of paid partnership, in which organisations are directly appointing Active Leeds to deliver a range of health and wellbeing services.

DfT Active Travel Social Prescribing Project

58 Active Leeds, Public Health, Leeds Integrated Care Board and partners have been successful in securing funding from the Department of Transport (DfT) for a 3-year revenue project (£1.3 million across 2022 - 2025) to implement an Active Travel Social Prescribing project in the Burmantofts,

Harehills and Richmond Hill (Primary Care Network) area of the city. The project aims to increase physical activity levels through prescribing walking and cycling in primary and secondary care. Links between infrastructure development (existing and new) will also aim to encourage more Active Travel.

59 The project is based on community and partner engagement, centred around several interventions including:

- communication,
- a focus on the physical and social environment,
- the development of three urban trails (one in each of the ward areas),
- a range of walking activities such as led walks and buddying schemes,
- learn to ride sessions,
- development of bike hubs
- a bike voucher scheme.

60 Two Walk It Ride It Officers have now been in post for five months with one Officer focusing on building the pathways from Social Prescribing into walking and cycling activities and the other leading on community conversations, engagement and activation.

61 There are now several different referral pathways in place, some examples include:

- Social Prescribing (Linking Leeds and from the Primary Care Network),
- Clinical pathways (including Shape Up 4 Surgery),
- Self-referral,
- and from the Third Sector.

62 Achievements to highlight are:

- Walking commissions have been set-up with Health for All and Touchstone.
- Cycling group has recently started with Shantona Women's Group.
- 15 walk leaders have been trained from the local area.
- Cycle North and British Cycling are adapting offers to better meet need.
- Love Exploring App in all three wards.
- Active Travel Master Plan and Complementary Measures guidance developed.
- 3 Urban Trails developed.

63 Development of the physical environment around healthy place making is a key focus of the project. The pilot is working with the community and partners to create safe, clean and traffic free spaces that are accessible and well-connected to support people to walk, wheel and cycle more often.

64 An Active Travel masterplan for the Burmantofts, Harehills and Richmond Hill area and Complimentary Measures strategy are now complete providing evidence-based plans, which include improving and connecting walking, wheeling and cycling routes, highlighting opportunities for pocket parks and recommendations on way finding.

65 Three Urban Trails have been co-produced with residents, the Third Sector and wider partners and services. They include a play trail in Burmantofts, a sensory trail in Richmond Hill and movement trails in Harehills. Trail packs have been produced and will be used to support a series of community stakeholder co-design events from April 2024.

66 The Project Team are currently planning a full calendar of walking, wheeling and cycling activities and events from Spring 2024. This will involve a varied programme ranging from taster walking

sessions for Social Prescribing Teams, “all things cycling” come and try family community days, launch of a community chest pot, continuing to build buddying schemes and the development of an adapted / accessible wheeling and cycling offer.

How does this proposal impact the three pillars of the Best City Ambition?

☒ Health and Wellbeing ☒ Inclusive Growth ☒ Zero Carbon

67 Embedding physical activity into everyday life provides a unique opportunity to contribute to the three city strategic pillars of Inclusive Growth, Health and Wellbeing and Zero Carbon. This work also aligns with other key strategies such as Mental Health Strategy, Transport Strategy and developing the Local Plan.

68 There is good evidence that the benefits of increasing physical activity are wide ranging including impact on employment and employability, promoting engagement and civic trust and reducing isolation. It is also clear that by increasing the amount of people actively traveling into and across Leeds will also contribute to reducing carbon emissions and help reach the city’s zero carbon target. Realising the ambition to increase levels of physical activity has the potential to contribute to a healthier place, a greener city and a stronger local economy.

69 The Health and Wellbeing Strategy refresh has brought the Physical Activity Ambition and this pillar closer together in developing priority 5: A city where everybody can be more active, more often. This aligns closely with the Physical Activity Ambition: Leeds is a place where everyone moves more every day. The priorities set out in this report directly impact and work towards this vision and the health and wellbeing strategy priority.

70 Looking closer at the priority workstreams; priority 1: A Child Friendly and Age Friendly City where people have the best start and age well links with the target populations within the Physical Activity Ambition. Play sufficiency is an issue which contributes to priorities across the three pillars of the Best City Ambition and is most likely to be incorporated into the revised Health and Wellbeing pillar. Building on the recent publication of the new Health and Wellbeing Strategy, to reflect the benefits for the physical, mental and emotional wellbeing of children and young people which play can have. The further promotion of Play Sufficiency through the Best City Ambition provides opportunity and support moving forward, helping to ensure it can be embedded into wider strategic planning across the Council and city.

71 Further still, Play provides a unique opportunity to contribute to the three city strategic pillars of Inclusive Growth, Health and Wellbeing and Zero Carbon. This work also aligns with other key strategies such as Mental Health Strategy, Transport Strategy and developing the Local Plan. Play is now a priority in the new Children and Young People’s Plan: Priority number 8: Children and young people have safe spaces to play, hang out and have fun. Play is also a priority within other strategies such as the Leeds Parks and Green Spaces strategy 2023 – 2032 and Child Poverty Strategy 2019 – 2022.

72 The Get Set Leeds Local Project is a great example of how this work reaches priority 2: Strong, engaged and well-connected communities by working in a placed-based and focusing on building on existing strengths and capacity in communities.

73 The Physical Activity Ambition work focuses on prevention and impacts priority 8: promoting prevention and improving health outcomes. An example of this is through the campaign work in the ageing well workstream. Here the target age was lowered to ensure prevention was the driving agenda for long-term conditions and risk of falls.

74 Priority 12: a mentally healthy city for everyone links directly with the aims and objectives of the Young Minds Get Active workstream which focuses on improving the mental health in young people.

Zero Carbon:

75 The DfT Active Travel Social Prescribing Project aims to increase active travel opportunities and decrease the reliance on the car. Additionally, this project and others such as the Get Set Leeds Local projects works with our local communities to improve the spaces around us to be active and play in.

76 Insight from children and parents/carers suggest there are several constraints that stop children from playing in the streets outside their homes, including traffic, (busy roads and cars going at high speeds) and parked cars. Where streets are quieter with adults to support children's play, conditions for play were reported as good.

Inclusive Growth Strategy:

77 Evidence shows physical activity has a positive impact on reducing sickness levels, helps manages conditions at work to stay in work and helps people to gain valuable skills to transfer into the workplace such as team working and leadership. In terms of Inclusive growth, a healthy workforce means a more productive higher resilient workforce. The Active Workplace project works directly to impact this.

78 Additionally Play Sufficiency positively contributes to several areas of the Inclusive Growth Leeds 2023 – 2030 strategy. In particular, Play Sufficiency links to the following 'Big Ideas':

- People: Tackling poverty and inequality to improve people's lives – ensuring Leeds is the best city for children to grow up in.
- Productivity: Stimulating innovation which drives and delivers measurable impact towards a healthier, greener and inclusive future.
- Place: Connecting and strengthening our communities.
- Place: Investing in our places and transport to create a sustainable economy and greener future.

What consultation and engagement has taken place?

79 The Physical Activity Ambition approach to reducing inactivity aims to connect work that is taking place at a city-wide level with a more in-depth engagement across the life course with priority neighbourhoods / communities and under-represented groups.

80 The Physical Activity Ambition benefits from clear and effective management and robust governance which ensures engagement at all levels continues. The involvement of a wide range of senior leaders through the Leadership Group benefits the programme of work towards the vision of Leeds is a place where everyone moves more every day.

81 Ongoing conversations continue to engage people across Leeds and encourages the co-production of physical activity through focus groups, community panels and attending community committee sessions. Working with communities, building partnerships and co-producing solutions is at the heart of the Ambition.

82 The physical activity co-production principles toolkit was established to ensure working with people is embedded into the ethos of this work. These guiding principles encourage all areas of the project to work towards an improved standard of co-producing. For example:

- Local engagement and working with the council communities' team and residents and community chest funding (as part of Get Set Leeds Local) has seen the establishment of community level projects co-produced with partners and residents.

- Through the Play work – over 50 hours of consultation with young people has been completed feeding directly in the research

- Engagement and co-production is embedded into the scoping process taken when working through any of the priorities agreed in the Physical Activity Ambition work.

Wards affected:		
Have ward members been consulted?	☒ Yes	☐ No

What are the resource implications?

83 Public Health, Active Leeds, Health Partnerships, Climate, Energy and Greenspaces, Planning and Transport colleagues all collaborate and contribute to the project along with partners in the Place Based Partnership, Sport Leeds Board, Leeds Becket University, and the Third Sector. By working together as a city this is an effective use of resources and enables whole-system changes to be made.

84 Locality working is resource intensive, however, long-term investment in some of the 1% areas has built reciprocal, trusting, and sustainable relationships which has underpinned successes. This has been successful by engaging flexibly and responsively with both residents and external organisations in these priority localities. In-depth engagement in advance of projects starting has been helpful as well as having in-depth knowledge of the assets available.

85 The social return on investment from increasing the numbers of people being more physically active is significant for the city including social, economic, physical and mental health benefits. Every £1 spent on community sport and physical activity generates nearly £4 for the economy and society based upon the findings of a recent study by Sheffield Hallam University.

86 The Physical Activity Ambition work is funded through time limited grants and for this programme of work to achieve long term behavioural change consideration needs to be given to the sustainability of the resources to fully realise the benefits. For example, Sport England has continued to invest into the Get Set Leeds Local programme for over five years allowing the team to work for long periods within some of the most deprived areas of Leeds.

What are the key risks and how are they being managed?

87 The programme of work is currently reliant upon short-term external funding to complete projects. Strong relationships and partnership working alongside careful financial management allows us to mitigate this and realise the long-term gains that can be made through reducing inactivity levels and associated health, economic and zero carbon benefits.

88 The programme of work is driven by LCC staff across numerous teams and directorates. In order for the Physical Activity Ambition to be realised this needs to remain a priority for those teams and within strategic policies despite financial pressures. The Leeds Everyone Moving More Leadership Group is now in place and can support and influence this for the future.

What are the legal implications?

89 There are no legal implications arising from this report

Options, timescales and measuring success

What other options were considered?

90 None.

How will success be measured?

91 Progress will continue to be measured through the annual Sport England Active Lives Survey, which in addition to the overall physical activity levels provides data across age ranges (including children and young people), by IMD (as highlighted in sections 9 and 10) and by gender. Yorkshire Sport Foundation also pulls together a Leeds dashboard of physical activity measures (collated from wider national sources) which includes, for example, data around walking, cycling and active travel. For children and young people, activity and inactivity levels will be measured through the My Health, My School survey, utilising a local and much larger sample size.

92 As referenced earlier in the report the Physical Activity Ambition sits as one of the twelve priorities of the Health and Wellbeing Strategy and the work will be monitored as part of the ongoing monitoring and evaluation of the Strategy.

93 The Physical Activity Ambition is underpinned by a Monitoring and Evaluation framework and work on this is led by a cross partner group, including Leeds Beckett University and Yorkshire Sport Foundation. It includes a range of indicators such as the Influencer Framework and Social Network Analysis to establish the baseline and to measure progress at both a systems and intervention level. This is annually reviewed.

94 Evaluation is embedded in the seven priority workstreams with examples shared earlier in the report. The Department of Transport Active Travel Social Prescribing project is another strong example of working with an evaluation partner, Urban Foresight, to collect a range of measures and insights through questionnaires / surveys, interviews, focus groups and case studies to better understand how we are making a difference and use this learning elsewhere.

95 On a project level there are monitoring and evaluation frameworks in place which are linked to the Physical Activity Ambition framework and provide more specific detail for those projects.

96 Active Leeds has service specific key performance indicators such as number of health referrals, physical and mental health improvements in participants, memberships, new joiners, membership yields, course programme utilisation, activity and participation figures, expenditure and income, staffing levels, social value indications and equality and diversity targets etc.

97 Working in partnership with Leeds Beckett University specific evaluation is embedded into projects such as LEAP to ensure that the pilot project is working for Leeds and meeting its objectives.

What is the timetable and who will be responsible for implementation?

98 In order to have significant impact on inactivity levels across Leeds a long-term commitment to the vision: "*Leeds is a place where everyone moves more every day*" is required. The Physical Activity Ambition is driven by Active Leeds and Public Health but relies on wider partnership working where everyone recognised that physical activity is everyone's business. This is supported by the governance structures surrounding the programme of work.

Appendices

- None

Background papers

- None

Leeds Community Healthcare NHS Trust

Trust Quality Committee Meeting: 28 March 2024
Agenda item number: 2023-24 (143)

Title: Bi Annual Patient Safety and Serious Incident combined Report- September 2023- February 2024

Category of paper: For assurance

History: QC 25 March 2024

Responsible director: Executive Director of Nursing and Allied Health Professionals

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Report author: Patient Safety Manager

Executive summary

Key Points for Consideration

In this report incidents which occurred before 01/01/2024 are managed under the Serious Incident Framework, 2015 and reported on the Strategic Executive Information System (StEIS) Incidents which occurred after 01/01/2024 are managed under the Patient Safety Incident Response Framework and are not externally reported to the Integrated Care Board.

The way LCH respond and manage Patient Safety Incidents is outlined within the Patient Safety Incident Response Plan and subsequent policy.

There was a total of 2779 LCH Patient Incidents reported between September 2023 and February 2024.

Pressure ulcers, medications and falls remain the three most reported incident categories.

Nine Serious Incident Investigations were StEIS logged, eight by LCH and the other by a partner organisation, this investigation is being completed as a joint review from a system perspective. One incident is being managed as a Patient Safety Incident Investigation.

The top Serious Incident causation factors are identified as a lack of identification of a deteriorating patient, delays in equipment and poor communication with the main contributory factors being staff capacity issues and a lack of case management.

Top themes of learning from Serious Incidents, Pressure Ulcers, Falls and Medications incidents are outlined in the appendices of the report.

Learning themes from Pressure Ulcers and Falls are held on a Trust Wide Improvement Plan and improvement activity will be monitored by the relevant improvement group to ensure learning is embedded.

A Trust Wide Improvement Plan linked to the deteriorating patient and a local improvement plan for incidents related to Clinical Triage and Meatal Tears are also in the process of completion linked to the Local priorities in the Patient Safety Incident Response Plan.

Recommendations

The Board of Directors are recommended to:

- Receive and note the contents of this paper.
- Provide any feedback required.

BACKGROUND/ INTRODUCTION

A report on Patient Safety, Serious Incidents (SI) and Patient Safety Incident Investigations (PSII) is produced bi-annually to provide the Board of Directors with the assurance that patient safety is well managed, that incidents are appropriately investigated, and that learning is acted upon to improve patient care.

This report will include an overview of incidents occurring in 2023 which have been managed under the Serious Incidents Framework (SIF), 2015 and incidents from 2024 which have been managed under the Patient Safety Incident Response Framework (PSIRF), 2019. (See Appendix One).

Key Opportunities Risks and Successes for consideration.

On the 01 January 2024 the Trust commenced a soft launch of the Patient Safety Incident Response Framework and subsequent Patient Safety Incident Response Plan (PSIRP). This is the blueprint of how the organisation intend to respond to patient safety incidents over the next 15 months with a focus on investigating less, learning more, and engaging with those affected as outlined in the NHS England Patient Safety Strategy.

Opportunities

Three Improvement Groups have been established for falls, pressure ulcer and deteriorating patients which are local priorities identified in the PSIRP. There are organisational improvement plans in development for each of these areas where system based improvement activity will be held ensuring that all known contributory factors have been addressed, and using appropriate data to measure progress.

Service led improvement plans are also in development, one held by the Continence Urology and Colorectal Service (CUCS) for meatal tears and one held by the Triage Hubs related to the clinical triage process in the Neighbourhood Teams.

See Appendix Two for the Local priorities and how incidents will be managed.

Learning from Patient Safety Events (LFPSE) has been implemented in LCH which replaces the previous National Reporting and Learnings System (NRLS) and there is ongoing work to redesign the Datix System for reporting, investigating, and learning from incidents whilst ensuring the system is as accessible and user friendly as possible.

The Duty of Candour Letters and a guide for staff are in the process of review to ensure these are accessible and to improve meaningful engagement with those affected by patient safety incidents. The Duty of Candour section in Datix will also be updated to reflect the changes.

Incident Investigators have been identified within the Business Units and planning for PSIRF training related to investigating and engagement is underway.

Four Care Quality Managers are now in post which was a role established as part of the Adult Business Unit phase two leadership redesign. The Care Quality Managers are responsible for the timely investigation and embedding of learning from patient safety incidents.

Risks
Despite the dedicated resource in ABU there remains a considerable backlog of incidents for the Adult Business Unit (ABU). At the time of writing the report there were 411 incidents in 'holding' for ABU, this includes all categories, of these, 283 are recorded as patient incidents occurring under LCH Care, with the oldest patient safety incident dating back to September 2023. The Trust standard is that incidents are moved from 'holding' to 'being reviewed' within two days.

In 'being reviewed there were 483 incidents, this includes all categories, of these, 374 are recorded as patient incidents occurring under LCH Care and 205 incidents are incidents from 2023. The Trust standard timescale for no harm and low harm incidents is 15 working days from reporting to closure. The timescale for moderate and above harm incidents is 30 working days from reporting to closure unless they require further investigation as an SI/PSII.

The business unit leads are aware and are reviewing how this can be managed, contributing factors to the delays include a high level of incident reporting and capacity with significant gaps in the Neighbourhood Team and Service Manager roles. A trial of pausing the reporting of Moisture Associated Skin Damage (MASD) in the Yeadon Neighbourhood Team has commenced and appropriate management of MASD will instead be reviewed via audit to try and reduce the amount of incidents and associated time to review and investigate these, a further review of other categories will be considered for alternative management if appropriate.

An internal audit of SI actions has been completed for 2022/23 and has identified that many actions are closed without the appropriate evidence to provide assurance that the requirement of the action is complete. This audit will be repeated for 2023/24. (See Appendix Three for recommendations for improvement).

Successes
Guidance has been created by the Patient Safety Team for staff who attend Rapid Review Meetings (Appendix Four) and who are involved in coroner's inquest (Appendix Five). This supports a Safety and Just Culture and includes details on the support that can be accessed through the Critical Incident Staff Support Pathway (CrISSP).

PATIENT SAFETY INCIDENTS OVERVIEW

The data for this reporting period has been extracted from Datix based on patient incidents occurring under LCH care reported during the period 01/09/2023-29/02/2024. As the data is taken from a live system the incidents are continually updated which results in some variation in the reported numbers over time. The data included in this report is accurate as of the 05/03/2024.

There were 2779 LCH patient incidents reported between September 2023 and February 2024 (Appendix Six**),** all three business units remained within the control limits throughout. Of the 2779 incidents 1599 (57%) were reported as causing harm; ABU (1223), SBU (357), Children's Business Unit (CBU) (15), Corporate Business Unit (3) and Operational Support Services (1).

The top four reported incident categories were:

- Skin Damage 908 incidents (33%)
- Medication 351 incidents (13%)
- Abusive, Violent, Disruptive, or self-harming behaviour 324 incidents (12%)

- Patient accident that may result in an injury 300 incidents (11%)

Although Abusive, Violent, Disruptive, or self-harming behaviour accounted for 12% of the overall incidents, there were multiple incidents for the same patients. These were discussed at Rapid Review Meeting and a local service risk panel was initiated to ensure the governance and oversight of incidents is regularly reviewed and maintained and therefore will not be reviewed further as a category in this report.

All incidents are reviewed in the monthly Business Unit reports for themes and learning and shared via the Quality Assurance and Improvement Group (QAIG).

Pressure Ulcer Incidents

A total of 908 skin damage incidents were reported, the highest sub-category of this was pressure ulcers and 410 were recorded. All business units remained within the control limits.

- ABU – 397 incidents
- SBU – 10 incidents
- CBU – 3 incidents

Of the 410 incidents recorded, 318 were minimal harm, 87 moderate harm and 5 major harm.

The top themes of learning from pressure ulcer incidents are included in Appendix Seven and **i**mprovement activity linked to these themes is held within the trust wide pressure ulcer improvement plan and overseen by the pressure ulcer improvement group (Appendix Eight).
Full details of LCH pressure ulcer incidents and learning are held in the six-monthly pressure ulcer report reviewed by the pressure ulcer improvement group and sent to QAIG for noting.

Medication Incidents

A total of 351 incidents involving medication were recorded; all business units remained within the control limits.

- ABU - 263 incidents
- SBU – 69 incidents
- CBU – 19 incidents

Of the 351 incidents recorded, three were moderate harm and three were minimal harm, high risk medication incidents (Appendix Nine).

The top themes of learning from medications incidents are included in Appendix Ten.
Full details of LCH medication incidents are held in the Medicines report, presented quarterly to QAIG.

Falls Incidents

A total of 300 patient accidents that may result in an injury were reported, the highest subcategory of this was slips, trips, falls and collisions where 282 incidents were recorded; all business units remained within the control limits.

- ABU - 200 incidents
- SBU – 80 incidents
- CBU – 2 incidents

Of the 282 incidents recorded, 29 were major harm, 30 moderate harm, 166 minimal harm, and 51 were no injury sustained, the remaining six falls were reported as deaths.

Deaths and falls

Of the six deaths with falls, four have been discussed at Rapid Review Meeting, three concluded as no further investigation and one requires more information. The remaining two are pending Rapid Review Meeting.

The top themes of learning from falls incidents are included in Appendix Eleven and improvement activity linked to these themes is held within the trust wide falls improvement plan and overseen by the falls improvement group (Appendix Twelve).
Full details of LCH falls incidents and learning are held in the six monthly falls report reviewed by the falls improvement group and sent to QAIG for noting.

SERIOUS INCIDENTS AND PATIENT SAFETY INCIDENT INVESTIGATIONS

There were nine Serious Incident recorded, the trust reported eight of these on the Strategic Executive Information System **(**StEIS) and an additional serious incident was logged by a partner organisation who are leading a joint investigation with LCH input. The remaining incident is a Patient Safety Incident Investigation (Appendix Thirteen).

Eight of the incidents remain under investigation and two have been completed and had Executive Director sign off.

The Trust had no Never Events in this reporting period.

The most common Serious Incident causation factors were communication breakdown within LCH services, equipment delays and a lack of identification of the deteriorating patient. The most common contributory factors were staff capacity issues and a lack of case management (Appendix Fourteen).

Learning identified from Serious Incident investigations is managed via action plans which are agreed at a final review meeting. The actions are then added to Datix for monitoring purposes and assigned to responsible leads to complete within an allocated timeframe.

Learning from Serious Incident Investigations are shared with the linked improvement groups for review against the Trust wide improvement plans. The top learning identified from closed Serious Incident Investigations is included in Appendix Fifteen.

Recommendations

The Board of Directors are recommended to:

- Receive and note the contents of this paper.
- Provide any feedback required.

Appendix One- Management of incidents under the Serious Incident Framework 2015 and the Patient Safety Incident Response Framework

Incidents which predate 01/01/2024 continue to be managed under the 2015 Serious Incident Framework. The triggers for completion of a Serious Incident investigation are incidents of moderate or major harm where contributing lapses in care are identified, patient deaths with lapses in care or no/minimal harm incidents which have associated high levels of risk that warrant further review. In this reporting period any incidents that were identified with lapses in care but with learning already known and held on the organisations action plan did not progress to a Serious Incident Investigation. Considering the organisations journey to PSIRF this ensures a proportionate response to incident management with a focus on learning more and investigating less, this was agreed with the ICB..

Incidents after 01/01/2024 are managed under PSIRF and in line with the LCH PSIRP. A Patient Safety Incident Investigation will be completed if there is potential for learning and improvement or a systemic risk.

Criteria for PSII response	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding. • Likelihood of influencing healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII • Value: extent of overlap with other improvement work; adequacy of past actions •
Systemic risk	• Complexity of interactions between different parts of the healthcare system

Incidents investigated under the SIF (2015) are reported externally to the Integrated Care Board (ICB) within 48 hours via the Strategic Executive Information System (StEIS) and a Serious Incident Investigation (SII) is completed within 60 days.

Patient Safety incidents (PSI) investigated under the PSIRF (2019) are managed within the organisation and time frames are decided internally based on complexity, this will be a two-, three- or six-month timescale. A Patient Safety Incident Investigation (PSII) is a learning response that is used for investigation and the incidents where this has been completed will be included in the report.

Incidents investigated under the SIF and PSIRF are externally reportable to the Care Quality Commission (CQC) on identification via direct communication.

On completion, SI and PSII reports are reviewed at a final review meeting chaired by the Deputy Director of Nursing and Quality or the Head of Clinical Governance. All reports are then reviewed for final approval by the Executive Director of Nursing and Allied Health Professionals or the Executive Medical Director. Approved SI reports are then shared externally to the ICB and the CQC. PSII reports are shared with the CQC only.

The criteria of which incidents will be notifiable to the CQC under PSIRF will be discussed and confirmed at a meeting in March.

Appendix Two- Local Patient Safety priorities

Priority	Patient safety incident type or issue	Planned response / Sampling technique	Improvement route
1.	Pressure damage with lapses in care causing moderate, major harm or death	Any incident with themes corresponding to the Trust Pressure Ulcer Improvement Plan will be managed via the associated improvement group. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, After Action Review (AAR), SWARM huddle, Multidisciplinary Team (MDT) review.	Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes PSII actions will be added and monitored through Datix. A quarterly PSIRF newsletter will be distributed to include learning from each improvement group.
2.	Patient falls with lapses in care and resulting in moderate, major harm or death	Any incident with themes corresponding to the Trust Falls Improvement Plan will be managed via the associated improvement group. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, AAR, SWARM, MDT.	Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes PSII actions will be added and monitored through Datix.

			A quarterly PSIRF newsletter will be distributed to include learning from each improvement group ABU audit CBU / SBU investigators share with safety team to cross reference with improvement plans
3.	Implementing care / deteriorating patient resulting in delayed admission to hospital or death	Thematic review of failure to recognise the deteriorating patient (review of incidents from 12 Dec 2023-12 Feb 2024) to inform a new Trust Improvement Plan which will be managed via the associated Deteriorating Patient Improvement Group. The Once established, new incidents will follow the approach of Priority 1 and 2.	Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes PSII actions will be added and monitored through Datix. A quarterly PSIRF newsletter will be distributed to include learning from each improvement group
4.	Successive minimal harm, self-harm incidents in children and young people within the Trusts secure estate	After ten consecutive low harm incidents (or less if clinical review suggests repeated incidents equate to moderate harm sooner or continued concerns despite clinical risk forum conversations) related to the same young person in a secure estate, a moderate harm incident will be reported for the same young person to assess the longer-term impact on their psychological harm. This will follow the existing rapid review process to determine if further investigation is required.	Taken to the weekly secure estate patient safety panel for initial review. Escalation to rapid review for any assessed as cumulative moderate harm. Appropriate learning response will be determined at rapid review meeting
5.	MRSA bacteraemia with LCH involvement.	A PSII will be completed where a PIR would have been completed	Learning and improvement to be determined by PSII and added to Datix to track actions. These will also be aligned with a Trust Improvement Plan if relevant

			Learning will also continue to be shared at IPC Committee with a resultant flash report to QAIG
Additional incident management processes:			
6.	Moderate and major harm incident relating to the clinical triage process in Neighbourhood Teams.	Service led improvement plan. This is expected to be a short-term (<6 months) local plan. If recurrent themes and trends continue this will be considered for future iterations of the PSIRP.	
7.	Moderate and major harm incidents (outside of priority 1, 2 and 3) will be reviewed for Patient Safety Incident Investigation consideration.	Initial service level review / learning to be cross referenced against the Trust Improvement Plans and managed in line with principles described in the PSIRP. A review of the legal requirement for Duty of Candour will be completed for all.	
8.	Moderate and major harm incidents relating to meatal tears	Any incident with themes corresponding to the specialist service (CUCS) Improvement Plan will be managed via the ongoing improvement work. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, AAR, SWARM, MDT.	
9.	Review of all E.coli bacteraemia, where circumstance is any of the following: • LCH inpatient,	Initial IPC review against the relevant Trust Improvement Plan Where new learning is identified, further review will be through a Rapid Review. A review of legal Duty of Candour will be completed for all.	

	• E. coli is specified on Part One of a death certificate • Identified trend by the IPC Team.		
10.	Near miss or no / low harm incidents identified to be high risk by the team or via the Business Unit Quality Lead monthly report	Reviewed for learning through a Rapid Review	
11.	Near miss, no and low harm incidents	Service level review and response.	

Appendix Three – Actions from SI Audit

Area of Learning identified: “How will you evidence completion of actions” box which is completed on the paper report is not a section in Datix meaning that staff are not guided on what is expected to be uploaded to provide evidence/ assurance that action has been completed appropriately.
Recommendation: The action module on Datix should map against the action plan on paper/electronic reports
Action- To update Datix System to include this so that action plans can be mapped against

Area of Learning identified: Actions that have been added to SI reports for audit are not consistent and therefore some are not clear in defining what is expected of the responsible leads.
Recommendation: There should be a prepopulated action on the Patient Safety Incident Investigation Report Template
Action: To ensure that a prepopulated action is scheduled on the new PSII reports that will be assigned to the PST. This action will be to inform CET and the responsible lead that an audit will need to be registered- including a copy of the action plan so they know which actions the audit refer to. This action will then be closed on Datix and enter the clinical audit cycle.

Area of Learning identified: Action owners are often not involved in the incident review process.
Recommendation: There should be a standardised process developed to ensure that action owners are aware of their assigned actions to ensure that these are understood and completed in a timely manner.
Action: Propose that under PSIRF any incident that progresses to PSII has an additional action planning meeting. This will be scheduled following the Final review meeting and the invite will include action owners and those responsible for oversight and will be completed prior to sign off. To be decided who should attend these meetings.

Area of Learning identified: Documents which provide assurance that actions have met the requirement are often not uploaded to the specific action and instead saved elsewhere in Datix.
Recommendation: There should be a one-minute guide created and available for this process
Action: One Minute Guide to be created and shared with Business Units, attached to the actions module for reference and attached to action plan meeting invites on how to complete an action.

Area of Learning identified: RAG rating action status not changed despite actions complete. Staff may not be aware how to accurately complete an action in Datix.
Recommendation: There should be a one-minute guide created and available for this process
Action: One Minute Guide to be created and shared with Business Units, attached to the actions module for reference and attached to action plan meeting invites on how to complete an action.

Area of learning identified: Some actions have more than one responsible lead assigned which leads to duplication actions being uploaded and confusion with who is leading these.
Recommendation: One responsible lead should be assigned to each action

Action: Only one person should be assigned to each action
To update the action plan on the PSII document to include responsible lead for action and responsibility for oversight.
To update Datix to ensure this information can be populated.

Appendix Four – What to expect when attending Rapid Review

What to expect when attending Rapid Review Meetings

The following guide has been created by the Patient Safety Team to help you prepare and know what to expect when attending a Rapid Review Meeting.

When are Rapid Reviews?

Rapid Review meetings are held every Monday and Wednesday afternoon.

Day	Time	Meeting chair	Support to chair
Monday	2-4pm	Sarah Hemsley Quality Lead for the Childrens Business Unit or Gil Ramsden (Quality Lead for the Adult Business Unit)	Sheila Sorby (Deputy Director of Nursing and Quality).
Wednesday	1-3pm	Frankie Skirrow Quality Lead for the Specialist Business Unit or Karen Otway Quality Lead for the Adult Business Unit	Claire Gray Sharpe (Head of Clinical Governance)

What is a Rapid Review Meeting and why do we have these?

Rapid Reviews are part of our clinical governance process, held to discuss patient safety incidents of moderate harm, major harm and near miss/ minimal harm incidents where the risk to safety is high.

The purpose of the meeting is to gather evidence and assurance of effective pathways of care and good practice, as well as identifying where we need to improve systems and processes in relation to care delivery.

Where the group feel there is further understanding required and therefore learning opportunities a further investigation may be requested. This may be a formal patient safety incident investigation (previously referred to as an RCA), but it may be a walkthrough, a service intervention or a reflective conversation following an incident.

The meetings intend to support our ‘Just Culture’, an open and honest conversation focussed on learning and improvement. These meetings are not about blame. If this is not your experience, we request you provide that feedback to the Patient Safety Team so we can review this in order to improve future experiences.

Who will be at the Rapid Review?

Alongside the chair and support the meeting will include:

- a member of the safeguarding team
- a member of the patient safety team
- The author of the investigation
- The case load holder or team member who knows the patient best
- Specialist reviewers dependent on the incident type (for example: Tissue Viability nurse for pressure ulcers; CUCS for meatal tears; community falls team for falls incidents)

What happens in a Rapid Review Meeting?
All incidents are allocated a 30-minute time slot.

In the meeting the investigator presents an overview of the incident and initial review findings. Those in the meeting may need to ask questions for clarity about the existing systems and processes, or a specific detail within the timeline. The good practice and learning is discussed. Input from the clinicians that know the patient is vital during the conversation as it provides essential context in relation to the patient, the incident and the circumstances in which care was delivered.

The meeting will conclude with a collective decision as to the requirement for any further investigation, actions required and whether statutory Duty of Candour applies.

We understand attending Rapid Review can be a daunting experience. If you have never been before and would like to attend for your understanding and development, please contact the Patient Safety Team at lchsafety@nhs.net and we would be happy to help.
We can arrange shadowing, provide support with the completion of Rapid Reviews and would welcome all feedback as this helps us to continuously improve. Thank you ☺

LCH Psychological Support is also available if you or your team have experienced an incident at work which has had an emotional and/or potentially traumatic impact and you think support may be helpful, LCH now have a team of staff able to offer 1:1 or group post incident support. Please email: Jen Gardner, Clinical lead for the Critical Incident Staff Support Pathway (CrISSP) on lcht.crissp@nhs.net
Helpful resources can also be found here:
Critical Incident Staff Support Pathway (CrISSP) (lch.oak.com)
Resources for me - critical incident support (lch.oak.com)
What is CrISSP and Post Incident Debriefs? (lch.oak.com)
Critical Incident Training Offer (lch.oak.com)

Appendix Five– information for staff involved in coroners inquest

What is a Coroner?

A coroner is a special type of judge appointed by a local authority to investigate certain deaths. Coroners are usually lawyers, but sometimes they can be doctors. Coroners work within a framework of law passed by Parliament. They are appointed by a local authority but remain independent judicial office holders.

What do Coroners do?

Coroners investigate deaths that have been reported to them to decide if:

- the cause of death is clear
- that a post-mortem is needed
- to hold an inquest

A coroner's investigation is different from a criminal investigation. If a coroner investigates, it does not mean there is suspicion of a criminal act or of any wrongdoing.

The coroner's investigation is to establish four facts:

- Who has died?
- When they died?
- Where they died?
- How they came to their death?
-

This allows the coroner to identify the cause of death so the death can be registered.

If the Coroner decides that the cause of death is clear, they will issue a certificate to the registrar to confirm that a post-mortem or inquest is not needed. The registrar will then register the death.

If the Coroner decides that a post-mortem is needed to find out how the person died this will be arranged and the coroner will then decide if an Inquest is required.

The coroner must hold an Inquest if:

- the cause of death is still unknown

- the person might have died a violent or unnatural death
- the person died in prison, police custody or another type of state detention (e.g. an immigration removal centre or while detained under the Mental Health Act 1983)

What is an Inquest?
An inquest is a fact-finding inquiry in a court, with or without a jury, into the circumstances surrounding a death, it is not a trial.
The coroner's findings may on occasion be critical of what happened, but the coroner cannot blame individuals or organisations or find them responsible for the death.

If the coroner has concerns, they can write a report to help prevent future deaths (also known as a Regulation 28). They will send this report following the Inquest to the organisations involved for them to act on.

Why might you need to be involved in a Coroners Investigation/Inquest?

- To provide a written witness statement to assist the coroner in the conduct of the investigation, as you were involved in providing care to the person prior to their death

- To provide an overview of the care provided by your service to the patient. This is often provided by a Team Manager.

- As you were the author of a Patient Safety Incident Investigation for the patient

- To provide an action plan statement based on the recommendations, learning and actions taken by the organisation following a Patient Safety Incident Investigation

- To attend an Inquest Hearing to provide verbal evidence, as a witness. Remember, you are not on trial, you are there to assist the court, and particularly the Coroner in establishing the answer to the four questions above .
  Arrangements will be made for a manager from your team to attend with you as support.
  A solicitor representing LCH may also attend the Inquest alongside the Patient Safety Team.

- To support staff members in your team through the Investigation/Inquest process

  Remember a thorough and well written witness statement means you will be better prepared to attend the inquest hearing if required or that you may not be summoned to attend. (See attached Witness Statement Template)

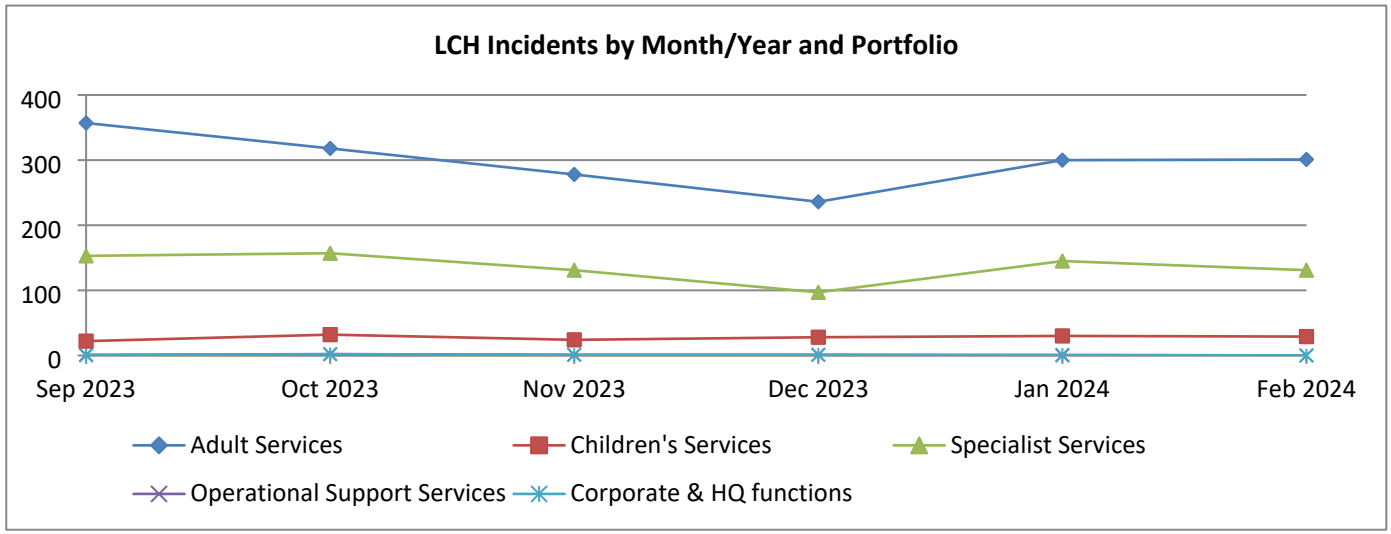
Solicitor Involvement in the Inquest process
LCH may instruct solicitors when a case is referred to Inquest, this is assessed on a case by case basis. The solicitor may support you in completing witness statements as they are able to advise on the information to include and can anticipate the information the coroner may want to know. They will also meet with you ahead of an Inquest hearing to talk through what will happen on the day, questions the coroner may be likely to ask and to answer any questions you may have.

How long might the Coronial process last?
There is not a set amount of time for this and it can often depend on the amount of information the coroner requires as this could be from multiple organisations.

The Patient Safety Team will be able to provide you with updates on the current progress/stage of the Inquest.
We understand that assisting a Coroner's Investigation in completion of a witness statement or attending an Inquest Hearing to give evidence can be worrying especially if this is something you have never done before, or if you have previously had a challenging experience.

Support is available so please speak with your line manager or contact the Patient Safety Team at lchsafety@nhs.net and we will be happy to support and talk through any questions you may have.
Further information is available here: Watch how to prepare for an inquest - NHS Resolution

Appendix Six- LCH incidents by month and business unit



Appendix Seven- Themes of learning from pressure ulcer incidents

Pressure ulcer risk assessment not completed at appropriate times i.e. new to caseload, return to caseload, change in clinical condition
Lack of personalised care for patients based on risk assessment findings
Multi-agency care not joined up (e.g. home care, care homes, hospice)
Lack of case management
Pressure relieving equipment to be provided in a timely manner and used / maintained appropriately
Lack of pain assessment
Lack of timely referral to specialist services (e.g. TVN, Podiatry, Vascular, CUCS)
Identifying and documenting the correct are of the body where pressure damage has occurred.
A task focused approach to care delivery with a lack of holistic review.
Lack of wound photography when pressure ulcers are identified or improve/deteriorate.

Appendix Eight– Pressure Ulcer Improvement Plan

To be added when received from improvement group chair

Appendix Nine– Moderate Harm and minimal harm high risk medication incidents

Team	Incident	Harm	Status
Woodsley NT	No anticipatory medications available for an end-of-life patient.	Moderate	Pending harm confirmation
Middleton NT	Delay in administering analgesia as no medication available	Moderate	Pending harm confirmation
Wetherby NT	Missed visit to administer insulin resulting in hospital admission	Moderate	Pending Rapid Review Meeting
Middleton NT	Insulin administered to a non-diabetic patient	Minimal	Rapid Review identified processes need to be more robust - consideration of whether it should be mandatory that carers accompany NT on insulin visits as they can assist in correct identification. QNI guidance has been brought out which details 30 minutes as the amount of time given for insulin administration - currently LCH standard is 15 minutes and time is likely a factor - staff report to feel rushed- this requires consideration whether a standard approach or adapted based on skillset/role/familiarity and personalised to the person who is visiting to deliver the care. Time is a

			contributory factor to staff cutting corners when delivering care and lack of checking patient ID sufficiently. Learning shared with Insulin working group
Middleton NT	Insulin administered to a non- diabetic patient	Minimal	Rapid Review Learning as above shared with Insulin working group
Community Dental	Patient received local anaesthetic to the wrong side of the mouth prior to a dental procedure.	Minimal	Rapid Review identified learning in relation to the Local Safety Standards for Invasive Procedures (LocSSIPs) was not followed, actions to standardise the location of the LocSSIP document across clinics is underway to improve consistency.

Appendix Ten-Themes from medication incidents in Q3

Overall - Wrong time was the most frequently reported LCH medication incident, alongside wrong dose and record keeping.

ABU - There has been an increase in incidents involving insulin and an increase in incidents with harm. There were three wrong patient incidents in care homes, a member of care staff accompanying staff on medication visits to ensure correct patient identification is being considered.
There were two incidents where a second dose of insulin was given, allocation of visits and not checking the MAR chart were identified as contributing factors. The business unit are working with the SystmOne Team to raise the awareness of how these care plans are allocated.

SBU - Lower number of incidents reported overall due to a reduction from the previous period in incidents reported for Wetherby Young Offenders (WYOI) and Police Custody.

CBU – Five incidents for Hannah House (x3 wrong dose, x1 medication given at incorrect frequency and x1 missed dose)

Appendix Eleven- Themes of learning from falls incidents

Theme
Inaccurate completion of Tier 1 falls risk screening questions
Tier 2 falls risk assessment not routinely completed when change of environment from patient's own home into a care home
No lying and standing BP completed or no documented rationale why
Lack of follow-through or escalation when postural hypotension identified
Falls risk management template not completed after a fall on caseload
Missed opportunity to identify and action osteoporosis risk
Delays in provision of Neighbourhood Team Physiotherapy
Strength and balance not consistently assessed as part of physiotherapy assessment for a falls risk patient Limited provision of evidence-based strength and balance exercise programmes to falls risk patients, with tendency to provide seated exercises only and no rationale for why no further progression into standing
Inappropriate delegation to therapy assistant practitioner
Task orientated approach to patient visits
Missed opportunity to identify and manage a deteriorating patient
Lack of case management

Appendix Twelve– Falls Improvement Plan

GOAL	ACTION REQUIRED	LEAD	HOW WILL THIS BE ACHIEVED	HOW WILL THIS BE MONITORED	TIME SCALE
Staff training To ensure clinical staff working with adults in LCH services are trained in falls risk assessment, prevention and management in line with their defined role/responsibilities	- Implementation of the falls training to LCH registered clinical staff, ensuring that all relevant staff attend the training (new starter and refresher)	Community Falls Service and Clinical Service Leads	- Community Falls Service to provide the training, and individual Clinical Service Leads to ensure staff book and attend training	- ESR compliance report	Six monthly
	- To consider the potential for the development of an e-learning package related to falls awareness for non-registered clinical staff	Community Falls Service	- To liaise with falls lead colleagues within the Yorkshire and Humber falls network to identify any existing e-learning packages or joint working to develop across the region	- Feedback at LCH falls improvement group and documented in minutes	December 2023
	- To identify and confirm the Trust standard for the frequency of the falls training to LCH registered clinical staff	Falls improvement group	- To add to the agenda for discussion and agreement at LCH falls improvement group, considering alignment with the pressure ulcer training	- Discussion and consensus agreed at LCH falls improvement group for training to be every 2 years - documented in the minutes	16th November 2023
Falls risk screening To ensure that all patients aged 65+years old assessed in their home environment are screened for falls risk	- All patients aged 65+years old assessed in their home environment are screened for falls risk using the Tier 1 falls risk screening questions	Clinical Advisors ABU and SBU – Clinical Systems Management	- SystmOne reporting to ascertain data for completion of the Tier 1 falls risk screening and by which services, and review of Datix incidents to ascertain if relevant completion on initial assessment	- QAIG, documentation audit, Datix investigations	Six monthly
	- To review the appropriateness of the current LCH falls risk screening tool in conjunction with the publication of the new World Falls Guidelines	Jo Brayshaw	- Review of World Falls Guidelines algorithm and incorporate into the review of the LCH falls pathway	- Review completed with Tier 1 falls risk screening questions incorporated into new LCH falls pathway with additional screening questions added to support clearer stratification of falls risk	31st May 2023

GOAL	ACTION REQUIRED	LEAD	HOW WILL THIS BE ACHIEVED	HOW WILL THIS BE MONITORED	TIME SCALE
Multifactorial falls risk assessment and interventions To ensure that all adult patients identified as being at risk of falling are offered a multifactorial falls risk assessment and offered evidence-based interventions	- Identified registered clinical staff to complete a Tier 2 falls risk assessment with all patients who are identified as a high falls risk on the service caseload - Use of the Falls Risk Management template for falls that occur on the service's caseload, to ensure appropriate detail is obtained to identify any patterns to be able to action and reduce the risk of further falls - Neighbourhood Team Physiotherapy staff to routinely assess strength and balance for patients at risk of falling on their caseload, and offer patients an evidence-based strength and balance exercise programme, supported by regular reviews and progression of exercises	Quality leads responsible for oversight of relevant assessor services Quality leads responsible for oversight of relevant assessor services, Care quality managers Neighbourhood Team Physiotherapy Leads, Practice Development Lead (Rehabilitation)	- Completion of documentation audit - Completion of documentation audit, Datix investigations when patient falls incidents occur - Education of registered and non-registered Physiotherapy staff within the Neighbourhood Teams on evidence-based assessment and exercise provision for falls risk patients, completion of Neighbourhood Team Physiotherapy-specific documentation audit -	- Annual documentation audit, review of Datix falls incident investigations - Annual documentation audit, outcome and learning identified from Datix investigations - Neighbourhood Team Physiotherapy-specific documentation audit, outcome and learning identified from Datix patient falls investigations	Ongoing Ongoing
Evidence-based falls guidance To ensure that the LCH falls pathway offers the ability for clinical staff and services to provide assessment and care to meet relevant evidence-based falls guidance and quality standards	- To identify the NICE quality falls standards relevant to community service provision - To monitor the development of the updated NICE falls guidance (NICE Clinical Guideline 161) and align to LCH service provision - LCH services are providing falls risk assessments and evidence-based interventions in line with NICE guidance and quality standards, and	Jo Brayshaw Jo Brayshaw (representing LCH as stakeholder in review of NICE guidelines) Quality leads responsible for oversight of	- Review of NICE falls quality standards and discussion at falls steering group for agreement on standards to benchmark against - Benchmark against updated guidance once published - Training, awareness raising, processes and practices	- Documented in falls improvement group meeting minutes - Review once updated guidance published - Annual and random documentation audit, QAIG	31st July 2023 New guidance due for publication 2024/25 Six monthly

GOAL	ACTION REQUIRED	LEAD	HOW WILL THIS BE ACHIEVED	HOW WILL THIS BE MONITORED	TIME SCALE
	in conjunction with the World Falls Guidelines	relevant assessor services			
Datix falls incident themes and learning To ensure that all relevant patient falls incidents are reported via the Datix system To ensure that all new and established learning from patient falls incidents is identified and embedded in clinical practice to reduce the potential for future patient safety incidents	- To educate clinical staff on when to report a patient falls incident	Clinical Service Leads, Quality leads, Care quality managers	- Resend Datix falls reporting advice leaflet to clinical staff, discuss at team meetings	- Datix falls dashboard, review of falls incidents on Datix via individual teams for potential increase in reporting due to raised awareness	Ongoing
	- To review key themes, trends and learning from Datix patient falls incidents	Sarah Yeomans, Claire Gray-Sharpe, Jo Brayshaw	- Six monthly aggregated falls performance and assurance report	- QAIG	Six monthly
	- To explore the reasons behind common themes from patient safety incidents to identify how to support embedding learning	Patient safety specialist, Claire Gray-Sharpe, Jo Brayshaw, ABU/SBU Clinical heads of service	- Review of systems and processes, cultural and behavioural change, internal engagement, staff survey, focus group with clinical staff, task and finish group to support change		
	- To develop a template for all Datix reported patient falls incidents that informs a standardised investigation and learning aligning to PSIRF and common themes identified	Jo Brayshaw, Care quality managers	- Initial meeting to discuss the key components of the template on 29th November 2023 with plan for follow-up meeting in January 2024 to confirm template	- Template developed and being used by Datix falls incident investigators	January 2024
	- To identify if recurring themes and learning are continuing to emerge from Datix falls incidents as below: • Inaccurate completion of Tier 1 falls risk screening questions • Tier 2 falls risk assessment not routinely completed when	Care quality managers, quality leads, Community Falls Service	- Cross reference learning from Datix investigations to themes identified in falls improvement plan	- QAIG	Ongoing

GOAL	ACTION REQUIRED	LEAD	HOW WILL THIS BE ACHIEVED	HOW WILL THIS BE MONITORED	TIME SCALE
	change of environment into a care home • No lying and standing BP completed or no documented rationale why • Lack of follow-through or escalation when postural hypotension identified • Falls risk management template not completed after a fall on caseload • Missed opportunity to identify and action osteoporosis risk • Delays in provision of neighbourhood team physiotherapy • No assessment of strength and balance as part of physiotherapy assessment for a falls risk patient • Inappropriate delegation to therapy assistant practitioner • Task orientated approach to visit with lack of holistic overview • Lack of case management • Missed opportunity to identify and manage a deteriorating patient		- Feedback to individual staff/teams at team meetings and safety huddles to raise awareness - Registered clinical staff to complete falls training every 2 years - Six monthly aggregated falls performance and assurance report to ascertain if a reduction in themes from incidents		
LCH and citywide falls pathways To ensure that the LCH falls improvement group is cited on all aspects of the citywide falls pathway and is an active partner within any developments	- Review of the existing LCH falls pathway in light of the publication of the new World Falls Guidelines - Collaborative working with Primary Care to develop and support a streamlined falls pathway across primary and community care	Jo Brayshaw Jo Brayshaw	- Updated LCH falls and bone health pathway drafted, reviewed by LCH falls improvement group, disseminated to relevant adult services for consultation and feedback, and finalised - Development of falls pathway across primary and community care based on the World Falls Guidelines algorithm	- Review and updates completed, and disseminated to relevant staff/services - Through the citywide falls steering group	Launched 1st August 2023 Launched 1st August 2023

GOAL	ACTION REQUIRED	LEAD	HOW WILL THIS BE ACHIEVED	HOW WILL THIS BE MONITORED	TIME SCALE
locally and regionally	- Collaborative working with the neighbourhood network schemes, Enhance delivery partners and WYFRS to develop and implement a consistent falls pathway across the system	Jo Brayshaw	- Workshop with the Third sector for feedback on the falls pathway and to identify training/education needs	- Through the citywide falls steering group	5th December 2023
	- To provide representation at the citywide falls steering group and to feedback from this to the LCH falls improvement group	Jo Brayshaw	- Relevant feedback, information and updates provided to the LCH falls improvement group - Attending relevant falls pathway meetings	- Documented in the falls improvement group meeting minutes	Quarterly
	- To provide direction to the citywide falls pathway, supporting developments across the different organisations	Jo Brayshaw		- Documented in the falls improvement group meeting minutes	Bimonthly
	- To provide representation at the Yorkshire and Humber falls and deconditioning network, and to feedback from this to the LCH falls improvement group	Jo Brayshaw	- Relevant feedback, information and updates provided to the LCH falls improvement group	- Documented in the falls improvement group meeting minutes	Quarterly
Health equity To understand if there is a disproportionate level of harm across our caseloads and population from a health equity perspective	- To review health equity data to support the development of the citywide falls pathway and accessible service provision to falls risk patients	Jo Brayshaw and Sarah Yeomans	- Obtain health equity data related to LCH adult service provision including Datix falls incidents, task and finish group from citywide falls steering group leading on citywide data to identify patient and service need	- Through the LCH and citywide falls steering groups	November 2023
Dementia and MCA To understand how a patient's clinical risk is managed and provision of safe	- To provide assurance that all patients with reduced capacity have accurate and appropriate risk assessments completed, with care	Clinical service leads, quality leads, care quality managers	- Training, awareness raising, processes and practices	- Annual documentation audit, caseload reviews, completion of MCA4 as appropriate	Ongoing

GOAL	ACTION REQUIRED	LEAD	HOW WILL THIS BE ACHIEVED	HOW WILL THIS BE MONITORED	TIME SCALE
care when a patient has reduced capacity	planning to meet their individual needs				
Audit To provide assurance that any new themes and actions identified from patient safety incident investigations are captured, addressed and improvements embedded	- All audit reports from patient safety incident investigation actions will be shared with the improvement group for review - To record areas of embedded improvement and consider how to support areas where further improvement is needed - To audit the actions identified on the falls improvement plan	Adele Archer, Sarah Yeomans	- Audit of lessons learned field in Datix - Audit of falls improvement plan	- Falls improvement group	Quarterly Annually

Appendix Thirteen– Serious Incidents/Patient Safety Incident Investigations by Quarter and Category

	2022 Q2	2023 Q2	2023 Q3	2023 Q4	2024 Q1	Total
Implementation of care or ongoing monitoring - other	1	0	0	0	0	1
Unexpected Death	0	1	0	1	0	2
Homicide	0	0	0	1	0	1
Self harm in primary care, or not during 24-hour care	0	0	1	0	0	1
Pressure sore / decubitus ulcer	0	0	2	0	0	2
Fracture - Discharge failed or delayed	0	0	0	1	0	1
Possible delay or failure to Monitor	0	0	0	1	0	1
Infection control	0	0	0		1	1
Total	1	1	3	4	1	10

Appendix Fourteen– Serious Incident Causation and Contributory factors

Causation Factors	
Lack of identification of deteriorating patient	3
Infection	1
Lack of effective pressure ulcer or falls management	1
Risk Assessment not completed / patient risks not identified	1
Failure to follow policy or agreed procedure	1
Communication breakdown within LCH services	4
Communication - Breakdown with patient or carer	1
Delay in provision of equipment.	2

Contributory Factors/Themes	
Lack of reviewing clinical records	1
Patient concordance	2
Staff capacity issues	6
Failure to follow pressure ulcer prevention and management policy or agreed procedure	2
Lack of / inadequate staff training	2
Communication - Breakdown with external services	1
Failure to identify Risks	2
Documentation standards – missing information	1
Lack of case management	4
Patients mental capacity and escalation	2

Appendix Fifteen - Learning from closed Serious Incident Investigations

Learning from closed SIs
More reactive response to supporting patient with the management of their diabetes
Escalating postural drop to GP.
Recognising signs of deteriorating patient and completing a set of observations.
Highlight Key information as a high priority reminder so it shows on the electronic record
Knowledge of the switching opioid routes from sub cut to a patch and knowing when to seek specialist advice.
Escalation of patient concerns to the relevant clinicians.
Communicating via phone call rather than task when a patient is unwell.
Gaps in clinical support following the introduction of the triage hubs. To implement a shift lead role.
Equipment process from local stores needs to be more robust
Completion of MCA 4 when patients decline care
Caseload management or oversight from senior clinicians.
Communication, specifically escalation of concerns to include all members of staff including temporary/agency staff.
Thorough holistic assessments at initial visits.
Patients on amber pathway for pressure ulcer risk monitoring must have skin inspected at every clinical visit as per guidance
Staff must photograph any changes they observe in skin integrity.
Escalating delay in assessment for the hoist to clinical leadership team
PURM should be completed alongside Pressure ulcer prevention assessment.
Documenting patients discussed in handover.

Leeds Community Healthcare NHS Trust

Agenda item 2023-24 (144)

Public Board workplan 2023
Version 6: 20 03 24

Topic	Frequency	Lead officer	4 August 2023	6 October 2023	8 December 2023	2 February 2024	28 March 2024	7 June 2024	19 June 2024-Annual Report and Accounts only	2 August 2024	4 October 2024	6 December 2024
Preliminary business												
Declaration of interests table	every meeting (from April 2024)	cs						X	X	X	X	X
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X		X	X	X
Action log	every meeting	CS	X	X	X	X	X	X		X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X		X	X	X
Patient story	every meeting	EDN&AHPS	X	X	X	X	X	X		X	X	X
Quality and delivery												
Chief Executive's report	every meeting	CE	X	X	X	X	X	X		X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X		X	X	X
Performance brief:Measures for inclusion in the performance brief	Annual	EDFR					X					
Perfomance Brief: annual report	Annual	EDFR						X				
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X		X	X	X
Care Quality Commission inspection reports	as required	EMD										
Quality account	annual	EDN&AHPS						X				
Mortality report	4 x Year	EMD	X -Blue box		X main agenda from Dec 23	X		X		X		X
Staff survey	annual	DW					X					
Safe staffing report	2 x year Feb and August	EDN&AHPS	X			X				X		
System flow	Every meeting	EDO	X	X	X	X	X	X	X	X	X	X
Serious incidents report and patient safety report combined report from March 2023	2 x year (Mar and October)	EDN&AHPS		X -Blue box			X -Blue box				X -Blue box	
Patient experience: complaints and concerns report	2 x year (Feb and August Annual report)	EDN&AHPS	X Blue box Annual report			X				X Blue box Annual report		
Freedom to speak up report	2 x year (Feb and Aug)	FTSUG	X plus Annual report			X				X Annual report		
Guardian of safe working hours report	4 x year	GoSWH	X		X		X	X Plus Annual report		X		X
Patient Safety Incident Response Framework (Plan)	As required	EDN&AHPS				X						
Strategy and planning												
Organisational (Trust) priorities (for the coming year) for approval	Annual March	EDFR				Draft Taken at Board Workshop January 2024	Final X					
Trust priorities update quarterly report	3x year February/June/Oct	EDFR/EDN&AHPS		X		X		X			X	
Third Sector Strategy	2x year (February and August)	EDO	X			X				X		
Estate Strategy	4xyear (Mar, Aug, Oct and Feb)	EDFR	X Blue box item -deferred to October 2023	X Blue box item deferred to December 2023	X -Blue box		X -Blue box			X Blue box item	X -Blue box	
Digital Strategy	2x year To be confirmed	EDFR		X Blue box item deferred to December 2023	X Blue box item deferred to February 2024	X Blue box item deferred to March 2024	Deferrred to June	X			X -Blue box	
Business Development Strategy	2x year(March and October)	EDO		X -Blue box taken in private			X -Blue box - taken in private				X -Blue box	
Business Intelligence Strategy	2x year First presented Feb 2022 and August	EDFR	Deferred									
Learning and Developement Strategy	2x year (March and October)	EDN&AHPS		X Blue box item deferred to December 2023	X Blue box item deferred to February 2024	X Blue box item deferred from March 24	X -Blue box				X -Blue box	
Engagement Principles	2xyear (March and October)	EDN&AHPS		X			X				X -Blue box	X -Blue box
Patient Safety Strategy	2xMarch/October	EDN&AHPS		X			X				X	
Health Equity Strategy	3 x year(March, August and December)	EMD	X		X		Write up from Board Workshop via email X			X		X
Children, Young People and Families Strategy	2xyear - Feb and August	EDO	X -Deferred to October Blue Box	X -Blue box		X Blue box item deferred to March 24	X - Blue box item			X -Blue box		
Quality Strategy	2xyear May and December	EDN&AHPS			X - Blue box item			X - Blue box item				X - Blue box item
Workforce Report and Strategy update	3x year Aug,Dec and June (from 2024)	DW	X - Blue box item		X - Main agenda item Dec 23			X - Blue box item		X - Blue box item		X - Blue box item
Research and Development Strategy	annual	EMD				X Blue box						
Governance												
Medical Director's annual report	annual	EMD	X							X		
Nurse and AHP revalidation	annual	EDN&AHPS	X							X		
Well-led framework	as required	CS										
Annual report	annual	EDFR							X			
Annual accounts	annual	EDFR							X			
Letter of representation (ISA 260)	annual	EDFR							X			
Audit opinion	annual	EDFR							X			
Audit Committee annual report (part of corporate governance report)	annual	CS						X				
Standing orders/standing financial instructions review October	annual October	CS		X - deferred to December 2023	X - deferred to February 2024	X					X	
Annual governance statement (Presented with Annual Report and Accounts)	annual	CS							X			
Going concern statement (part of corporate governance report March)	annual	EDFR					X					
Code of Governance compliance	annual	CS					X	X				
Committee terms of reference review	annual	CS					X	X				
Register of sealings	4 xper year	CS	X		X		X			X		X
Risk appetite statement (part of corporate governance report March)	annual	CS					X					
Declarations of interest/fit and proper persons test (part of corporate governance report March)	annual	CS					X					
Board Assurance Framework -process update (July Audit Committee)	annual	CS	X - Blue box item							X - Blue box item		
Information Governance Annual Report	annual	EDFR				X						
Reports												
WDES and WRES -annual report and action plan	annual	DW		X							X	
Equality and diversity - annual report combined with WDES and WRES from 2023	annual (Dec)	DW										
Sustainability report (Annual Green Plan)	2xyear (March and October)	EDO		X Deferred to December 2023	Deferred X June 2024			x			X	
Non-Executive Director Service Visits Report	3xyear (June, October,February) from June 2024	EMD						x First Report				
Safeguarding -annual report	annual	EDN&AHPS	X							X		
Health and Safety Annual Plan	Annual	EDFR	X - Blue box item							X - Blue box item		
Infection prevention control assurance framework	2x year(October and March)			X -Blue box			X -Blue box				X -Blue box	
Infection prevention control annual report	annual (August)	EDN&AHPS	X deferred from March 2023							X		
Policies reserved for Board approval												
Business Continuity Management Policy	as required	EDO										
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR										
Policy for the Development and Management of Policies (3 yearly)	(Next due for review Jan 2026)	EDN&AHPS										
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Oct 2025)	CS										

Key

CE	Chief Executive
EDFR	Executive Director of Finance and Resources
EDN	Executive Director of Nursing
EDO	Executive Director of Operations
EMD	Executive Medical Director
DW	Director of Workforce
CELs	Committees' Executive Leads
CS	Company Secretary

= received
= deferred to another meeting
= not required